ShowUp 4Health

Building Trust in Roma Communities and Internally Displaced People for NCD Prevention

D3.4 TRAINING PROGRAMME AND TRAINING MATERIAL ON MENTAL HEALTH SCREENING FOR UKRAINIAN PROFESSIONALS

Co-funded by the European Union

PROJECT TITLE	BUILDING TRUST IN ROMA COMMUNITIES AND INTERNALLY DISPLACED PEOPLE FOR NCD PREVENTION
PROPOSAL ACRONYM	ShowUp4Health
PROPOSAL NUMBER	101129427
CALL IDENTIFIER	EU4H-2022-PJ-3
TOPIC	EU4H-2022-PJ-12
STARTING DATE	01/12/2023
DURATION	36 months
WP NUMBER	WP3
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DATE OF PUBLISHING	08.10.2025
TYPE	Public
VERSION	0.2
RIGHTS	©Copyright: ShowUp4Health Consortium
Dissemination level of this deliverable	Public
REVIEW STATUS	√ WP Leader accepted
	√ Coordinator accepted

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ACRONYM	TERM
AH (BP)	Blood pressure
BFI	Big Five Inventory
CBT	Cognitive behavioural therapy
D	Deliverables
GSE	General Self-Efficacy Scale
HCSOM	Hungarian Charity Service of the Order of Malta
ICE	In case of emergency
IDP	Internally displaced person
IOM	International Organization for Migration
MCQ	Multiple choice question
NCD	Non-communicable disease
NGO	Non-governmental organization
OSCE	Objective structured clinical exam
PTSD-DS	Post-Traumatic Stress Disorder Diagnostic Scale
STAI	State-Trait Anxiety Inventory
TIPE	Trauma-Informed Psychoeducation
WHO	World Health Organization

1. Executive summary

1.1. Background

The refugee crisis in Europe began in late February 2022 following Russia's invasion of Ukraine. By May 2022 over six million people had fled Ukraine, while an estimated eight million were displaced within the country. Approximately one-quarter of the country's total population had left their homes in Ukraine by 20 March. 90% of Ukrainian refugees are women and children, while most Ukrainian men between the ages of 18 and 60 are banned from leaving the country.[6] By 24 March, more than half of all children in Ukraine had left their homes, of whom a quarter had left the country. The invasion caused Europe's largest refugee crisis since World War II and its aftermath, is the first of its kind in Europe since the Yugoslav Wars in the 1990s, as well as the fourth largest refugee crisis in history, and is the largest refugee crisis of the 21st century, with the highest refugee flight rate globally.

The ongoing conflict has devastated Ukraine's healthcare infrastructure, leaving many IDPs without access to essential services. Facilities in host regions are often overwhelmed, and shortages of medications and healthcare professionals are common. Mental health care is particularly under-resourced, despite significant demand.

In light of this context, the ShowUp4Health project has developed targeted training materials to address these challenges, with a particular focus on the mental health needs of internally displaced persons (IDPs) and the professionals supporting them.

The ShowUp4Health project aims to strengthen the prevention of non-communicable diseases (NCDs) in vulnerable populations through integrated, people-centred, and trust-based approaches. Within this framework, internally displaced persons (IDPs) in Ukraine represent one of the most affected and underserved communities, facing not only limited access to healthcare but also a severe and growing mental health crisis.

This deliverable focuses on training healthcare professionals and NGO outreach workers who work directly with IDP communities. They are the first point of contact for displaced persons and therefore play a critical role in detecting risks, providing early interventions, and building trust. The training materials have been designed to equip professionals with trauma-informed knowledge, practical screening tools, and community-based approaches to address mental health challenges such as depression, anxiety, PTSD, and dementia.

The ultimate goal of these training resources is to increase the capacity of healthcare providers, improve resilience within IDP communities, and contribute to the broader objectives of ShowUp4Health: reducing inequalities, strengthening trust, and preventing NCDs in vulnerable groups.

1.2. Main beneficiaries and Target Groups

1.2.1. Internally Displaced People

According to the International Organization for Migration (IOM) in October 2024 estimated that 3,555,000 de facto IDPs and 4,294,000 returnees reside in Ukraine.

- The largest IDP populations are in Dnipropetrovska (14%) and Kharkivska (12%) Oblasts.
- Most IDPs originate from Donetska Oblast (28%).
- High levels of intra-oblast displacement are found in Khersonska (93%), Donetska (86%), Zaporizka (85%), and Kharkivska (83%).

Household characteristics:

- 7% are single-parent households (one adult with children under 18).
- 70% intend to remain in their current location beyond three months; 13% consider returning, mostly after the war ends.
- 10% spent at least 14 days abroad since February 2022.
- 80% have been displaced for over a year; the median duration of displacement is two years and three months.

The most pressing needs are power banks or generators (26%), income-earning opportunities (10%), and medicines (9%). Many IDPs rely on negative coping mechanisms, with 24% of households adopting emergency-levelstrategies, compared to 16% among the non-displaced population.

The most pressing needs are power banks or generators (26%), income-generating opportunities (10%), and medicines (9%). Many IDPs rely on negative coping mechanisms, with 24% of households adopting emergency-level strategies, compared to 16% among the non-displaced population.

1.2.2. Health professionals for health promotion of the IDP community

Healthcare professionals working with IDPs are both a primary target group and central implementers in ShowUp4Health. This group includes family doctors, nurses, public health workers, and NGO outreach staff, who often act as the first point of contact.

Their dual responsibility is to:

1. Build trust with communities that have experienced war-related trauma and institutional distrust.
2. Detect and manage physical and mental health problems disproportionately affecting displaced populations.

Training is crucial because well-prepared professionals can identify risks early, apply evidence-based practices, and engage IDPs more effectively. This strengthens trust, improves care quality, and supports the overarching goals of ShowUp4Health: resilience, equity, and NCD prevention.

