

Guidelines for International Training in Mental Health and Psychosocial Interventions for Trauma Exposed Populations in Clinical and Community Settings

STEVAN WEINE, YAEL DANIELI, DERICK SILOVE, MARK VAN OMMEREN, JOHN A. FAIRBANK, JACK SAUL, FOR THE TASK FORCE ON INTERNATIONAL TRAUMA TRAINING OF THE INTERNATIONAL SOCIETY FOR TRAUMATIC STRESS STUDIES

Objective: To develop consensus-based guidelines for training in mental health and psychosocial interventions for trauma-exposed populations in the international arena. *Participants:* The Task Force on International Trauma Training of the International Society for Traumatic Stress Studies. *Evidence:* The Task Force engaged in a 1-year dialogue on the practice of international training, drawing upon field experience, literature review, and consultation with key informants. *Consensus Process:* This statement was prepared on the basis of shared dialogue, consensus decision making, and a writing process involving all Task Force members. It was then disseminated for review to more than 200 professionals of more than 60 service and academic organizations. Written and oral suggestions from over 80 persons were incorporated and revisions made on the basis of consensus. *Conclusions:* The generated guidelines addresses four dimensions: (1) values, (2) contextual challenges in societies during or after conflicts, (3) core curricular elements, and (4) monitoring and evaluation. The guidelines can improve international training

The authors would like to thank the International Society for Traumatic Stress Studies, the University of Illinois at Chicago, and the Jerome Frankel Family Foundation for financial support. We would also like to thank Yasmina Kulauzovic, Amer Smajkic, Schuyler Henderson, Ivan Pavkovic, Joseph Flaherty, Dan Luchens, Greg Schultz, Steve Ketchum, Bonnie Green, and John Briere, as well as all those persons who read the Guidelines and offered their comments and suggestions.

Stevan Weine, MD, is at the University of Illinois at Chicago; *Yael Danieli, PhD*, is with the Group Project for Holocaust Survivors and their Children; *Derick Silove, MD*, is at the School of Psychiatry, University of New South Wales; *Mark Van Ommeren, PhD*, is with the Transcultural Psychosocial Organization; *John A. Fairbank, PhD*, is at Duke University; *Jack Saul, PhD*, is at New York University.

The remaining members of the Task Force on International Trauma Training of the International Society for Traumatic Stress Studies are Ferid Agani, MD, David Eisenman, MD, Joop T. V. M. de Jong, PhD, Irfanka Pasagic, MD, Arieh Shalev, MD, Barbara Smith, PhD, and Robert Ursano, MD.

Earlier versions have been presented in part at (1) the International Society for Traumatic Stress Studies Annual Meeting, November 2000, San Antonio, TX; (2) the World Assembly for Mental Health 2001, Vancouver, BC; and (3) the International Society for Traumatic Stress Studies Annual Meeting, December 2001, New Orleans.

The Task Force invites comments, criticisms, suggestions and queries. Please submit in writing to Task Force on International Trauma Training, c/o Stevan M. Weine, M.D., Health Research and Policy Centers, Suite 400, 850 W. Jackson Street, Chicago, IL, 60607. E-mail: smweine@uic.edu.

in mental health and psychosocial interventions for trauma-exposed populations by providing principles and strategies intended to steer those who seek informed recommendations, to generate focused debates on areas where there is as yet no broad consensus, and to stimulate research and inquiry.

During the 1990s, the international trauma mental health movement came to the Balkans in the form of "trauma training." Traumatic stress and mental health knowledge were applied widely and enthusiastically, but the outcomes were not always beneficial, and in many cases may have been hurtful, (Maynard, 1999). The Red Cross's *World Disaster Report 2000* sharply criticized international mental health initiatives and issued the urgent call for standards to better structure relief efforts (Walker and Walter, 2000).

