BEYOND CONFLICT

GDC

GLOBAL DEVELOPMENT CONSORTIUM

IMPACT REPORT AND RECOMMENDATIONS

Training on Mental Health and Psychosocial Support for NGO Frontline Staff Working in Rohingya Refugee Camps

The Rohingya Refugee Pilot Project, Cox's Bazar, Bangladesh, by Beyond Conflict and Global Development Consortium

2021

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Training on Mental Health and Psychosocial Support for NGO Frontline Staff Working in Rohingya Refugee Camps: Report on Pilot Project undertaken at Cox's Bazar, Bangladesh, by UK charity Beyond Conflict, and Global Development Consortium (2021)

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Foreword

EDMUND NEWELL
CHAIR, BOARD OF TRUSTEES, BEYOND CONFLICT

Beyond Conflict would not exist had it not been for a refugee. The young woman had been invited to the UK to speak at a conference about the impact of the ISIS attacks on Yazidis in northern Iraq. In a private conversation, Edna Fernandes, who had been deeply moved by meeting her, asked what was most needed in the refugee camp to which she was about to return. Her answer was clear and simple: mental health care.

The need for mental health care in refugee camps is enormous, but the resources are scarce. What is more, those in the best position to help – frontline workers for non-governmental organisations – can also suffer from mental ill-health because of the situations and conditions in which they work. They, too, need help for their own welfare and to ensure they are fit and able to carry out their essential work to care for others.

The ambition of Beyond Conflict is to develop a simple and effective way of scaling up mental health care for people in desperate need of help who are living and working in the most difficult of settings in which to obtain it. Our approach is to help those already working on the frontline. By forming strategic partnerships, we can provide training and resources to enable them to maximise the help they can give to those in need, and at the same time 'care for the carers'.

We are delighted to be working with the Global Development Consortium on our pilot project in Cox's Bazar, Bangladesh, and are particularly grateful to Golam Abbas and Dr Abdul Saleh, without whom the project would not have been possible. The report that follows is highly encouraging. We feel we have taken the first significant step in realizing the vision of that young woman, who speaks for the millions of people who suffer from mental illness because of warfare and conflict.

> "The ambition of Beyond Conflict is to develop a simple and effective way of scaling up mental health care for those living and working in the most difficult of settings in which to obtain it."

Foreword

M GOLAM ABBAS
FOUNDING DIRECTOR, GLOBAL DEVELOPMENT CONSORTIUM

The tragic history of the Rohingyas, coupled with camp conditions and now the Covid-19 pandemic, have placed refugees and those serving them at an enormous risk from trauma and mental health crises. It is important for local non-governmental organisations (NGOs) who work in refugee camps to understand how to support the psychological wellbeing of their staff, who are constantly exposed to traumatic working conditions. These employees have little or no training in how to prepare for or cope with the emotional impact of their working environment.

Considering the "need to equip those to assist others", the UK charity Beyond Conflict and the Global Development Consortium (GDC) agreed to undertake a pilot project to train frontline NGO staff working in Cox's Bazar, Bangladesh refugee camps. The pilot demonstrated the value and usefulness of the three main components of the project: frontline staff training, the telephone support hotline, and the referral pathway for refugees. The project highlighted the personal and domestic stresses endured by the frontline workers, who mostly came from fragile and vulnerable backgrounds; also, the unique mental trauma and stress of working with refugees in camp settings.

The findings of the pilot revealed that there is an urgent and continued need for mental health training and support for frontline workers who work with displaced, traumatized, and incredibly vulnerable populations. This is even more urgent after the public health impact and restrictions of the Covid-19 pandemic.

Whilst Covid-19 posed a significant challenge in the scope and conduct of this pilot project, it also provided an opportunity to develop a digital and remote basic mental health programme for frontline workers to receive mental health training and support during a pandemic. The lessons learned from implementing this remote facility can inform and drive interventions in future.

I am indebted and would like to profoundly thank Beyond Conflict for its interest and support to the first ever pilot project of this kind in Bangladesh. GDC is looking forward to embarking on a substantive joint cooperation with Beyond Conflict, especially, to build the capacity of local NGOs in the field of mental health support, which will cascade down to benefit Rohingya refugees.

> "Mental health support should be a basic right, not a luxury. We must leave no one behind. Let's change the attitude on mental health. Equipping NGO frontline workers will enhance their ability to help others."

Abstract

BACKGROUND

A total of 1.1 million Rohingya refugees reside in Cox's Bazar district; the largest concentration of a refugee population globally. Over 70% of refugees are women, children, and elderly persons. This is a highly vulnerable community. The historic circumstances, camp environment, and current climate have placed Rohingya refugees at enormous risk of mental health crises. It is also important for local non-governmental organisations (NGOs) who work in refugee camps to understand how to support the psychological well-being of their staff who are exposed to traumatic working conditions. These employees have little or no training in how to prepare or cope with the emotional impact of their working environment. This is why the UK charity Beyond Conflict (BC) collaborated with the Global Development Consortium (GDC) in Bangladesh to support the current project. The two objectives of this pilot project were:
1. To provide basic mental health support and training to frontline staff.
2. To equip the trained frontline staff to identify refugees who require mental health support and refer these refugees to mental health experts for the necessary support.

METHODS

A four-month pilot project was conducted with a selection of frontline NGO staff working in Cox's Bazar refugee camps in Bangladesh. The project Directors were Mr Golam Abbas (former Country Manager, United Nations High Commissioner for Refugees) and Dr Abul Hussain Mohammad Saleh (British Bangladeshi leading mental health expert and consultant for GDC). Participants received a total of 10 hours of remote mental health training across 5 sessions (each 2 hours in duration). The training was delivered in the local Bengali language. The training content helped promote understanding of mental health needs of frontline workers and mental health support for refugee clients. A remote hotline was established for training follow-up, to support frontline workers who encountered stress and for guidance on how to refer refugees for mental health support from existing accredited aid agencies on the ground. The training was evaluated using a post-training evaluation questionnaire designed prior to the implementation of the project.

RESULTS

A total of 37 frontline staff participated in this pilot project (59% male, 41% female), across 7 local Bangladeshi NGOs. Of these, 17 participants (47%) completed and submitted their post-training evaluation questionnaire. The mean age of participants who completed their questionnaire was 38 years (range: 24 to 65 years). Most participants reported a university-level education (n=13, 76%). Participants reported that they live with an average of 6 people. When asked to what extent specific factors negatively impact their well-being, most participants gave highest ratings for their JOB (41% reported moderate impact), HEALTH (59% said moderate or a lot), and FINANCES (89% reported moderate or a lot). Most participants (59%) had not received any mental health training or trauma counselling before the current training. All 17 participants said that they found the training to be helpful. In answer to whether/to what extent the training helped them to identify trauma counselling needs of refugees, most participants reported that the training had helped a lot (47%) or moderately (29%). Participants were asked whether they would require hotline advice before referring or if they felt able to directly refer clients without hotline advice; the vast majority of participants said that they would require hotline advice (n=15, 88%). The trainer referred three participants for further and regular mental health support during this pilot project; including a young man who had attempted suicide twice.