1.3. Scope of the training and focus on IDP's

The war in Ukraine has severely affected the mental well-being of IDPs, making mental health decline the most urgent non-communicable disease in these populations. To address this, the project has developed specialised training programmes and materials for Ukrainian healthcare professionals and NGO outreach workers. These resources provide knowledge and approaches to recognise, assess, and respond to mental health challenges in IDP communities.

1.4. Brief Overview of the Training Programme Developed

Within the project we developed a five-module training programme that covers prevention, screening, management, and rehabilitation in family medicine.

- **Module 1 – Primary Prevention:** two thematic trainings on preventing smoking and obesity (motivational counselling, stigma-sensitive communication).
- **Module 2 – Screening of Common Diseases:** three trainings on evidence-based screening (CheckMe tool; person-centred planning—"Four Steps to Longevity"; population-oriented screening).
- **Module 3 – Tertiary Prevention:** five trainings (10 clinical cases of arterial hypertension; "How to Tame the Dragon" [HTN]; cardiovascular risk—"How to Escape a Heart Attack"; virtual consultations in family practice; cardio-reno-metabolic orchestration).

- **Module 4 – Rehabilitation after Cardiovascular Catastrophes:** four trainings focused on post-event rehabilitation and team-based care.
- **Module 5 – Mental Health Screening & Management:** two trainings (depression and dementia) aligned with WHO mhGAP.

1.5. The objectives of the training materials

The objective of these training materials is to equip Ukrainian healthcare professionals and NGO outreach workers with the knowledge and skills needed to recognize, screen, and respond to mental health challenges among internally displaced persons (IDPs). In this way, the training directly supports the project's target groups and reinforces ShowUp4Health's overarching goal of building trust and resilience in vulnerable communities.

Main objectives:

- Address the urgent mental health crisis among IDPs, which represents the most pressing non-communicable health issue in war-affected populations.
- Strengthen professional competencies of doctors, nurses, public health workers, and and NGO staff in screening for depression, anxiety, PTSD, dementia, and other mental health conditions.
- Build trust between healthcare providers and displaced persons, reducing barriers to care and promoting access to services..
- Introduce preventive approaches and practical screening tools applicable in family practice, primary care, and community health settings.
- Promote trauma-informed and community-based methods, such as psychoeducation, group activities, and identity-supporting programmes.
- Share international best practices and **validated tools**, including WHO guidelines and validated psychometric instruments (e.g. PTSD-DS, STAI, GSE, WHO-5).
- **Enhance the resilience and well-being of IDP communities** by increasing the capacity of professionals to provide integrated, people-centred, and sustainable support.

1.6. How the mental health screening / training material connects / fits to the project

1.6.1. Fit matrix

Project element	Alignment with training material
Target populations	The training targets IDPs, a group explicitly prioritised in ShowUp4Health.
Health focus	The project addresses NCD prevention. Mental health disorders (depression, anxiety, PTSD) contribute to NCD risk or qualify as NCDs themselves. The training addresses this link.
Methods / tools	ShowUp4Health develops the Integrated Social-Healthcare Development Methodology (ISHDM). The training contributes tools for screening, trust-building, community engagement, and psychoeducation, fitting within this framework.
Capacity building	Training programmes and materials are key project deliverables. This material directly contributes to that goal.
Trust & vulnerable groups	The project emphasises building trust in Roma and IDP communities. The training fosters trust through trauma-informed methods and by lowering barriers to care.
Prevention / early detection	Effective NCD prevention requires early detection of risk factors. Mental health screening supports this preventive aim.

1.6.2. Role of the material in the project structure

This training module is one of the specific training programmes provided by ShowUp4Health. It isintegrated into the Integrated Social-Health Development Methodology (ISHDM),ibecoming a component of its tools and curriculum. It helps disseminate best practices: after testing, these materials can be widely used in the partner countries and regions, and beyondthe project context. It contributes to the "outcomes" of ShowUp4Health, which are related to better health outcomes, improved access, and reduced inequalities, especially in mental health - a key but often neglected aspect of NCD prevention.

A detailed overview of the training programmes, including updated Google Drive links and English summaries, is provided in Annex 1.

Training Package

As an outcome of this deliverable, a complete training package has been developed to support professionals working with internally displaced persons (IDPs) and vulnerable communities. The package includes:

- **Training Modules** – structured content on hypertension management, smoking cessation, NCD screening, depression and dementia detection, and prevention planning.
- **Participant Workbook** – task sheets, case studies, and reflection exercises to engage learners.
- **Trainer's Guide** – facilitation tips, time allocation, and assessment guidelines to ensure consistent delivery.

The full training package is provided in Annex 1 – IDP Mental Health and NCD Screening Training Package.

2. Training Programmes

Module Map — Overview

This deliverable documents a five-module training programme. Detailed, ready-to-use syllabi are provided in **Annex 2–5** (Hypertension; Motivational Interviewing for Smokers; Depression & Dementia; Evidence-based Screening). Additional module items are listed for completeness where translation is in progress.

2.1. Patient-centred care of patient

10 cases of AH

Summary: Training for healthcare professionals to improve basic patient communication, risk factor evaluation, and tertiary prevention approaches. Duration: 4 hours, blended format. Includes case presentations, interactive discussions, and accredited certification.

Who is the course material intended for?	Healthcare Professionals, Public Health Workers, Educators
What are the input requirements for the training?	See Annex 2
What knowledge will the participants have acquired by the end of the training?	Technical Skills Familiarity with any software or tools that will be utilized during the training, especially if the training involves data collection or analysis.