International trauma training, the training in mental health and psychosocial interventions for trauma-exposed populations, occurs when professionals with expertise in trauma mental health travel from one international locale to another to train local practitioners to respond optimally to trauma-related problems.¹ These trainers can find themselves ill prepared (Maynard, 1999; Walker and Walter, 2000). The literature on international trauma work demonstrates neither a comprehensive nor a serious attempt to address the values, frameworks, techniques, challenges, and the outcomes of international training (Belgrad and Nachmias, 1997; Weine, 2000).

These concerns about international training are similar to the ones voiced by others about the efforts of international helpers in situations of complex emergency. U.S. State Department documents were critical of the humanitarian aid effort in Kosova, especially of the lack of prioritization, coordination, standards, and professionalism (Perlez,

2000). Several international organizations have moved in the direction of developing standards and training, but these efforts have not included a systematic effort focused on trauma per se (People in Aid Code of Best Practices, 1997; Sphere Humanitarian Charter and Minimum Standards in Disaster Response, 2000).

In 1999, the International Society of Traumatic Stress Studies (ISTSS), an organization of over 2,000 members from at least 40 countries, created the Task Force on International Trauma Training. The Task Force's central concern is that the established scientific knowledge and clinical practices of traumatic stress and trauma mental health are being heavily deployed in the international arena in response to conflicts and disasters, often with the presumption that doing anything is better than nothing. The Task Force believes that progress requires changes in training by trauma mental health professionals. It also believes that training in mental health and psychosocial interventions for trauma-exposed populations requires an integrative approach across disciplines and sectors. The overall goal of the Task Force is to advance international training in mental health and psychosocial interventions for trauma-exposed populations as it is currently practiced. The drafting of consensus-based guidelines (see Appendix) was chosen as a first step.

PARTICIPANTS

The ISTSS Board of Directors created the Task Force on International Trauma Training in November 1999. The chair (SW) and co-chair (YD) along with the then-President of ISTSS (JF) selected mental health professionals with extensive international experience and expertise in international training to serve on the committee. The chair and co-chair also

¹The phrase "international trauma training," while widely used, has been found by some to be potentially confusing. This text, therefore, will use phrases such as "international training in mental health and psychosocial interventions with trauma-exposed populations," "international training," and "training."

selected several mental health professionals from postconflict societies who had been involved in international training as trainees, trainers, or organizers. All Task Force members participated in preparing the guidelines through a 1-year process that included both closed and open meetings.

EVIDENCE

In developing the guidelines, the Task Force, first and foremost drew upon its members' direct experiences in conceptualizing, designing, implementing, and evaluating training (Danieli, 2001; Danieli, Rodley, and Weisaeth, 1996; de Jong, 2000; Silove, 1999; Van Ommeren, Sharma, Prasain, and Poudyal, 2002). The Task Force also conducted reviews of all the relevant literatures. Because of the importance of the Internet as a means of distributing health and mental health information, Web based-materials were reviewed as well (Henderson and Weine, 2001). In addition, the Task Force consulted with around 30 international experts in training and trauma mental health from a range of organizations, including academic, nongovernmental and governmental.

CONSENSUS PROCESS

To produce the guidelines during the first year, the Task Force took the following steps: (1) presentations and discussions of each area (values, contextual challenges, core elements, and monitoring and evaluation); (2) preliminary draft of guidelines by subgroups on each area; (3) discussions of preliminary draft statements by the full Task Force; (4) second drafts by subgroups; (5) preparation of text of guidelines assembled by chair and co-chair; (6) critical review of draft guidelines by all members; and (7) further drafts based on revisions by chair and co-chair.

During the second year, the Task Force disseminated the guidelines to more than 200 professionals within the ISTSS and other professional societies, to professionals in 60 service and academic organizations involved in international training, and to consumers in 6 countries. The Task Force held open fora at two professional meetings (Weine, Danieli, Silove, and Van Ommeren, 2001; Weine et al., 2000) and at two university meetings. The Task Force reconvened to review the more than 40 written and 40 verbal comments and critiques on the guidelines through (1) small subgroups incorporating suggestions through revision of sections of the guidelines; (2) final drafting by chair and co-chair; (3) review, acceptance, and approval of the Guidelines by the board of directors of ISTSS in December 2001.