DISCUSSION AND CONCLUSIONS

This project highlighted the unique mental trauma and stress of both working with Rohingya refugee populations and of refugees living in this camp. The pilot demonstrated the value and usefulness of the three main components of the project: frontline staff training, the telephone support hotline and the referral pathway for refugees themselves. The project also highlighted the personal and domestic stresses endured by the frontline workers, all of whom came from fragile and vulnerable backgrounds: the local Bangladeshi community is already struggling with personal poverty, uncertain employment and finances, and inadequate public services.

There is an urgent and continued need for mental health training and support for frontline workers who work with displaced, traumatized, and incredibly vulnerable populations. This is even more urgent after the public health impact and restrictions of the Covid-19 pandemic, which continues to have a unique impact on the mental health of frontline workers and refugee populations.

Whilst Covid-19 posed a significant challenge in the scope and conduct of this pilot project, it also provided an opportunity to develop a digital and remote basic mental health program for frontline workers to receive mental health training and support during a global pandemic. The strengths, limitations, and lessons learned from implementing this remote facility can inform and drive both remote and in-person mental health programs for local NGO frontline workers in future.

Background

The Rohingya people have faced decades of systematic discrimination, statelessness and targeted violence in Rakhine State, Myanmar (Joint Response Plan, Rohingya Humanitarian Crisis, 2020). In Myanmar, entire villages were burned to the ground, families were separated and killed, and women and girls were gang raped. Most of the people who escaped were severely traumatized after experiencing and witnessing unspeakable atrocities.

Between August and September 2017, over 870,000 Rohingya refugees entered Bangladesh to fleeing from mass killing, military attack, rape and the systematic massacre inflicted by the Myanmar Army in the Rakhine State, where the Muslim majority population lived for many generations. The newly arrived Rohingyas joined those who arrived over the past decades. Currently, a total of 1.1 million Rohingya refugees reside in Cox's Bazar district, in a cluster of 35 makeshift camps (covering an area of 15 square kilometres); the largest concentration of a refugee population globally. The United Nations has characterized the Rakhine situation as a "Text Book Genocide Case".

The people and Government of Bangladesh continue to show enormous generosity to host the repeated influx of Rohingya refugees over the past 40 years, often at the cost of its national security interests. In addition to the demographic imbalance, pressure on local infrastructure and environmental degradation, this large vulnerable population is targeted for human trafficking, smuggling, drugs and narcotics dealing, as well as targeted by regional and global terrorist rings to serve their ill motives.

The majority of refugees (over 70%) are women, children, and the elderly. Many are single-mothers, orphans, or members of female-headed families, all of whom depend solely on external assistance. This is a highly vulnerable community. The UN reports revealed that over 60,000 babies were born during the first half of 2018, with a considerable number as "war-babies". These children are the outcome of rapes mainly by the Myanmar military but also by other criminals preying on the community which occurred before women were driven out of their ancestral land. Within the camps, abduction and rape and sexual exploitation of toddlers and young girls is very common, creating an atmosphere of intense fear.

The refugee hosting communities in the south-eastern part of Bangladesh are equally in need of basic living and livelihood assistance. Like elsewhere, at the onset of refugee influx, the local population in Cox's Bazar shared their meagre resources with the newly arrived refugees, until the arrival of external assistance. Unfortunately, over the years the international assistance dropped drastically (in 2020 only 50% of the total refugee needs were funded). In 2021 thus far, only 16% of donor funding received covers basic needs (e.g., food, water, health, shelter).

The Covid-19 pandemic continues to seriously affect the donations for refugee operations. Due to funding shortages, often the basic daily refugee assistance has been reduced to a bare minimum, resulting in an immediate cut down of services considered "non-essential", like education, community services and individual and group assistance targeted to the most vulnerable populations (i.e., elderly, orphan and those suffering from mental and psycho-social issues). Furthermore, the community has been re-traumatized as a result of a fire which swept through Cox's Bazar in March, killing at least 11 people and making more than 45,000 homeless.

> "Services to support refugee mental health and combat and prevent trauma are very limited. This places an additional burden on the frontline workers who support the refugees."

The historic circumstances, camp environment, and current climate have placed Rohingya refugees at considerable risk of mental health crises. But Rohingya refugees may not seek formal help for mental health problems, partly because of a limited familiarity with concepts of mental health and counselling, and knowledge of where to seek services, but also because of stigma and feelings of shame associated with mental illness. The entire refugee population depends solely on external assistance and donor support for their daily survival needs. The lack of basic resources continues to push mental health needs further down the priority list. Services to support refugee mental health, and to combat and prevent trauma, are very limited. This places an additional burden on the frontline workers who support the refugees.

WHY FOCUS ON FRONTLINE WORKERS?

It is important for local non-governmental organisations (NGOs) who work in refugee camps to understand how to support the psychological wellbeing of their own staff who are exposed to traumatic working conditions. These employees have little or no training in how to prepare for, or cope with, the emotional impact and demands of the working environment, as well as with their own personal and family concerns. The mental health of frontline workers is negatively impacted by the pressures of being under-resourced and of responding to the needs and distress of refugees round the clock. Frontline and key workers, especially those in social care roles, are often worried about their own vulnerability, and experience additional stress because they have to offer psychological and practical support for traumatised refugees as part of their work. Employees who are in roles where they are exposed to new or additional trauma may therefore have a higher risk of mental ill-health, such as depression, anxiety and post traumatic stress disorder (PTSD), which could result in long-term mental and physical sickness absence, either now or when existing crises have passed. It also means frontline workers are poorly equipped to support their own refugee client base, when confronted with mental health issues inside the camp.

This is why the current project focuses on supporting the mental health of frontline workers in the first instance. It enables them to support themselves and continue to do their job effectively, whilst providing a better understanding of the mental health needs of the refugees.

> "The mental health of front-line workers is negatively impacted by the pressures of responding to the needs and distress of refugees."

NGOs AND THEIR LIMITATIONS

The NGOs selected to participate in this project all operate on a shoestring budget at grassroots level, and are the local players engaged in daily activities in the camps. None of the selected NGOs are in a position to provide Mental Health Psychosocial Support (MHSSP) support to their workforce. The NGO frontline staff are low paid, often on short term contracts with no certainty of renewal and have to deal with their own work and familial issues, as well as regularly encounter/listen to the traumatic stories of vulnerable refugees, which further drains their personal emotional energy.

Interventions on mental health issues in general are complex and diverse in nature, especially in displaced people or refugee settings. They also lack sufficient resources to cover the huge needs and often require prolonged expert intervention. Presently, some UN agencies and international NGOs with large operations in the camps only provide mental health and psychosocial support in the form of policy formulation, training and guidance as part of staff welfare to their workforces. The local NGOs cannot afford to provide mental health support to their frontline staff, who are expected to provide quality care and services to a large number of refugees in the camps. The huge MHSSP need vis-à-vis the excess to current support is woefully insufficient. This is a global phenomenon and a challenge faced in many refugee operations, where mental health issues are put aside to prioritize basic physical needs.