Who is the training aimed at?	Internal training for your own colleagues and open to external participants
What are the main objectives, and what skills or knowledge are participants expected to gain?	1.Understanding basic communication with patient 2. Evaluation of patients' risk factors 3. Basics of tertiary prevention in example of AH 4. Improving Public Health Outcomes
What is the duration of the training?	4 hours
What is the schedule?	Introduction, Icebreaking, Topic presentation, Interaction, Break, Case presentation, Discussion, Feed back
Is the curriculum itself available in some form? In what language (possibly English)?	Moodle for senior students both in Ukrainian and English
What is the ratio of practical to theoretical content?	1:2
What form can the training take?	Full e-learning, Blended
If it is e-learning or blended, please specify the platform it was made for.	Moodle, Google meet, Zoom
What software do you use for the training?	Power point, Word, Excell
Will the training be interactive, involve case studies, group work, lectures, or a different approach?	All types of approaches
Is there a predefined curriculum, and what resources or materials will participants receive during the training?	Screening adviser web-based program
Are there any prerequisites?	yes, with cases
Equipment requirement of the training:	overhead projector, screen, handouts, flipchart, markers
Number of trainer(s) required for the training:	10
Qualifications required for the trainer(s):	full national training courses for trainers, local training courses for trainers
Infrastructure requirements of the training:	training centre, training family doctor's office
How is the training completed?	100% completed

If there is an assessment, please specify the method:	OSCE, MCQs
Can a certificate be obtained from the training?	yes, including accreditation according to the Ukrainian credit system
Is the training accredited?	yes
Additional notes, training materials	Annex 2.

2.2. Basics of motivational interviewing of smoker

Summary: Equips healthcare professionals with skills to support smoking cessation using motivational interviewing. Duration: 10 hours. Focus on addressing patients' fears (ICE principle), conducting structured interviews, and role-play practice. Assessment via OSCE and MCQs, accredited under the Ukrainian credit system.

Who is the course material intended for?	Healthcare Professionals, Public Health Workers, Educators
What are the input requirements for the training?	See Annex 1 ...
What knowledge will the participants have acquired by the end of the training?	Technical Skills Familiarity with any software or tools that will be utilized during the training, especially if the training involves data collection or analysis.
Who is the training aimed at?	Internal training for your own colleagues and open to external participants
What are the main objectives, and what skills or knowledge are participants expected to gain?	1.Understanding basic communication with patient 2. Evaluation of patients fears (ICE principle) 3. Interviewing of smokers. 4. Improving Public Health Outcomes
What is the duration of the training?	10 hours
What is the schedule?	Introduction, Icebreaking, Topic presentation, Interaction, Break, Case presentation, Discussion, Feed back
Is the curriculum itself available in some form? In what language (possibly English)?	Moodle for senior students both in Ukrainian and English
What is the ratio of practical to theoretical content?	1:2
What form can the training take?	Full e-learning, Blended

If it is e-learning or blended, please specify the platform it was made for.	Moodle, Google meet, Zoom
What software do you use for the training?	Power point, Word, Excell
Will the training be interactive, involve case studies, group work, lectures, or a different approach?	All types of approaches
Is there a predefined curriculum, and what resources or materials will participants receive during the training?	Screening adviser web-based program
Are there any prerequisites?	yes, with cases
Equipment requirement of the training:	overhead projector, screen, handouts, flipchart, markers
Number of trainer(s) required for the training:	10
Qualifications required for the trainer(s):	full national training courses for trainers, local training courses for trainers
Infrastructure requirements of the training:	training centre, training family doctor's office
How is the training completed?	100% completed
If there is an assessment, please specify the method:	OSCE, MCQs
Can a certificate be obtained from the training?	yes, including accreditation according to the Ukrainian credit system
Is the training accredited?	yes
Additional notes, training materials	Annex 3.

2.3. Evidence-based screening of the main non-communicable diseases in family doctors' practice

Summary: Training on evidence-based tools and best practices for screening non-communicable diseases. Duration: 6 hours. Covers screening tools, implementation into practice, and improving public health outcomes.

Who is the course material intended for?	Healthcare Professionals, Public Health Workers, Educators and Trainers
What are the input requirements for the training?	Give access to resources (specific texts, journals, or online materials related to evidence-based practices and screening tools).
What knowledge will the participants have acquired by the end of the training?	Technical Skills Familiarity with any software or tools that will be utilized during the training, especially if the training involves data collection or analysis.
Who is the training aimed at?	Internal training for your own colleagues and open to external participants
What are the main objectives, and what skills or knowledge are participants expected to gain?	1.Understanding Screening Tools 2. Implementing Best Practices 3. Integrating Screening into Practice 4. Improving Public Health Outcomes
What is the duration of the training?	6 hours
What is the schedule?	Introduction, Icebreaking, Topic presentation, Interaction, Break, Case presentation, Discussion, Feed back
Is the curriculum itself available in some form? In what language (possibly English)?	Moodle for senior students both in Ukrainian and English
What is the ratio of practical to theoretical content?	2:04
What form can the training take?	Full e-learning, Blended
If it is e-learning or blended, please specify the platform it was made for.	Moodle, Google meet, Zoom
What software do you use for the training?	Power point, Word, Excell
Will the training be interactive, involve case studies, group work, lectures, or a different approach?	All types of approaches
Is there a predefined curriculum, and what resources or materials will participants receive during the training?	Screening adviser web-based program

Are there any prerequisites?	yes, with cases
Equipment requirement of the training:	overhead projector, screen, handouts, flipchart, markers
Number of trainer(s) required for the training:	from 1 to 25
Qualifications required for the trainer(s):	full national training courses for trainers, local training courses for trainers
Infrastructure requirements of the training:	training centre, training family doctor's office
How is the training completed?	100% completed
If there is an assessment, please specify the method:	OSCE, MCQs
Can a certificate be obtained from the training?	yes, including accreditation according to the Ukrainian credit system
Is the training accredited?	yes
Additional notes, training materials	Annex 4. ...

2.4. How to Uncover a Spy: Detecting Depression / Fog on the Horizon or Coping with Dementia

Summary: Focused on screening and diagnosing depression and dementia. Duration: 10 hours, blended learning with case studies and interactive exercises. Methodology based on WHO mhGAP guidelines. Accredited under the Ukrainian credit system.