CONCLUSIONS

International training in mental health and psychosocial interventions for trauma-exposed populations is a new, developing field. Guidelines facilitate the process of its development by providing principles and strategies intended to steer those who seek informed recommendations, to generate focused debates on areas where there is as yet no broad consensus, and to stimulate inquiry. Although the Guidelines are a consensus statement of what the Task Force believes to be minimally acceptable in general for international training, not all of the recommendations will be easy nor even possible to implement in all contexts. The development of international training is a process. These guidelines will need to be updated over time. Future additional formulations and further elaborations are anticipated, including the topics of ethics of training, training of primary care workers, training and self-care, and training under and following terrorist siege.

APPENDIX: THE GUIDELINES

A. THE VALUES UNDERLYING INTERNATIONAL TRAINING

International training in mental health and psychosocial interventions for trauma-exposed populations ought to be based on a central set of values and this set of values, ought to be made explicit. Engaging with these values is meant to enhance the capacities of trauma mental health professionals to meet their ethical obligations as professionals involved in training in situations of catastrophe. These values should inform all aspects of the professionals' work, from conceptualization through design, implementation, monitoring, evaluation, and reporting.

1. Values tie professionals to humanity and to professions. These values are:

a. Respecting the concerns, needs, resources, strengths, and human rights of individuals, their families, communities, cultures, and nations.

b. Grounding in established scientific and clinical knowledge of trauma mental health and other related professional knowledge.

2. Values guide professionals in addressing the dilemmas that arise from competing or conflicting obligations. These values are:

a. Recognizing the legitimacy of multiple perspectives on trauma and related concerns.

b. Promoting an open dialogue among differing voices on trauma and related concerns.

c. Integrating different perspectives and positions on trauma in the quest for what is helpful.

B. CONTEXTUAL CHALLENGES IN SOCIETIES DURING OR AFTER CONFLICTS

A thorough, integrative understanding of the multiple dimensions of each context is needed to inform training design and implementation. This is especially true when international training occurs in societies during or after conflicts, or in societies in transition. Fundamental questions need to be addressed: To whom is the training directed? For what purposes? Who will be the ultimate beneficiaries? Who will train? Understanding the context requires an integrative analysis of the complex interplay of multiple spheres or systems evolving over time. This analysis recognizes that each di-

mension may be a subject of one or more overlapping disciplines, such as anthropology, economics, international development studies, law, philosophy, political science, psychiatry, psychology, religious studies, and sociology.

1. Training must address cultural dimensions.

a. Training needs to be culturally sensitive and appropriate.

A deep appreciation of the culture, its historical roots, and the way it has shaped indigenous concepts of mental health and healing requires an ongoing commitment to learning. The process of familiarizing oneself with the indigenous society and culture needs to evolve throughout the period of training and may take several forms. The informal ongoing contact with individuals, families, and communities in their everyday lives is an important element in this learning process.

b. Training is itself an element of the process of rapid cultural change in societies during or after conflicts.

A delicate balance needs to be achieved in which training teams endorse and promote a genuine, deep interest in indigenous ways of approaching human suffering while, at the same time, recognizing that local professionals will be exposed to international trends in trauma treatment methods. Ultimately, local conditions, resources, and aspirations should be respected in shaping the choices that are made so that a context-specific, integrated model of healing may evolve that suits best the needs of the emerging society.

2. Training initiatives must identify ways to appropriately enter complex environments in conditions that may be insecure.

a. Trauma training in societies during or after conflicts takes place within a complex social and political context in which multiple sectors and stakeholders seek a voice in shaping the reconstruction process.

The United Nations and its agencies, international and local non-governmental organizations (NGOs), local political groupings, previously warring factions, armed liberation movements, religious groups, and traditional structures of justice and civil government may all be involved in various interventions. The potential for tension, friction, and even overt conflict may continue after a ceasefire. Locating the sources of power, decision making, priority setting, and planning may be difficult because authority may shift from one leadership structure to another. Legitimacy and consent are

likely to be a challenge, as it may be difficult to establish which sector is responsible for endorsing mental health initiatives in general and trauma training in particular.

b. Essential components to ensure that the broader needs of all subgroups are considered are engagement, consultation, and ongoing feedback in partnership with all interested sectors and their stakeholders.