BEYOND CONFLICT AND GLOBAL DEVELOPMENT CONSORTIUM COLLABORATION

The UK charity Beyond Conflict collaborated with the Global Development Consortium (GDC) in Bangladesh to implement a four-month pilot MHPSS training project for a selection of frontline NGO staff working in Cox's Bazar refugee camps in Bangladesh: https://globaldevelopmentconsortium.co.uk/rohingya-mental-health-project/.

/ Background

PILOT PROJECT OBJECTIVES

The primary objective of the pilot project was to provide basic mental health support and training to frontline staff (e.g. health professionals, community workers), in 7 local Bangladesh NGOs, who provide support to the residents of Cox's Bazar. This training aims to equip frontline staff with knowledge and understanding of basic mental health and psychological issues, so that they can deal more effectively with their own mental and psychosocial concerns, as well as that of their immediate family members and peers.

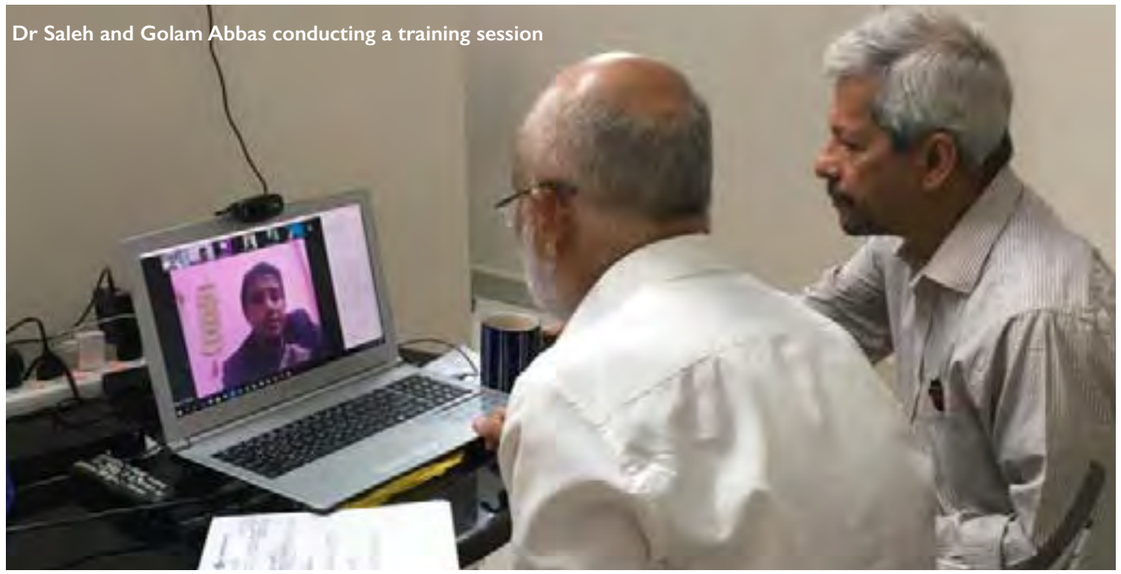
The secondary objective of the pilot project was to equip the trained frontline staff to identify refugees who require mental health support and refer these refugees to service providers/professional mental health support workers (whilst ensuring confidentiality) for the necessary support.

PILOT PROJECT ADAPTATION AS A RESULT OF COVID-19 CHALLENGES

Ideally, the MHPSS training would have been organized in Cox's Bazar Refugee Camp (close to point of delivery) by gathering all the participants in one place. Refugee representatives would also have been invited to attend the training sessions to listen to and learn from the stories/problems frontline workers and refugees commonly experience. In-person group discussions would have been arranged to agree on joint strategies and develop a Plan of Action, which would provide a holistic approach to support and assist mental and psychosocial issues. However, due to the Covid-19 pandemic, it was not possible to organize face-to-face group training as initially planned. Therefore, a wider project was temporarily shelved until a suitable opportunity arises to implement it (subject to the availability of resources and Covid-19 restrictions easing).

The Covid-19 pandemic created extra anxiety for the refugee community and those who work for and with refugees, day to day in the camps. The pandemic continues to create anxiety and frustration among the staff and those around them, and ultimately could impact their motivation, performance and quality of work for refugees. Naturally, the caregivers need to be helped first, so they can continue to effectively serve refugees (World Health Organization, 2020).

At the request of Beyond Conflict, GDC adapted their initial project plans and developed a pilot project with the expectation to:
i) Support mental health and psychological needs of NGO staff (i.e. frontline workers);
ii) Create a-24-hour advice hotline for the frontline workers;
iii) Establish a pathway for refugees to access mental health support from existing accredited aid agencies on the ground in Cox's Bazar refugee camp.



Dr Saleh and Golam Abbas conducting a training session

Methods

TRAINER

Dr Abul Saleh is a committed mental health expert, with over three decades of National Health Service (NHS) experience. He also has extensive experience of trauma counselling within the Cox's Bazar refugee camp. Previously, he was the Lead Consultant hired to implement a similar project on "Staff Mental Health Support" for Action Contre la Faim (ACF – Action Against Hunger, a French NGO) staff and refugee volunteers in Cox's Bazar, Bangladesh, over an 18-month period (October 2017 to March 2019). This resulted in several thousand people receiving training.

Under the Beyond Conflict/GDC project, Dr Saleh conducted the pilot training sessions and attended the Hotline by providing on-call support to the project participants. In addition to his other training and hotline responsibilities during the day, he attended the hotline for an average of 2.5 extra hours per evening for free (and has continued to do so since the project completed).

PILOT PROJECT DURATION AND DURATION OF TRAINING SESSIONS

The pilot training took place over a four-month period, from 15th October 2020 to 15th February 2021. Participants received a total of 10 hours of training across five sessions (i.e. each training session lasted two hours), which were delivered in Bengali language.

PARTICIPANTS AND PARTICIPATING NGOS

A total of 37 frontline staff members were identified across seven national NGOs and participated in this project, namely:
- Meghna Social Health and Development Foundation
- MUKTI
- Hope Foundation
- PULSE
- Coast Foundation
- Young Persons Social Action (YPSA)
- AGRAJATTRA

The frontline staff selected to participate in the pilot training sessions were those who regularly visit camps and are in direct contact with the refugee community.

TRAINING DELIVERY LOCATION

Prior to the Covid-19 pandemic, the training was intended to be delivered in-person with all participants gathered in one location. However, due to the movement and access related restrictions imposed by the pandemic, virtual training was conducted from Dhaka using Zoom calls. The participants attended from their own location, respecting movements and health restrictions imposed in Cox's Bazar.

TRAINING CONTENT

The training content included inter alia group discussions about expectations of training, 1:1 sessions, workshops, case studies, question and answer sessions, referral and individual problem-solving techniques. Participant confidentiality was maintained at all times.

Over three months of online training, a 24-hour Hotline was used for follow-up and assessments on the effectiveness and impacts of training as well as troubleshooting during the fourth month of the project.