Who is the course material intended for?	Healthcare Professionals, Public Health Workers, Educators and Trainers
What are the input requirements for the training?	Annex 1.
What knowledge will the participants have acquired by the end of the training?	Technical Skills Familiarity with any software or tools that will be utilized during the training, especially if the training involves data collection or analysis.
Who is the training aimed at?	Internal training for your own colleagues and open to external participants
What are the main objectives, and what skills or knowledge are participants expected to gain?	1. screening and correctly diagnosing depression. 2.screening and correctly diagnosing dementia and dealing with its most frequent manifestations

What is the duration of the training?	10 hours
What is the schedule?	Introduction, Icebreaking, Topic presentation, Interaction, Break, Case presentation, Discussion, Feed back
Is the curriculum itself available in some form? In what language (possibly English)?	Moodle for senior students both in Ukrainian and English
What is the ratio of practical to theoretical content?	1:1
What form can the training take?	Full e-learning, Blended
If it is e-learning or blended, please specify the platform it was made for.	Moodle, Google meet, Zoom
What software do you use for the training?	Power point, Word, Excell
Will the training be interactive, involve case studies, group work, lectures, or a different approach?	All types of approaches
Is there a predefined curriculum, and what resources or materials will participants receive during the training?	MhGAP guideline
Are there any prerequisites?	yes, with cases
Equipment requirement of the training:	overhead projector, screen, handouts, flipchart, markers
Number of trainer(s) required for the training:	4
Qualifications required for the trainer(s):	full national training courses for trainers, local training courses for trainers
Infrastructure requirements of the training:	training centre, training family doctor's office
How is the training completed?	100% completed
If there is an assessment, please specify the method:	OSCE, MCQs
Can a certificate be obtained from the training?	yes, including accreditation according to the Ukrainian credit system
Is the training accredited?	yes
Additional notes, training materials	Annex 5. ...

2.5. Basics of prevention, screening planning, tools for screening

Summary: Covers principles of prevention, planning, and screening tools. Duration: 10 hours. Interactive blended format, with practical exercises and accreditation.

Who is the course material intended for?	Healthcare Professionals, Public Health Workers, Educators and Trainers
What are the input requirements for the training?	See Annex 1.
What knowledge will the participants have acquired by the end of the training?	Technical Skills Familiarity with any software or tools that will be utilized during the training, especially if the training involves data collection or analysis.
Who is the training aimed at?	Internal training for your own colleagues and open to external participants
What are the main objectives, and what skills or knowledge are participants expected to gain?	1.Understanding Screening Tools 2. Implementing Best Practices 3.Integrating Screening into Practice 4. Improving Public Health Outcomes
What is the duration of the training?	10 hours
What is the schedule?	Introduction, Icebreaking, Topic presentation, Interaction, Break, Case presentation, Discussion, Feedback
Is the curriculum itself available in some form? In what language (possibly English)?	Moodle for senior students both in Ukrainian and English
What is the ratio of practical to theoretical content?	1:2
What form can the training take?	Full e-learning, Blended
If it is e-learning or blended, please specify the platform it was made for.	Moodle, Google meet, Zoom
What software do you use for the training?	Power point, Word, Excell
Will the training be interactive, involve case studies, group work, lectures, or a different approach?	All types of approaches
Is there a predefined curriculum, and what resources or materials will participants receive during the training?	Screening adviser web-based program
Are there any prerequisites?	yes, with cases
Equipment requirement of the training:	overhead projector, screen, handouts, flipchart, markers
Number of trainer(s) required for the training:	10
Qualifications required for the trainer(s):	full national training courses for trainers, local training courses for trainers

Infrastructure requirements of the training:	training centre, training family doctor's office
How is the training completed?	100% completed
If there is an assessment, please specify the method:	OSCE, MCQs
Can a certificate be obtained from the training?	yes, including accreditation according to the Ukrainian credit system
Is the training accredited?	yes
Additional notes training materials	Annex ..6.

2.4. Mental health screening in Hungary

Summary: Structured programme with psychoeducation, community activities, and psychometric tools such as PTSD-DS, BFI, STAI, GSE, and WHO-5. Includes 8 structured sessions aimed at improving resilience and mental health among refugees and IDPs.

The training programme will be structured around key theoretical and methodological components essential for understanding and addressing mental health challenges among refugees. The theoretical background will cover the psychological burden of refugees, the psychosocial framework of integration, and the general emotional process of integration, including identity loss, pseudo-identity, and the role of community in integration.

The methodological section will focus on psychoeducation, community activities, and psychometric tools used for assessment. Key psychometric instruments incorporated in the training will include:

Post-Traumatic Stress Disorder Diagnostic Scale (PTSD-DS) for assessing PTSD symptoms.

Big Five Inventory (BFI) for evaluating personality traits.

State-Trait Anxiety Inventory (STAI) for measuring anxiety levels.

General Self-Efficacy Scale (GSE) for assessing self-efficacy.

WHO Psychological Well-being Scale for evaluating overall psychological well-being.

Additionally, the training programme will include a detailed description of eight structured sessions designed to equip professionals with practical tools and strategies for mental health screening and intervention. These sessions will incorporate psychoeducation, skills training, trauma-informed approaches, and strategies for fostering community resilience among migrants.

The initiative aims to increase the resilience and wellbeing of refugees and asylum seekers in a foreign country, in this case Hungary, by empowering professionals working with refugees, and to address mental health as a key component of humanitarian assistance.

Methodology

Psychoeducation

During group work with refugees in HCSOM, we observed that groups based solely on cultural and social information were not effective. Additionally, groups focused on ventilation proved to be counterproductive (Kovács & Vörös, 2023). As an experimental approach, we incorporated psychoeducational elements, which appeared to be more effective in reducing refugees' anxiety.

Furthermore, within the framework of the program, it was often difficult or impossible for refugees to participate in classical group therapy, making psychoeducational care the most accessible method. Another key objective of this proposal is to assess the impact of psychoeducational interventions.