Psychosocial interventions may only be effective as a public health strategy if these activities support and, in turn, are supported by progress in reestablishing the fundamentals of a stable social environment. Repair of the social environment involves reestablishing the structures, institutions, and cultural framework that moderate the impact of mass threats, losses, and injustices. Multilateral partnerships are needed to achieve an integrated outcome, with indigenous structures taking a leadership role over time in directing the process. In addition to training, mental health professionals may make important contributions as consultants to the relevant agencies and indigenous structures working to recreate a stable society.

c. Training is more likely to succeed when it is integrated with general development efforts.

In many low-income countries, general mental health services have never existed or have been destroyed during the conflict. Hence, the service setting in which trainees will implement their newly acquired skills needs to be considered carefully. Newly acquired knowledge is likely to be lost or diminished if a coherent framework for practicing such skills is lacking.

d. It is critical to prepare personnel practically and mentally for conditions in the field and for taking active responsibility in managing risk once they are deployed.

Personnel who enter societies during or after conflicts are often at risk of physical and emotional stress, injury, and illness. Self-care activities (physical and emotional) before, during, and after missions should be an intrinsic strategy supported by the training agency. Infrastructure support (adequate shelter, food, water, transport, and means of communication) can be problematic in the early phases because of logistical and financial constraints. Personnel need to be prepared to undertake multiple tasks, many of them novel, to establish an optimal infrastructure that ensures their own safety prior to concentrating on the task of training per se.

3. Training must help recipients face both short- and long-term challenges.

a. Providing training that is very brief

and not followed by ongoing supervision to persons who themselves have been subject to severe and or traumatic stressors may result in both poor practices and a sense of demoralization in the workers.

Trauma training, if poorly implemented, may do harm. The risks, pitfalls, and potential dangers of trauma counseling and more general mental health treatments need to be inculcated into the curricula. Consideration of ethics, self-care, inter-professional conduct, and risk management must be integrated into the teaching of all substantive areas. Training should develop the capacities of local leaders, experts and managers, and local organizations to provide ongoing support and guidance.

b. When training personnel, their future roles in an emerging service structure need to be considered.

If training occurs outside the mainstream planning processes, trainees may find that their personal and professional aspirations are ultimately thwarted since their credentials (e.g., “trauma counselor”) may not fit the professional designations (e.g., nurse, physician, social worker, psychologist) adopted by the public service system. Training design should be supportive of the trainee’s role within this system.

c. As potential future players and even leaders in the field, the partnership between the trainees and the trainers must aim at transparency and mutual sharing of concerns and opportunities.

Contracts with funders often require the training team to take the major responsibility in administering finances and acquitting accountability requirements. The risk is that indigenous trainees may not gain the knowledge needed to undertake these tasks or to be in a position to apply independently for future funding. Almost invariably, trainers are remunerated at much higher levels than trainees. In each environment, these issues need to be negotiated and considered in relation to local constraints and opportunities to mitigate such imbalances. However, in all settings a willingness to debate the issues and their potential impact on the distribution of power in the relationship is essential to creating an environment of honesty and transparency, principles that must be embedded within the training philosophy. By discussing the broader context that influences the program and vice versa, the training team assists trainees in developing skills relevant to leadership, advocacy, accountability, management, planning, problem solving, and team building. As leadership and initiative

is developed in trainees, responsibility for the sustainability of the program (including fund-raising) may be shared, and the risk of dependency and unrealistic expectations may be reduced.

4. Curricula must be designed to fit best the realities of the local situation.

a. Training should be tailored to health care professionals, health-related paraprofessionals, and/or other helping professionals.