The training was structured and delivered as follows:
- promote understanding of mental health;
- promote understanding of mental health needs for self and others (including family members, Peer, co-workers);
- promote understanding of mental health support for beneficiaries (ensuring confidentiality and without raising any expectations of material assistance); and
- promote understanding of referral pathway mechanism.

The above structure/topics were used for guidance, while the participants were encouraged to contribute and design the agenda for discussion according to their own needs and priorities based on their personal experiences, as well as their day-to-day exposures and inter-action with the refugees. As such, the training was guided by participants and tailored to their needs.

At the beginning of each Zoom session, a general lecture was delivered. The group then discussed substantive and unique points picked from the hotline dialogues. This covered the following areas of participants' ongoing work and areas where psychosocial and mental health support is needed in the camps:
- Adolescents with violent attitudes;
- Addiction and abuse of narcotic substances;
- Child marriage, and burden sharing at family level;
- Mass unemployment, domestic and gender-based violence;
- Anxiety related to on-going relocation to Bashan Char;
- Prevention of trafficking; social re-integration of those rescued.

/ Methods

TRAINING POST-EVALUATION QUESTIONNAIRE

Participants were encouraged to complete an anonymous post-training evaluation questionnaire (**see Appendix 1**). This questionnaire was written in English by the BC team, translated into the Bengali language by GDC, and administered in Bengali. GDC translated the participants' responses into English before sharing these with BC. Individual participant forms were collated and summarised (**see Results section**).

TRAINING ATTENDANCE

On average, at least 20 participants attended each session, depending on the internet connectivity and workload of the staff.

TRAINING FOLLOW-UP

A participants' WhatsApp group was created to allow for immediate and private follow up with Dr Saleh, as needed.

An additional "24-hour hotline" support service was set up, for the participating trainees to approach Dr Saleh for feedback, to discuss concerns, private mental health issues, and potentially refer candidates.

Results

POST-TRAINING EVALUATION QUESTIONNAIRE COMPLETION

Of the 37 participants who took part in the training, 17 (46%) completed and submitted the evaluation questionnaires.

DEMOGRAPHICS

Of the 17 participants who (at least partially) completed their questionnaires, the majority were male (10 males [59%], 7 females [41%]). The mean age was 38 years (range: 24 to 65 years). The majority of participants reported that they were married (n=11, 65%), whilst the remainder reported that they were unmarried (n=6, 35%). The majority of participants had a university level education (n=13, 76%) whilst a minority reported only secondary or high school level education (n=4, 24%). Participants reported that they live with an average of 6 people.

FACTORS THAT AFFECT WELL-BEING

Participants were asked to what extent their health negatively impacts their mental well-being; 24% (n=4) said not at all, 18% (n=3) said a little, 47% (n=8) said moderately, and 12% said a lot (n=2).

Participants were asked to what extent their job negatively impacts their mental well-being; 12% (n=2) said not at all, 47% (n=8) said a little, and 41% (n=7) said moderately.

Participants were asked to what extent their family relationships negatively impact their mental well-being; 24% (n=4) said not at all, 59% (n=10) said a little, 12% (n=2) said moderately and 6% (n=1) said a lot.

Participants were asked to what extent their finances negatively impact their mental well-being; 6% (n=1) said a little, 65% (n=11) said moderately and 24% (n=4) said a lot.

RESPONSES FROM AND NEEDS OF FEMALE PARTICIPANTS

Of the 17 participants who completed the questionnaire, females were the minority (n=7, 41%).

Of the participants who were educated to secondary or high school level (n=4/17), the majority were female (n=3/4).

In response to the request to describe some of the client problems that frontline workers deal with, one female participant reported that clients "Do not give importance to women's opinions. Physically, emotionally and sexually tortured by human traffickers. Ability to take any decision due to lack of freedom of women.

PARTICIPANT DESCRIPTIONS OF CLIENT PROBLEMS

In a free text field, participants were asked to describe some of the refugee problems. Of those who responded, below are verbatim (translated) examples of their responses:

"The distressed condition makes most of them seem to be going through mental stress and pressure. Sometimes few clients get terrified while explaining the incidents that happened to them. They are mentally traumatised as some saw their mother, some saw their father, some brother, sister, babies getting murdered in front of them."

"Physically, emotionally and sexually tortured by human traffickers."

"Child labour, child marriage, child mother, sexual harassment, trafficking, orphan, autism, mental distress, unnecessary fear."

"Some time I am face angry client. Who are not listen good advice easily."

"… previous exploitation, stress and violence, which is [what] they have faced in their own country. Some of them they have lost wealth, livelihood activities, parents and kids and family members in their own eyes. Some of them are facing unemployment and movement restriction… polygamy, early marriage, unequal marriage, sexual violence, sexual abasement and family violence. In time of Covid-19 situation maximum patient are facing early marriage, unequal marriage, sexual violence, sexual abasement and family violence in camp level and on the same in the host community patients also."

"Clients want money from me."

"Being unable to treat patients with mental disorder. Unsuitable environment for providing outreach and appropriate counselling. Repetition of same condition of malpractice patients even after counselling them in different ways. Even after explaining that mental disorder is an illness to the relatives of the patient, they do not want to understand. Like assuming it to be the effects of jinn/ghost possession they become victim of malpractice."

"Domestic abuse."

"Financial problems. Low earning from job and business."

"The client feels depressed and face physiological problems due to unemployment and sufficient assistance e.g. food, sanitation, nutrition and security, etc."

Being unaware of the skills and power of women."
In response to the question on whether participants had any suggestions on how to resolve/mitigate their problems, two female participants reported that they worried about the safety of transportation when visiting the camps. No males reported worries around transportation in response to this question.

In response to the question "What sort of support do you get from your employer to help you deliver your job (if any)?" two female participants reported that their employers are receptive to their childcare needs by allowing for them to log out from the office early if they have finished their official work.

The trainer, Dr Saleh, reported that, to protect their safety, women were given guidance on dress code and their work schedules were adapted (i.e. working during the day).

ADDITIONAL STRESS BECAUSE OF WORKING WITH REFUGEES

On a scale of 1 to 5, participants were asked to describe the additional stress they experience as a result of working with refugees, where 1 refers to no extra stress and 5 refers to extreme stress. The average response was 3. One training participant told Dr Saleh in person that such training was vital as "it helps me be sane in my job".

PREVIOUS MENTAL HEALTH TRAINING/ TRAUMA COUNSELLING

A total of 10 participants (59%) said that they had not received any mental health training or trauma counselling before the current training, and 6 participants (35%) said they had received some form of training before. One participant did not respond.

TRAINING EVALUATION: USEFULNESS

All 17 participants who completed the questionnaires said that they found the training to be helpful; with 9 (53%) saying that they would need more guidance and 6 (35%) saying that they found the training to be extremely helpful and would be willing to share what they learned.