Neuner et al. (2004) examined the effectiveness of Narrative Therapy, Classical Counseling, and Psychoeducation among refugees suffering from PTSD. Their findings highlight that psychoeducation alone did not result in significant post-traumatic growth among refugees, whereas Narrative Therapy proved to be particularly effective (Neuner et al., 2004). However, it is important to emphasize that Neuner and colleagues provided psychoeducation based on dry psychopathological concepts in an individual therapy setting, without offering coping strategies, only discussing the symptomatology and effects of PTSD and anxiety. A 2018 study conducted among Somali refugees, however, found trauma-focused psychoeducation to be effective in symptom reduction (Im et al., 2018). The researchers developed a program called Trauma-Informed Psychoeducation (TIPE), which consisted of 12 sessions incorporating interactive psychoeducational methods. Interaction was not limited to the learning process but also aimed at equipping refugees with tools to strengthen their coping mechanisms. Akinsulure-Smith (2009) worked with fewer sessions—seven in total—which closely resembled the TIPE method, being trauma-focused and providing refugees with coping strategies. Additionally, Akinsulure-Smith placed great emphasis on collective trauma processing, reducing stigma, and fostering a self-supporting community. While this study did not employ empirical methods to measure outcomes, participants reported positive changes and symptom reduction.

Findings from psychoeducational research with refugees indicate that the format of psychoeducation is crucial. It should be interactive, with participants actively engaged in the process. Moreover, it is essential that refugees receive practical tools for trauma processing, such as mindfulness, art therapy, or cognitive behavioral therapy (CBT). Above all, it is also critical to establish a supportive community, where discussing trauma is not taboo, thereby facilitating self-healing processes (Akinsulure-Smith, 2009; Im et al., 2018; Neuner et al., 2004).

Community Activities

The literature suggests that community development is essential for identity development. Therefore, it is beneficial to organize community activities for refugees that introduce them to Hungarian culture while also providing opportunities for them to present their own cultural background. One such example is collective cooking, which has been proven to be an effective way to bring cultures closer together (Harris et al., 2014).

Psychometrics

Post-Traumatic Stress Disorder Diagnostic Scale

To measure PTSD, we intend to use the severity subscale of the Post-Traumatic Stress Disorder Diagnostic Scale (PTSD-DS) (Foa et al., 2011). The questionnaire is short (17 items) and can be administered in a paper-and-pencil format as a self-report measure. The scale determines the severity of PTSD symptoms.

BFI

The 33-item version of the Big Five Inventory (BFI) (John et al., 2012) may or may not be included in the study, as it is a relatively long test. If applied, its purpose is to filter out trait-level neuroticism and anxiety from the results.

STAI

The State-Trait Anxiety Inventory (STAI) (Spielberger, 2012) has long been recognized as a valid and reliable tool for measuring anxiety. Its administration aims to assess the current level of anxiety among refugees.

GSE

The General Self-Efficacy Scale (GSE), developed by Schwarzer and Jerusalem (1995), is a short 10-item test designed to measure an individual's self-confidence and sense of control. Despite its brevity, it has been validated as both reliable and valid.

WHO – Psychological Well-being

The WHO-5 Well-Being Index, validated by the World Health Organization (Susánszky et al., 2006), consists of only 5 items, yet research indicates that it effectively measures psychological well-being. Its simplicity and brief administration time make it ideal for research purposes.

Description of the Eight Sessions

Based on the literature review, the thematic structure of the following eight sessions has been established. The trauma-focused approach by Im et al. (2018) in psychoeducational research has significantly influenced the structure of the sessions, as their study demonstrated effectiveness in reducing symptoms. Additionally, the theories of community building and identity development, as well as experiential knowledge gained from working with refugees (Kovács & Vörös, 2023), have also been incorporated. The resulting system is primarily focused on psychoeducation, but it is supplemented with community activities, language instruction, and the transfer of social and cultural information. It is assumed that this holistic approach may be effective in treating PTSD and other psychological disorders among refugees. The sessions are open to all participants and are held on a weekly basis. The following table outlines the themes of the eight sessions, along with additional activities, coping strategies, and interactive exercises. The literature review has already explained the rationale behind the selected topics in this plan. The table primarily serves to introduce the psychoeducational component, but each session also includes an informational group led by a social worker. Printed and/or email versions of the session materials are provided to all participants, including those who were unable to attend.

Session	Curriculum	Interaction	Coping Tool	Group Activity
I. Session	Presentation of the Group's Purpose Introduction to Community Sessions Establishing the Group Framework Presentation of Questionnaires and Research Completion of Questionnaires	Participants are welcomed with food Participants introduce themselves using an interactive method (e.g., ball tossing) They have the opportunity to ask questions	The group's thematic structure is provided in printed form, making it visible in advance, which helps the sense of control	Hop-On-Hop-Off bus tour
II. Session	The emotional effects of the integration process (see Figure 1). What is culture?	Before each thematic question, refugees can express their own opinions and share what culture means to them.	Writing a thought diary (CBT)	Visit to the Parliament or the Buda Castle

Session	Curriculum	Interaction	Coping Tool	Group Activity
	What impact does cultural transition have on our emotions and body? What are the differences between the country of origin and Hungary? What are the current difficulties?	After the educational section, they can share their personal experiences and what they can relate to.		
III. Session	Loss, Anxiety, and Trauma: What is trauma? What is stress and anxiety? The effects of stress and trauma. Loss as a trauma factor. The phases of processing loss. Managing loss: adaptive and maladaptive forms. The physical and psychological effects of anxiety and stress.	What are their own words for trauma, stress, anxiety, and loss? What solutions do they have for reducing stress?	Breathing exercises, stress-reducing relaxation techniques.	Hiking in nature
IV. Session	PTSD, Depression, Panic Attack, Substance Abuse Quick review of the previous session Symptoms of depression Symptoms of PTSD Symptoms of panic attacks Managing panic attacks Symptoms of substance abuse Where can they get help? What are the different forms of support? The role of social taboos in maintaining symptoms The power of open conversation	Stone and Flower Exercise Refugees can write down in an envelope whether they have any symptoms. The envelopes will be distributed, but they do not need to be filled out on the spot.	Mindfulness exercises	Craft activity
V. Session	Identity Loss of Identity False Identity What is identity? Group Identity The danger of false identity The process of identity loss resulting from being a refugee The formation of a new identity Tools to support identity development	Everyone receives name tags on which they can write three things that are truly important to them. They can pin these on themselves and look around to see what identity pillars others have.	Mandala creation techniques	Excursion to Hollókő
VI. Session	In-group Out-group	The group is divided into two parts based on a coin toss. Then, the two	"I" statement techniques	Team-building activity