Training should be directed toward the persons who are available to engage in service delivery. Because most low-income countries have few mental health professionals, services are generally provided by health care professionals and paraprofessionals. The training of personnel such as in the educational, human rights, and justice systems; the police; and the clergy offers other paths for providing services.

b. Training should draw on the principles and methods of public mental health in order to assess and determine the mental health and health needs in their specific contexts.

Decisions need to be made regarding (a) which types of problems are prevalent; (b) which types of problems are serious; (c) which types of problems motivate people to seek help; (d) which types of problems can feasibly be treated; (e) whether the program will be clinic-based or community-based; (f) whether the program will focus on individuals, families, or communities; (g) whether the program will provide both individual, family, and group therapy; (h) whether the program will include prescribing psychotropic medication; (i) whether the program will focus on both adults and children; (j) whether the program will focus on secondary and tertiary prevention only or also on primary prevention; (k) which local human resources are available; and (i) which interventions are likely to be cost-effective.

c. Training needs to include optimal care for the severely mentally disabled.

In locations with few facilities, trauma programs are likely to attract help-seekers who may or may not have been traumatized but who do need help urgently for other neuropsychiatric disorders (e.g., epilepsy and other brain disorders, schizophrenia and other major forms of mental illness, and psychological complications of physical disease). Where other services for these patients are absent or ineffective, program developers will need to anticipate and make preemptive decisions about who and what to treat, and who and what to refer to other agencies. Whatever the ultimate decisions, considering the needs of those with severe mental

disorders is essential. It is difficult to justify a program focusing exclusively on trauma reactions in the absence of a system of care for other forms of severe mental disturbance.

d. Although genuine debate about the content of training is important to generating new ideas and a wider synthesis of all contributing disciplines, it needs to take place in a framework of respect, professionalism, and constructive cooperation among participating agencies.

Competition for funding among United Nations Agencies, NGO's, torture and trauma services, and university-based centers, among others, is intense and can lead to excessive rivalry. Theoretical polarizations in the field (mental health programs vs. trauma programs vs. psychosocial programs) are often inappropriately exaggerated to promote the claims of legitimacy of particular training groups or disciplines. Such exaggerations need to be avoided and, where possible, all legitimate contributions to the development of mental health should be valued, even though it is inevitable that difficult choices about priorities will need to be made in resource-poor environments.

C. CORE CURRICULAR ELEMENTS OF TRAINING

Training in mental health and psychosocial interventions for trauma-exposed populations should develop and expand trainees' knowledge and skills. Those trainees are likely to include mental health professionals, but also health care professionals, other helping professionals and paraprofessionals. The Task Force has identified the core elements that should shape the development and implementation of training curricula.

1. Training includes competence in listening and other communication skills.

Teaching people the ability to establish a sound helping relationship is essential. Helping requires good communication skills by empathic helpers.

2. Training covers assessment.

Thorough training in properly recognizing psychosocial and mental health problems is important in order to avoid inappropriate diagnoses and interventions. Training in cultural formulations and approaches can be valuable.

3. Training includes teaching established interventions to diminish distress.

A wide range of specific social, psychological, and biological interventions exist in the professional literature. Training of relatively mainstream and accepted interventions, rather than highly alternative methods, is encouraged.

4. Full understanding of the local context determines the appropriateness and feasibility of specific interventions.

The context may effect choice of interventions in many ways. Important considerations include (a) help-seeking expectations (e.g., clients socialized by traditional healers may expect almost immediate relief); (b) duration of treatment (which may need to be short because of limited access to care); (c) attitudes toward intervention (e.g., preference for or dislike of medication); (d) cost-effectiveness of the intervention; and (e) family attitudes and involvement (many cultures emphasize the family over the individual).

5. Training provides strategies for problem solving.

Trauma training should not only be limited to treatment of stressor-induced symptoms or distress but also cover approaches to reducing problem situations whenever possible. Such approaches may be on the individual level (e.g., problem-solving treatment), the family level, and/or the community level.

6. Training includes the treatment of medically unexplained somatic pain.

In many settings, help-seeking involving medically unexplained somatic complaints is very common. Training in treatment approaches for these complaints is recommended. It is important to address the linking of psychosocial services to medical services to address medical needs.