TRAINING EVALUATION: ADDITIONAL SUPPORT NEEDS

Participants were asked if they found the training to be of help, and if so, what kind of support they would need to support their needs. A total of 6 participants (35%) said that would require booster/additional training, 4 participants (24%) said they would like continuing access to an advice line, and 2 participants (12%) said they would like regular one-to-one counselling. Two participants (12%) said they would like both regular one-to-one counselling and booster/additional training.

TRAINING EVALUATION: IDENTIFICATION OF CLIENT NEEDS

Participants were asked whether/to what extent the training helped them to identify trauma counselling needs of clients (i.e. not at all, a little, moderately, a lot). The majority of participants reported that the training had helped a lot (n=8, 47%) or moderately (n=5, 29%). A total of 3 participants reported that the training helped a little (18%).

TRAINING EVALUATION: APPROACHING COLLEAGUES

Participants were asked to indicate how confident they felt in approaching relevant colleagues offering extra mental health support to their clients. All participants said they felt either confident (n=12, 71%) or very confident (n=4, 29%) doing this. One participant left a blank response.

TRAINING EVALUATION: HOTLINE ADVICE

Participants were asked whether they would require hotline advice before referring or if they felt able to directly refer clients without hotline advice. The majority of participants said that they would require hotline advice (n=15, 88%), whilst 1 participant (6%) said they would not require advice, and one participant left a blank response.

A total of 6 participants (35%) said they would want the hotline advice line to run between 09:30-12:00, 5 participants (29%) preferred 13:00-17:00, and 4 participants (24%) preferred 18:00-20:00. Two participants left a blank response.

REFERRALS FOR FURTHER MENTAL HEALTH SUPPORT

The trainer said three participants were referred for further mental health support during this pilot project under its referral pathway. Some are referred for additional social services support, which can be monetary, and therefore contribute to the easing of mental health strain. He considered the reasons for these referrals to be common and typical of working with this population. Further details on these three referrals are provided below:

- A young man who was struggling with his mental health and sexual orientation. He faced pressure to marry and attempted suicide twice. The trainer advised for him to see a psychiatrist for regular mental health support and counselling. The participant now receives free counselling and psychological support and his mental health has stablised.
- A young woman whose husband was domestically violent. The trainer advised for her husband to be sent to hospital for drug addiction.
- A young woman with 3 or 4 children who cares for her father, who suffers with mental health issues. Her mother has died. The trainer advised that she attend government approved social services. She now receives financial support, equivalent to £50 per month.

SUMMARY OF FINDINGS IN CONTEXT OF INITIAL OBJECTIVES

The primary objective of this pilot project was to provide basic mental health support and training to frontline staff who work for local NGOs in Cox's Bazar refugee camp in Bangladesh. This objective was addressed by providing 37 frontline staff (from seven local NGOs) with mental health support and training during the course of this pilot project, followed by a 24-hour advice hotline for any follow-up support and guidance. This pilot project was locally led by a trained mental health professional, Dr Saleh. This training focused on improving knowledge and understanding of basic mental health and psychological issues, so that frontline staff could more effectively deal with their own mental and psychosocial concerns, as well as those of their immediate family members and peers.

The secondary objective of the pilot project was to equip the trained frontline staff to identify refugees who require mental health support and refer these refugees to service providers/ professional mental health support workers for the necessary support (whilst ensuring refugee confidentiality). As part of this pilot project, frontline staff did not provide any direct support or intervention to the refugees. NGO workers are not sufficiently trained to support refugees directly, but the knowledge gained from the training may be helpful in identifying simple mental health cases among the refugees, which frontline staff could bring to the attention of their managers who can direct the refugees to the relevant professional caregiving agencies. Identification, reporting and referral of mental health issues is complex and must be conducted by a fully qualified professional, ensuring full confidentiality to protect participants from harm and avoid possible stigmatization. Dr Saleh repeatedly discussed this process with the trainees. The trained NGO staff were provided with information that served as a conduit to the referral pathway for individual refugees in need of mental health support.

STRENGTHS OF THE PILOT PROJECT

The pilot provided basic mental health support for NGO workers who were struggling during the Covid-19 pandemic with their own mental health. This pilot also created a pathway for NGOs and refugee clients to access existing mental health support already approved by the government within the camp. Broadly all participants reported that their main objectives had been fully or partially met and that they had personally benefitted from the training, that they were more confident in dealing with familial problems as well those of the refugees. The 24-hour hotline proved particularly valuable, and all the respondents said they had used it. Dr Saleh reported that it was also used by those who had not responded to the questionnaires. All frontline workers requested continued availability of the hotline and most requested booster training.

> "All frontline workers requested continued availability of the hotline and most requested booster training."

Dr Saleh agreed to provide counselling and consultation, if any pilot project participants approach him in future. This project improved understanding of and access to mental health support in this highly vulnerable community.

LIMITS OF THE PILOT PROJECT

- Online sessions limit understanding of non-verbal communication: Because the project was delivered online, the nuance of the in-person interaction between the participants and the trainer could not be used to supplement the training. For example, body language could not be read as easily in an online format and this may have provided detail on any distress participants were experiencing.

- Validity of participant responses: Participant responses for specific questions highlighted inconsistencies in responses between questions for the same participants. For example, some of those who reported the worst personal pressures or health problems, indicated that personal pressures had little or no bearing on their mental health. This highlights that the participants may have misunderstood the questions and/or there may have been problems with transcription/translation. This questions whether the responses truly reflect what the participants meant.

Even in the 17 participants who attempted to complete the questionnaire, several participants did not complete the free-text field responses; they only completed structured questions with pre-defined response options that required a tick box. This is largely why all the responses to the questions detailed in Appendix 1 have not been summarized in the Results section of this report. To avoid this low response rate and incomplete completion in future, the questionnaire will be administered during the final training session, with support from project trainers.

/ Discussion

WIDER ISSUES: GDC CANNOT DIRECTLY INTERVENE BETWEEN FRONTLINE WORKERS AND THE NGO

The majority of local NGO frontline staff are on a temporary employment contracts, have no job security and are not entitled to pension benefits. The limited funds raised locally by the NGOs are to benefit refugees, not to spend on agency overhead costs. This limits any planned activities for the NGO frontline staff. Low staff morale, frustration and working under pressure are some of the major complaints amongst staff. Sexual harassment of female staff, discrimination and lack of respect in workplace settings and around camp areas are other core challenges faced by the staff.

Unfortunately, GDC is not in a position to resolve or directly intervene in staff complaints about the NGO. Even raising broader issues with NGO employers after this project that involved a small number of participants from each NGO would potentially make individual participants identifiable, which may threaten their job security and work relationships. Feeding back to the employers would be possible in future if the project were large enough such that the NGOs could not identify individual participant identity. If GDC agrees with the NGOs to implement activities in future, a standard Code of Conduct will be implemented for all concerned parties and an MOU between GDC and the NGOs setting out and agreeing on the responsibilities of each party.

HOW WOULD THE SAME/SIMILAR PROJECT BE IMPROVED IN FUTURE?

Training sessions should be recorded and archived (with the permission of the trainers and trainees) to improve access to the content for participants who were not able to attend the live sessions. Furthermore, if sessions were recorded and made available to trainees who attended, this would provide the opportunity for participants to listen again to improve their learning and reinforce training.