Session	Curriculum	Interaction	Coping Tool	Group Activity
	Social psychological phenomena experienced by refugees Group formation Intergroup conflicts Stereotype Stereotypes about ourselves Breaking down stereotypes	new groups are given a small task in which they can compete. Based on the experience, we explain the minimal group paradigm phenomenon.	Assertive communication	
VII. Session	Empathy, The Retentive Power of Community The concept of empathy in general Why is it important? The question and importance of self-empathy The community-building nature of empathy The negative effects of stigma The power of community The self-healing functions of community The importance of shared activities and their integrative effect	Video about empathy What does everyone think about it? What are their own words for empathy?		Group cooking

ANNEXES

Annex 1: IDP Mental Health and NCD Screening Training Package (Complete Modules, Participant Workbook, Trainer's Guide)

Annex 2: Methodological Guide – Basics of Tertiary Prevention - Patient-Centred Management of Arterial Hypertension

Annex 3: Basics of Motivational Interviewing of Smokers

Annex 4: Detecting and Managing Depression (mhGAP-aligned)

Annex 5: Evidence-Based Screening: Live Long, Live Well

ANNEX 1: Complete Training Package – IDP Mental Health and NCD Screening

This document was developed within the framework of the ShowUp4Health project. It provides a comprehensive training package consisting of three core components: (1) Training Modules, (2) Participant Workbook, and (3) Trainer's Guide. The package has been designed for healthcare professionals and NGO outreach workers working with internally displaced persons (IDPs) and vulnerable communities.

1. Training Modules

2. Participant Workbook

3. Trainer's Guide

Training Modules – IDP Mental Health and NCD Screening

This document was developed based on Deliverable D3.4 of the ShowUp4Health project, transforming the training modules into structured educational material. The modules follow a unified template: Introduction, Learning Outcomes, Content, Learner Activities, Methodology, Assessment, Summary, and Supplementary Materials.

Overview of Developed Training Programme (Modules 1–5)

Within the ShowUp4Health project, a comprehensive training programme consisting of **five modules** was developed to cover prevention, screening, management, rehabilitation, and mental health in family medicine practice.

Module 1 – Primary Prevention

Two thematic trainings focused on prevention of **smoking** and **obesity**.

Module 2 – Screening of Common Diseases in Family Medicine

Three trainings:

- **CheckMe** platform for evidence-based screening;
- Patient-oriented approach to screening planning (*Four Steps to Longevity*);
- Population-oriented screening and prevention.

Module 3 – Tertiary Prevention

Five trainings:

- Arterial Hypertension: "How to Tame the Dragon";
- Cardiovascular Risks: "How to Escape a Heart Attack";
- Virtual consultations in family practice ("Teleport to the Visit");
- Ten clinical cases of arterial hypertension in family practice;
- "Become the Conductor of the Cardio-Reno-Metabolic Orchestra."

Module 4 – Rehabilitation after Cardiovascular Catastrophes

Four trainings dedicated to **rehabilitation** following cardiovascular events.

Module 5 – Screening and Management of Mental Health Problems
Two trainings: **dementia** and **depression** (assessment and management).

Detailed syllabi and full materials for selected topics are provided in Annexes 2–5.

HYPERTENSION MANAGEMENT – PATIENT-CENTRED APPROACH

Introduction
The aim of this module is to provide participants with the basics of hypertension management using a patient-centred approach, grounded in prevention and international guidelines.

Learning Outcomes

- Understands the levels of prevention and their application in hypertension care.
- Can identify risk factors through case studies.
- Develops patient collaboration using motivational interviewing techniques.

Content

- *Theoretical part:* short overview, definitions, international guidelines.
- *Practical part:* case study, testing screening tools, group work.

Learner Activities

Icebreaker exercise, case study analysis, role play, reflection questions.

Methodology and Tools

Blended learning format, PPT slides, Moodle module, flipchart, workbook, projector.

Assessment
Pre- and post-test, competency-based assessment (role play, case study), self-reflection.

Summary and Closing

Highlighting key messages, providing further readings and resources.

Supplementary Materials

PPT slides, trainer's guide, participant workbook, online questionnaires.

MOTIVATIONAL INTERVIEWING WITH SMOKERS

Introduction
This module focuses on communication methods that support smoking cessation, building on motivational interviewing techniques.

Learning Outcomes

- Understands the psychological and somatic aspects of smoking.
- Can conduct a structured interview with smoking patients.
- Improves skills in building trust and supporting behavioural change.

Content

- *Theoretical part:* short overview, definitions, international guidelines.
- *Practical part:* case study, testing screening tools, group work.

Learner Activities

Icebreaker exercise, case study analysis, role play, reflection questions.

Methodology and Tools

Blended learning format, PPT slides, Moodle module, flipchart, workbook, projector.

Assessment
Pre- and post-test, competency-based assessment (role play, case study), self-reflection.

Summary and Closing

Highlighting key messages, providing further readings and resources.

Supplementary Materials

PPT slides, trainer's guide, participant workbook, online questionnaires.

NON-COMMUNICABLE DISEASE SCREENING – EVIDENCE-BASED PRACTICE

Introduction
This module focuses on NCD screening tools applicable in primary care and methods grounded in evidence-based practice.

Learning Outcomes

- Knows the international recommendations on NCD screening.
- Can select and integrate screening tools into daily practice.
- Evaluates the impact of screening on community health.

Content

- *Theoretical part:* short overview, definitions, international guidelines.
- *Practical part:* case study, testing screening tools, group work.

Learner Activities

Icebreaker exercise, case study analysis, role play, reflection questions.