7. Training includes learning to collaborate with existing local human resources and change agents.

Local human resources (e.g., clergy, teachers, traditional healers, formal and informal leaders) may help trainers and trainees understand indigenous perceptions of suffering, illness, loss, pain, and healing. Collaboration with traditional healers is important because of their knowledge of and role in the community and the potential effectiveness of their interventions. Local leaders may help to sanction programs, reach feasible solutions for

problems situations, provide information on community concerns, mediate conflicts, and provide referrals. Also, local leaders may play an important role in helping build or rebuild social support networks.

8. Training ensures the establishment of an ongoing supervision structure.

Many failures and some successes in international development over the last 50 years demonstrate that program developers need to focus on (a) feasibility (Is it possible to carry out this intervention effectively in this situation?) and (b) sustainability (Will the program last? Will the effects of the program last?). In terms of a specific intervention by paraprofessionals, these questions may be phrased as follows: (a) Is it possible to train paraprofessionals to carry out this intervention effectively in a given setting? (b) For how long will trainees retain the knowledge and skills obtained in the training and for how long will they be in the situation to practice what they learned? Paraprofessionals are likely to be able to master most interventions if these interventions are socioculturally appropriate and if they receive sufficient supervision. However, to train in an area without setting up a structure of ongoing supervision is unlikely to be sustainable and may lead to harm. When competent supervisors are not available, an expatriate mental health professional may have to be stationed locally to function as a supervisor for as long as it takes to train competent local supervisors. Sustained supervised practice is an essential prerequisite before trainees are ready to train and supervise a new group of trainees in turn.

9. Training covers self-care.

Self-care and encouragement of support among trainees are essential for two reasons. First, previous traumatization may limit the trainees' effectiveness. Second, caring for severely traumatized people may lead to vicarious traumatization or other forms of burnout.

D. MONITORING AND EVALUATION

It is necessary to establish a monitoring and evaluation system to facilitate planning, enhance

accountability, and improve future trainings. Monitoring and evaluation are increasingly required by donors for these reasons as well. Within the framework proposed by the Task Force, objectives, indicators, evaluation methodology and budget for internal or external evaluation need to be determined before the training. Objectives should be based on: (a) a clarification of the values underlying the training, and (b) an understanding of how training fits within the context. Training objectives that do not recognize the values or the context may end up reinforcing or covering up positions that are misguided or confused.

1. Training initiatives should incorporate monitoring and evaluation components to ensure that training is beneficial.

Evaluation of the benefits of training should address the question: To what extent, on which dimensions, was the training regarded as helpful or possibly harmful? Harm may be manifest directly upon trainees or those they serve, or indirectly when training leads to undermining competencies.

2. Training initiatives must involve identification of appropriate objectives and indicators for monitoring and evaluation. These include:

a. Identifying objectives on the basis of a training needs assessment.

The results of a needs assessment dictate the choices of objectives, as well as the content of training.

b. Identifying process indicators to evaluate training.

Process evaluation is mostly concerned with the acceptability, adaptability, and comprehensibility of training methods.

c. Identifying indicators to evaluate the impact of training on trainees' skills.

Indicators are needed to evaluate changes in trainee's knowledge and skills, and if possible, in the capacities of the trainee's organizations. If possible, it is valuable to determine whether the effects of training are maintained over time or whether there are serious drifts in the practice of learned skills, which are likely to happen without ongoing supervision.

d. Identifying indicators to evaluate the impact of training on services.

It is valuable to draft measurable indicators

to evaluate, on an ongoing basis, changes in the quality of services after training.

e. Identifying indicators to evaluate the impact on beneficiaries of services.

Indicators identifying the impact on beneficiaries depend on the training objectives. Examples of dimensions to be assessed are: (a) physical and psychological distress; (b) psychopathology; (c) physical and social functioning; (d) social isolation and relatedness; (e) family and community processes; (f) managing competing cultural beliefs; (g) obstacles to recovery; (h) truth, justice and reconciliation processes; and (i) satisfaction with services.