Once the restrictions imposed by the Covid-19 pandemic are lifted, future training should be delivered in person. This will enhance interaction between trainers and trainees and between trainees, and enable sharing of cases, problems and approaches. In-person sessions should be supplemented by the facility to listen at leisure to recordings of the live sessions to reinforce training and understanding.

The training should reflect evidence-based practice and participants should be provided with paper/online materials on the training content. This will enable them to reflect on the training, refer back to the training, and revisit and re-learn the contents of the training, when needed during the project and afterwards. Participants should also be provided with the contact information of the trainers should they have any questions or queries on the training and its implementation.

The post-evaluation questionnaire should be administered in the final training session to facilitate a higher response rate. Participants should have the opportunity to ask questions on the questionnaire to ensure they have understood the questions (without leading their responses). The questionnaire should include an additional question to explore why participants undertook the training. Once the participants have completed their questionnaire, a trainer should check their questionnaire to ensure that all required fields are complete, and to provide the opportunity for participants to ask for clarifications and/or further questions (without leading their responses).

Participants who complete the training should be provided with a training certificate to evidence that they have completed the training. This could encourage training completion and evaluation completion, and support future employment prospects. This was not possible this time due to the pandemic.

More than one trainer is needed to reduce burden on the individual trainer, share workload, and discuss complex cases. The trainer, Dr Saleh, has contacts in other specialties, including clinical psychology and university teaching, who could also conduct the training with Dr Saleh's oversight, if this project were extended in future.

(Recommendations , page 18).

/ Discussion (Recommendations)

RECOMMENDATION: PROVIDE MENTAL HEALTH SUPPORT FOR FRONTLINE WORKERS AND IMPROVE THEIR COMPETENCE TO SUPPORT REFUGEES

The recommendations for the way forward are based on participants' feedback, group and one-to-one discussions, and NGO input.

• **Mental health hub inside the camp:** There is a need to create one or two mental health hubs physically within the camp. This would allow for easier communication (between mental health trainers and frontline staff), which would help with facilitating training and follow-up sessions with frontline staff once the pandemic restrictions are lifted. It would also help in providing booster training for those already trained, and help to enable frontline staff who were not trained during the pilot project to receive training too. Sessions could also be held for employers within the NGOs to improve knowledge about the importance of supporting their frontline staff and improving their work conditions.

• **Continuation of Hotline and referral pathway:** Considering the interest shown and usefulness generated among the participants during the pilot phase, continuation of a permanent designated telephone Hotline and referral pathway mechanism should be considered.

• **Continue training:** Organize updated training for newly appointed local NGO staff; provide re-fresher training so that those who received training during the pilot phase can re-visit the training content and further improve their skills.

• **Organize discussions and motivational talks:** Using feedback from the frontline staff on the mental health issues they typically deal with when working with refugees, organise discussions on these specific topics.

• **Crisis counselling team for serious cases**: A crisis counselling team for adult men and women with severe PTSD, who suffer domestic violence, relocation anxiety, need more psychosocial support from the frontline staff/counsellors and mental health mentors, should be considered. A home-based crisis counselling team should be established with the frontline outreach workers. For example, training could be tailored to cater to the specific needs of elderly people.

RECOMMENDATION: PROVIDE DIRECT SUPPORT FOR REFUGEE COMMUNITIES

The government policy on access to the camps for provision of direct assistance and support to refugees requires formal approval by multiple entities. To obtain permission is time consuming and very bureaucratic. Considering the volume and scope of the planned intervention by BC, it is advisable to use local partner(s) for the delivery of project activities with clear guidance for the partners and participants.

• **Mental health ambassadors/volunteers:** Refugees, who wish to receive basic mental health training, could receive training to become focal points within their community so that specific mental health issues, including combatting stigma, can be flagged to relevant frontline workers/ senior staff. The refugees would be paid for this role. This will help to scale up mental health support in the camp by using refugee advocates, as well as help break down the mental health stigma within the community itself.

• **Formation of community support groups:** One of the frustrations felt by the frontline workers is their inability to assist their refugee clients directly. In response, youth, adolescent, young-mother, female-headed families, and elderly person forums may be created, where trained NGO staff and refugee volunteers can gather and interact at a community/social venue to discuss familial concerns. Social clubs could help develop peer support networks in the camp, reduce stigma, and cover a wide series of topics (e.g. child marriage, drugs and other addictions, domestic violence, concerns of young mothers). Structured activities for youth, adolescents, and other vulnerable parts of the camp population, may protect and distance these groups from unwarranted activities in and around the camps.

Frontline workers identified the value of establishing a club aimed at supporting mothers of war babies. These mothers' clubs could be based on cooking, sports, and craft and sewing, as ways of motivating people to attend and create community group(s) for sharing stories and lending mutual support. To encourage participation and retain participants on the activities, club participants could be provided with useful items (usually not part of assistance packages; e.g. hygiene and Covid-19 kits). For example, simple tools such as sewing kits, or pots and pans, may be given to the participants. Such informal forums help to build community cohesion, encourage continued participation, reduce boredom, provide support in an informal setting, develop leadership abilities, as well enhance peaceful co-existence and rebuild personal dignity and self-worth and confidence. This club would assist one of the most vulnerable groups of women refugees and their young children, and would require additional training for the frontline workers (e.g. club set-up and maintenance, identifying the specific mental health and trauma issues experienced by these mothers, and how to respond and tackle them). By helping set up and maintain such a club, both the frontline workers and the ultimate refugee clients are helped. It would also bind frontline workers closer to the people they are assisting.

Conclusion

With the support of Beyond Conflict, the Global Development Consortium implemented a pilot project to support the mental health of frontline staff in Cox's Bazar refugee camp in Bangladesh. The pilot demonstrated the value and usefulness of providing such training and ongoing support. The frontline staff work every day with Rohingya refugees who experienced significant trauma in Myanmar, which is exacerbated by living in Cox's Bazar.

This pilot project aimed to provide basic mental health support for frontline workers, and also to establish a remote mechanism by which frontline workers can continue to receive this support from trained mental health professionals during the course of their employment. The initial response from the frontline workers indicated that they and their families benefitted from the project and would welcome its continuation.

The project also established a referral pathway to enable refugees to be placed in contact with professional and approved mental health professionals inside the camp. In at least one case, this pathway provided urgent help for a suicidal refugee. In another case, it helped a refugee receive practical assistance from social services that alleviated mental health pressures.

The project highlighted the unique mental trauma and stress of both working with Rohingya refugee populations and of refugees living in this camp. Feedback to the pilot indicated that the pilot has been successful in helping people on the ground. Going forward, there is an urgent and ongoing need for mental health training and support for frontline workers who work with displaced, traumatized, and extremely vulnerable people. This is even more urgent after the public health impact and restrictions of the Covid-19 pandemic, which continues to have a unique impact on the mental health of frontline workers and refugee populations. There is little being done to support mental health during and after Covid-19 amongst frontline workers and refugees.