Methodology and Tools

Blended learning format, PPT slides, Moodle module, flipchart, workbook, projector.

Assessment
Pre- and post-test, competency-based assessment (role play, case study), self-reflection.

Summary and Closing

Highlighting key messages, providing further readings and resources.

Supplementary Materials

PPT slides, trainer's guide, participant workbook, online questionnaires.

Recognising Depression and Dementia in IDP Communities

Introduction
This module focuses on recognising and differentiating depression and dementia in IDP communities, based on the WHO mhGAP guidelines.

Learning Outcomes

- Lists the main symptoms of depression and dementia.
- Applies screening tools (WHO-5, STAI).
- Practices a trauma-informed, stigma-reducing approach.

Content

- *Theoretical part:* short overview, definitions, international guidelines.
- *Practical part:* case study, testing screening tools, group work.

Learner Activities

Icebreaker exercise, case study analysis, role play, reflection questions.

Methodology and Tools

Blended learning format, PPT slides, Moodle module, flipchart, workbook, projector.

Assessment

Pre- and post-test, competency-based assessment (role play, case study), self-reflection.

Summary and Closing

Highlighting key messages, providing further readings and resources.

Supplementary Materials

PPT slides, trainer's guide, participant workbook, online questionnaires.

PREVENTION AND SCREENING PLANNING

Introduction

This module introduces the principles of prevention and methods of screening planning, including the use of both practical and digital tools.

Learning Outcomes

- Understands the basic concepts of prevention.
- Can design a screening plan for their own context.
- Applies both digital and traditional screening tools.

Content

- *Theoretical part:* short overview, definitions, international guidelines.
- *Practical part:* case study, testing screening tools, group work.

Learner Activities

Icebreaker exercise, case study analysis, role play, reflection questions.

Methodology and Tools

Blended learning format, PPT slides, Moodle module, flipchart, workbook, projector.

Assessment

Pre- and post-test, competency-based assessment (role play, case study), self-reflection.

Summary and Closing

Highlighting key messages, providing further readings and resources.

Supplementary Materials

PPT slides, trainer's guide, participant workbook, online questionnaires.

Participant Workbook – IDP Mental Health and NCD Screening

This workbook was created to accompany the ShowUp4Health training modules. It supports participants in processing the material, engaging in self-reflection, and applying the knowledge in practice.

Hypertension Management – Patient-Centred Approach

Tasks

☐ Write down the risk factors you know that contribute to the development of hypertension.
☐ Case study: A 45-year-old IDP male presents with high blood pressure. What questions would you ask him?

☐ Reflection: How could you integrate a patient-centred approach into your own work?

Notes

MOTIVATIONAL INTERVIEWING WITH SMOKERS

Tasks

☐ List the motivational interviewing techniques you are familiar with.
☐ Pair exercise: Conduct a short (5-minute) interview with a 'patient' who smokes.
☐ Reflection: What challenges did you encounter during the exercise?

Notes

NON-COMMUNICABLE DISEASE SCREENING – EVIDENCE-BASED PRACTICE

Tasks

☐ Write down an example of an evidence-based screening tool you have used or would use.
☐ Group exercise: Develop a short screening protocol for the IDP community.
☐ Reflection: What barriers might arise in implementing NCD screening?

Notes

RECOGNISING DEPRESSION AND DEMENTIA IN IDP COMMUNITIES

Tasks

☐ List the 5 main symptoms of depression and the 5 main symptoms of dementia.
☐ Case study: A 62-year-old refugee woman complains of fatigue and forgetfulness. How would you differentiate between depression and dementia?

☐ Reflection: How could you empathetically reduce the impact of stigma in the community?

Notes

PREVENTION AND SCREENING PLANNING

Tasks

☐ Write down the three levels of prevention and give an example for each.
☐ Task: Prepare a mini screening plan (target group, tools, timeframe).
☐ Reflection: How could you involve IDP community members in preventive activities?

Notes

Final Reflection

Write down which module was the most valuable for you, and how you plan to apply the knowledge in your work.

Trainer's Guide – IDP Mental Health and NCD Screening

This guide was developed to accompany the ShowUp4Health project training modules. It supports trainers in delivering the modules effectively by providing time allocations, facilitation tips, and assessment guidelines.

Hypertension Management – Patient-Centred Approach

Time Allocation
Recommended duration: 2.5 hours

Facilitation Tips

- Use real case studies from the IDP population.
- Encourage participants to share their own experiences.
- Visualise the levels of prevention (e.g., pyramid diagram).

Assessment Suggestions
• Use pre- and post-tests.
• Observe role plays and apply a checklist.
• Assess the processing of case studies.
• Review participant self-reflection journals.

Motivational Interviewing with Smokers

Time Allocation
Recommended duration: 3 hours

Facilitation Tips

- Alternate participants between patient and physician roles during role play.
- Emphasise empathy and the 'ICE' technique (Ideas, Concerns, Expectations).
- Provide feedback after interviews, with positive reinforcement.

Assessment Suggestions
• Use pre- and post-tests.
• Observe role plays and apply a checklist.
• Assess the processing of case studies.
• Review participant self-reflection journals.

Non-Communicable Disease Screening – Evidence-Based Practice

Time Allocation
Recommended duration: 2 hours

Facilitation Tips

- Present the ESC/WHO recommendations in a short PPT.
- Ask groups to develop a screening protocol.
- Jointly evaluate the feasibility of the proposed protocols.

Assessment Suggestions
• Use pre- and post-tests.
• Observe role plays and apply a checklist.
• Assess the processing of case studies.
• Review participant self-reflection journals.

Recognising Depression and Dementia in IDP Communities

Time Allocation
Recommended duration: 3 hours

Facilitation Tips

- Conduct a role play involving a short anamnesis interview.
- Explain the differences between depression and dementia symptoms.
- Use WHO-5 and STAI questionnaires in the practical session.

Assessment Suggestions
• Use pre- and post-tests.
• Observe role plays and apply a checklist.
• Assess the processing of case studies.
• Review participant self-reflection journals.