3. Training initiatives must choose appropriate approaches for assessing indicators. The Task Force recommends:

a. Collaborative approaches.

Involving local investigators, professionals, paraprofessionals, and service recipients in setting objectives and indicators will help to keep the training oriented toward real world concerns and hierarchies of needs. If possible, different parties involved in the training should monitor the indicators.

b. Mixed-method approaches of data collection and analysis.

Combining qualitative and quantitative methods, including surveys, individual interviews, focus groups, and participant-observation, is more likely to render useful results.

4. Training initiatives should report and disseminate the results of monitoring and evaluation. Reports should aim to:

a. Incorporate the views of both providers and recipients of training.

A balanced look at both perspectives upon the training experience is likely to offer more than either of them alone.

b. Include successes, difficulties, failures, and lessons learned.

Proper documentation is helpful to those pursuing future trainings.

c. Share materials and resources that will be of value to further training initiatives.

The Task Force encourages sharing of training and evaluation materials to contribute to the growing field of training in mental health and psychosocial interventions for trauma-exposed populations.

REFERENCES

- BELGRAD, E.A., and NACHMIAS, N. *The Politics of International Humanitarian Aid Operations*. Praeger, 1997.
- DANIELI, Y., ed. *Sharing the Front Line and the Back Hills, International Protectors and Providers: Peacekeepers, Humanitarian Aid Workers and the Media in the Midst of Crisis*. Published for and on behalf of the United Nations by Baywood Publishing Company, 2001.
- DANIELI, Y., RODLEY, N.S., and WEISAETH, L., eds. *International Responses to Traumatic Stress: Humanitarian, Human Rights, Justice, Peace and Development Contributions, Collaborative Actions and Future Initiatives*. Published for and on behalf of the United Nations by Baywood Publishing Company, 1996.
- DE JONG J.T.V.M. Psychiatric problems related to persecution and refugee status. *Contemporary Psychiatry* (2000): 2:279–298.
- HENDERSON, S., and WEINE, S.M. *Mental Health Trauma Training on the World Wide Web*. International Society for Traumatic Stress Studies 17th Annual Meeting, New Orleans, 2001.
- MAYNARD, K. *Healing Communities in Conflict: International Assistance in Complex Emergencies*. Columbia University Press, 1999.
- People in Aid Code of Best Practices, The*. London, United Kingdom, 1997. Available at: www.peopleinaid.org.uk/codeintro.htm.
- PERLEZ, J. State department faults U.S. aid for war refugees as inept. *New York Times* (2000, May 9) A1.
- SILOVE, D. The psychosocial effects of torture, mass human rights violations and refugee trauma: Towards an integrated conceptual framework. *Journal of Nervous and Mental Disease* (1999) 187(4): 200–207.
- Sphere Humanitarian Charter and Minimum Standards in Disaster Response, The*. Stylus Publishing, 2000. Available at: www.sphereproject.org
- VAN OMMEREN, M., SHARMA, B., PRASAIN, D., and POU DYAL, B. N. Addressing human rights violations: A public mental health perspective on helping torture survivors in Nepal. In J. T. V. M. de Jong JTVM, ed., *Trauma, War and Violence: Public Mental Health in Socio-cultural Context*. Plenum, 2002.
- WALKER, P., and WALTER, J. *World Disasters Report: Focus on Public Health*. International Federation of the Red Cross and Red Crescent Societies, 2000.
- WEINE, S.M. International trauma training: Report on the task force. *Stresspoints* (2000) 14:3–4.
- WEINE, S.M., DANIELI, Y., SILOVE, D., and VAN OMMEREN, M. *Guidelines for International Trauma Training*. World Assembly for Mental Health 2001, Vancouver, BC, Canada.
- WEINE, S.M., DANIELI, Y., SILOVE, D., VAN OMMEREN, M., FAIRBANK, J., and DE JONG, J.T.V.M. *Guidelines for International Trauma Training*. International Society for Traumatic Stress Studies 16th Annual Meeting. San Antonio, TX, 2000.