Whilst Covid-19 posed a significant challenge in the scope and conduct of this pilot project, it also provided an opportunity to develop a digital and remote basic mental health programme for frontline workers to receive mental health training and support during a global pandemic. The strengths, limitations, and lessons learned from implementing this remote facility can inform and drive both remote and in-person mental health programmes for local NGO frontline workers in future.

> “The initial response from the frontline workers indicated that they and their families benefitted from the project and would welcome its continuation.”

References

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World Health Organization (WHO). Mental health and psychosocial considerations during the COVID-19 outbreak: interim guidance. 2020. Accessed from: https://www.who.int/publications/i/item/WHO-2019-nCoV-MentalHealth-2020.1 [Accessed on 6 June 2021].

Appendix 1 (first of three pages)

POST-TRAINING EVALUATION QUESTIONNAIRE GIVEN TO PARTICIPANTS (TRANSLATED INTO BENGALI)

POST-TRAINING EVALUATION QUESTIONNAIRE

i. Age (in years)				
ii. Gender	Male	Female		
iii. Civil status (tick all relevant boxes)	Married	Unmarried	Widowed	Divorced
iv. Level of education	No formal education			
	Primary school			
	Secondary / high school			
	University (please specify degree level)			

v. How many family members live in your household?

vi. Please indicate which family members you live with (tick all relevant boxes).

Mother	Father	Sister(s)	Brother(s)
Son(s)	Daughter(s)	Husband	Wife
Other (please specify):			

vii. Who is responsible for household duties in your family? (tick all relevant boxes).

Me	Mother	Father	Sister(s)
Brother(s)	Son(s)	Daughter(s)	Husband
Wife	Other (please specify):		

viii. If YOU are responsible for household duties (e.g. caring, domestic, health-related) in your family, to what extent does this increase your stress?

Not relevant	Not at all	A little	Moderately	A lot

ix. If YOU <u>are not</u> responsible for household duties (e.g. caring, domestic, health-related) in your family, are you expected to contribute?

Not relevant	Not at all	A little	Moderately	A lot

x. To what extent does your HEALTH negatively impact your mental well-being?

Not at all	A little	Moderately	A lot
Briefly specify what these *health issues* are:			

xi. To what extent does your JOB negatively impact your mental well-being?

Not at all	A little	Moderately	A lot
Briefly specify what these *job-related issues* are:			

xii. To what extent do your FAMILY RELATIONSHIPS negatively impact your mental well-being?

Not at all	A little	Moderately	A lot
Briefly specify what these *family relationship issues* are:			

xiii. To what extent do your FINANCES negatively impact your mental well-being?

Not at all	A little	Moderately	A lot
Briefly specify what these *financial issues* are:			

xiv. To what extent do any OTHER ISSUES (e.g. security, sexual abuse, domestic violence) negatively impact your mental well-being?

Not at all	A little	Moderately	A lot
Briefly specify what these *other issues* are (e.g. security, sexual abuse, domestic violence):			

xv. Do you have any suggestions on how to resolve / mitigate your problems (briefly)?

xvi. Have you had any other mental health training / trauma counselling before this?

No	
Yes (please specify)	

xvii. What sort of support do you get from your employer to help you deliver your job (if any)?

xviii. Describe some of the client problems you have had to deal with (in no more than 200 words).

xix. On a scale of 1-5, please tick the box that best describes the additional stress you are experiencing as a result of working with refugees.

1 **No extra stress**	**2**	**3**	**4**	**5** **Extreme stress**

xx. Please tick the box that best describes how you think the training sessions will help you to cope with your own stress going forward.

No help at all.	Helpful but I require more guidance & support.	Helpful. I require no further support.	Extremely helpful. I'm willing to share what I've gained from training with my colleagues.

xxi. If you found the training to be of no help, or you require more support, which of the following would you use to support your needs?

Regular one-to-one counselling	
Access to you own advice line	
Booster / additional training	
Other (please specify)	

Appendix I (continued)

POST-TRAINING EVALUATION QUESTIONNAIRE GIVEN TO PARTICIPANTS (TRANSLATED INTO BENGALI)

xxii. Please indicate how this training has helped you to identify the trauma counselling needs of the clients / refugees you work with.

Not at all	A little	Moderately	A lot

xxiii. Please indicate how confident you feel in approaching relevant colleagues offering extra mental health support to your clients.

Not confident at all	A little confident	Confident	Very confident

xxiv. Please indicate what you would require *personally* before referring a client to relevant support networks.

Hotline advice before referral	Direct referral without hotline advice

xxv. If an advice line was available, what would be the best DAYS for it to operate?

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

xxvi. If an advice line was available, what would be the best HOURS for it to operate?

09:30 – 12:00	13:00 – 17:00	18:00 – 20:00

xxvii. Do you have any other comments on the training? If so, please limit your response to 200 words.

Thank you very much for completing this questionnaire. We value your feedback. If you have any questions or queries about this questionnaire, please ask the administrator.

Appendix 2

BEYOND CONFLICT AND GLOBAL DEVELOPMENT CONSORTIUM MISSION STATEMENTS

Beyond Conflict is the mental health charity for conflict zones. Our mission is to tackle the psychological suffering of victims of war, terrorism and displacement. We believe there can be no lasting peace without addressing the psychological fallout of war.

Working with local partners, we aim to deliver: free mental support to civilians and NGO frontline workers; training for frontline workers on how to identify and treat trauma. In partnership with some of the world's top experts from the Royal College of Psychiatrists in London, Beyond Conflict is working to boost mental health support from the ground up, using remote and face-to-face training. Our first projects are in Bangladesh and Iraq.

War, displacement and terrorism have wreaked grave damage on the mental health of millions. Survivors of war continue to suffer from depression and PTSD long after a ceasefire. The worst hit are children. Covid 19 has increased those pressures. In light of the pandemic, Beyond Conflict is committed to helping within a Covid-safe environment. Our first project went live in October 2020 in Cox's Bazar refugee camp In Bangladesh. The world's largest refugee camp is home to 1.2 million Rohingya refugees who fled persecution in Myanmar. BC is working with our local partner Global Development Consortium (GDC) to deliver mental health support to frontline workers from 7 NGOs in the camp; set up a support telephone hotline and open a referral pathway to enable refugees to access psychiatric support in the camp.

Our second project is in Iraq and will go live in 2021 once the Covid travel ban is lifted. Our Iraqi partner is the Al Kawthar widows and orphans charity. Al Kawthar is part of the respected international Al Khoei Foundation.

Beyond Conflict website: https://beyond-conflict.co.uk

Mission and Vision of Global Development Consortium (GDC) aims, and is determined, to:

- Turn today's challenges into opportunities for a better tomorrow.
- Create opportunities for the disadvantaged to be the Agent of Change Makers.
- Engage in community empowerment through social cohesion, greater participation and inclusion to transform a dignified and equitable society.
- Work with the marginalized communities, particularly in the UK and Bangladesh, to bring lasting and positive changes through research, front line work, advocacy and consultancy in the area of health, education, livelihood and social justice.
- Uplift those lagging behind to be on the mainstream in-line with the UN Sustainable Development Goal principle – "Leaving No One Behind".

GDC website: https://globaldevelopmentconsortium.co.uk

Appendix 3

CVS OF PROJECT DIRECTORS

Mr Abbas and Dr Saleh are on the Board of Trustees for GDC. Their experience and expertise are described on the GDC website (see https://globaldevelopmentconsortium.co.uk/our-board/) and are also detailed below.

Director: M Golam Abbas
Golam Abbas is the Founder Director of Global Development Consortium (GDC); he has over 40 years of work experience with the United Nations, Government of Bangladesh and NGOs in Asia, Africa, Middle-East, Europe and UNHCR Headquarters in Geneva. He managed a number of large scale complex regional and country level UN operations. Coordinated high level diplomatic and political portfolios; donor relations and resource mobilization; media and partner relationship; formulated strategies on UN mandated issues; participated in conflict resolution, peace negotiation and reconciliation both in conflict and post-conflict settings.

Since 2018, Abbas is a local Representative of the Italian Ministry of Interior/Gruppo Umana Solidarity (an EU initiative to support rehabilitation/reintegration of Bangladeshi migrants, opted to return home voluntarily).

As a Project Director managed a psycho-social/mental health project (Oct. 2017 – March '19) funded by "Action Contre La Faim" – a French NGO, for the Rohingya refugees in Cox's Bazar, Bangladesh. Currently manages a psycho-social & mental health support project for frontline NGO workers in Cox's Bazar, with the funding from Beyond Conflict – a British Charity.

Abbas is engaged in a number of philanthropic works (e.g., school and library establishment, education, social inclusion and livelihood activities) in Bangladesh. Also a Board of Trustee, Acid Survivors Foundation, Bangladesh; Member of Association of Former UN Staff Association of Bangladesh; and Vice-President, Jahangirnagar University Economic Alumni Association.

Abbas studied economics and prior joining the UN he served as a civil servant in Bangladesh.

Consultant: Dr Abul Hussain Mohammad Saleh MBBS(BG), CCCH (EDIN), DIPMHE (London), DIPSW (England). Nationality: Bangladeshi and British
Dr Saleh is a consultant Talking Therapist, Motivational therapist specialising in emotional, social, psychological and psychiatric problems. He also has keen interest in religious/cultural conflicts in family relationship problems. With over 30 years of experience working in the UK in the NHS and social services in London he has developed his special interest in conflict management, mediation. Early onset mental health problems and its relationship with trauma, spirit possession and substance misuse among minority ethnic population are the major driving force and motivation behind his long career in Child and Adult mental health sector. He regularly provides free therapeutic consultation and support around "migration and mental health problems" via email, Skype, teleconsultation to Bangladeshi people with psychosocial difficulties living in Europe, Australia, Canada, USA, Middle east and in many other countries. He is registered with social work England. He is also a member of British Association of Social Workers, England. He is an honorary clinical advisor to several London based charity and Advisor to several health and social care organisations in Bangladesh.

Education, employment and training
Dr Saleh received his medical qualification from Bangladesh in 1981. He has worked in his way in Government Medical College Hospitals in Bangladesh for few years before moving to UK. His postgraduate qualification and training began in 1985 at the University of Edinburgh and Royal Hospital for Sick Children around Community Child Health, postgraduate diploma in Social Work from the University of London, postgraduate certificate in Systemic Practice with Individuals and Couples from the Institute of family therapy and University of London and postgraduate diploma in Mental Health and Ethnicity from the University of Surrey, England.

In the mid-80s he started working with physical and learning disabilities in Scotland alongside his training. In late 80s he began his therapeutic career working with people with substance misuse, Alcohol, drug addiction, HIV/AIDS at the Royal London Hospital.

He has attended trainings on Mental Health legislations, Childcare and child protection legislations, Specialist Counselling courses on drug abuse, HIV and AIDS, substance misuse and alcohol abuse. He is trained in Motivational Milieu Therapy. He has also attended and facilitated many national and international conferences, seminars and workshops in London on Trauma, Violence, Physical and intellectual disability, mental health and on various psychological therapeutic approaches to mental health difficulties.

In early 90s he joined the Adult Mental Health services with NHS, East London until the year 2000 and worked in Hospital and community settings. He then moved to Child and Adolescent Mental Health services also with NHS, East London until the late 2017 as a cultural and complex case consultant.

Contribution to health and social care
He was involved in a major Child abuse inquiry in 1989 in East London. In early 90's he has developed Bilingual care assistant programme with NHS, East London to support Bangladeshi adult inpatient with mental health problem. He also developed Muslim chaplaincy services in London Hospitals to support the religious/cultural needs of the hospital staffs, carers, in-patient and outpatient community. His pioneering Liaison work with referrer, users and family members still plays important role in triage work in Child and Adult Mental Health services, in East London Mental Health.

Contribution to community and voluntary sector
He was involved in project development on Mental health, drugs, HIV and AIDS in London and nationwide between 1988 and 1996 and was an active member of voluntary / community sector organisations in London.

Between 1991 and 1996, Dr Saleh has served as a management committee Advisor, specialist cultural advisor to several voluntary sector organisations in Tower Hamlets, London. His focus was in the field of Drugs, alcohol misuse, domestic violence and mental health problems in the Bangladeshi community. During that period, he has encouraged NHS, East London and voluntary sector to start Anti-smoking campaign in Ramadan and it is still an ongoing programme. He then developed Community rehabilitation projects for Bangladeshi men and women with severe and enduring mental health difficulties with support from Health and Local Authority in East London and this project is serving residents of Tower Hamlets till today.

From October 2017 till March 2019 Dr Saleh has taken up new challenges in Bangladesh after massive Rohingya Refugee influx from Myanmar to Cox's Bazar, Bangladesh. His role as a lead consultant of "Global Development consultants "(GDC) to provide "staff support programme" in order to facilitate the Rohingya beneficiaries on the ground. He and his team has arranged numerous trainings, seminars, workshops, conferences, motivational talks and motivational tours to boost the morale of staff members and volunteers of Action Against Hunger (ACF) an international NGO working with Rohingya refugee community, in Cox's Bazar, Bangladesh. During this time, he has developed an innovative communication system "Teleconsultation room (TCR)" to support and assist staffs / volunteers in post conflict zones from a remote location. This is now regularly used by ACF for staff support, supervision, seminars and on safety security issues. ACF "staff support programme" is the first of its kind and is the only programme for staff and volunteers in the NGO sectors working in Cox's Bazar, Bangladesh.

IMPACT REPORT AND RECOMMENDATIONS

Training on Mental Health and Psychosocial Support for NGO Frontline Staff Working in Rohingya Refugee Camps

The Rohingya Refugee Pilot Project, Cox's Bazar, Bangladesh, by Beyond Conflict and Global Development Consortium

2021

BEYOND CONFLICT

GDC

GLOBAL DEVELOPMENT CONSORTIUM