Prevention and Screening Planning

Time Allocation
Recommended duration: 2.5 hours

Facilitation Tips

- Ask participants to prepare a mini screening plan.
- Use a flipchart to visualise the plans.
- Encourage creative ideas for community engagement.

Assessment Suggestions
• Use pre- and post-tests.
• Observe role plays and apply a checklist.
• Assess the processing of case studies.
• Review participant self-reflection journals.

General Advice for Trainers

1. Be sensitive to the traumatic experiences of IDP participants.
2. Apply trauma-informed facilitation techniques.
3. Keep within the allocated timeframes but remain flexible to group needs.
4. Use positive feedback to increase motivation.
5. Document participants' progress and suggestions.

ANNEX 2: Methodological Guide

Basics of Tertiary Prevention – Patient-Centred Management of Arterial Hypertension

1) Training Overview

- Title: Basics of Tertiary Prevention – Patient-Centred Management of Arterial Hypertension
- Duration: 4 hours
- Target Audience: Family doctors, primary care physicians, nurses, public health workers
- Format: Blended training (interactive lecture, small-group work, case analysis, testing, feedback)
- General Goal: Strengthen competencies for patient-centred hypertension management using tertiary prevention principles and real clinical case discussions.

2) Learning Objectives

By the end of the training, participants will be able to:

1. Define and differentiate primary, secondary and tertiary prevention in HTN care.
2. Apply a patient-centred approach, including shared decision-making and motivational interviewing.
3. Identify risk factors and adapt management strategies accordingly.
4. Use evidence-based screening and apply international guidelines (ESH/ESC/WHO).
5. Manage special populations (diabetes, obesity, older adults, pregnancy, post-MI) through case-based scenarios.
6. Demonstrate knowledge gain via MCQs and reflective feedback.

3) Training Structure (Agenda)

Session	Activity	Duration	Method
Introduction	Organisational matters	5 min	Trainer briefing
Icebreaker	“Name one thing that makes you unique”	10 min	Group round
Ground rules	Define rules (captured on flipchart/board)	5 min	Group discussion
Pre-test	Short knowledge test	5 min	MCQs
Activation	Patient-centred care & family doctor competencies – Expectation Tree	5 min	Brainstorm
Goals	Programme aims; 10 clinical cases as examples	3 min	Mini-lecture
Stage 1	Types of prevention; emphasis on primary prevention	10 min	Guided discussion
Stage 2	Risk factors & management in HTN	20 min	Interactive lecture + Q&A
Break	—	5 min	—
Stage 3	Diagnostic approach; BP thresholds across categories	20 min	Case-prompted discussion
Stage 4	Small-group work: case analysis	20 min	Clinical cases
Break	—	20 min	—
Stage 5	Group presentations & plenary debate	70 min	Reports + moderated discussion

Session	Activity	Duration	Method
Q&A	Open questions	10 min	Moderated
Post-test	MCQ test	10 min	Written
Conclusion	Key take-aways	5 min	Trainer
Feedback	Basket / Pot / Bin reflective exercise	15 min	Reflection

4) Training Content

- Tertiary prevention in HTN: definitions, scope, integration into primary care.
- Risk factors: smoking, obesity, diabetes, dyslipidaemia, family history, psychosocial stress.
- Diagnostics: BP measurement rules; ESH/ESC 2018 categories; SCORE2 risk estimation.
- Case-based learning: 10 scenarios (young adults, elderly, pregnancy, diabetes, multimorbidity, psychosocial context).
- Patient-centred communication: motivational interviewing steps; shared decision-making (preferences, values, options, agreement).
- Therapy principles: lifestyle interventions; pharmacological strategies (mono/dual/combination); statins and aspirin only when indicated by risk.

5) Learning Materials

- Slides: "10 Cases of HTN Management" (PPT).
- Handouts: Hypertension brochure; statin therapy; smoking cessation counselling.
- MCQs: Pre/post (10 items on guidelines, risk, special populations).
- Case sheets: 10 printed scenarios (for ~9 groups).

6) Teaching Methods

- Interactive lecture anchored in current guidelines.
- Small-group clinical problem-solving.
- Role-play (motivational interviewing, patient communication).
- Plenary debrief and peer learning.
- Reflective practice & feedback.

7) Assessment

- Knowledge: MCQs before and after the course.
- Skills: Group case presentations; clinical reasoning observed via checklist.
- Attitudes: Reflection using the Basket / Pot / Bin method.

8) Trainer's Notes

- Invite personal clinical experience sharing.
- Emphasise local adaptation: how European guidance translates to Ukrainian primary care.
- Facilitate sensitively around psychosocial risk and stigma.

- Use contextual CVD mortality data (Ukraine vs. Europe) to motivate prevention.

9) Expected Outcomes

- Improved knowledge of tertiary prevention and HTN management.
- Stronger patient-centred skills and shared decision-making.
- Practical strategies tailored to IDPs and high-risk patients.
- Increased trust between providers and patients.

Clinical Reference Aids

A) Blood Pressure Categories (ESH/ESC 2018)

Category	SBP (mmHg)	and/or	DBP (mmHg)
Optimal	<120	and	<80
Normal	120–129	and/or	80–84
High-normal	130–139	and/or	85–89
Grade 1 HTN	140–159	and/or	90–99
Grade 2 HTN	160–179	and/or	100–109
Grade 3 HTN	≥180	and/or	≥110
Isolated systolic HTN	≥140	and	<90

Diagnosis: measure both arms (use the higher reading). Confirm with repeated readings on different days; home/ambulatory monitoring is useful.

B) Minimum Work-up in Newly Diagnosed Hypertension

- Physical examination (including neurological status).
- 12-lead ECG (assess LVH).
- Laboratory tests: CBC, urinalysis, fasting glucose, creatinine/eGFR, lipids (± ALT, TSH, albumin-creatinine ratio as indicated).

C) Treatment Targets – Quick Guide

- General clinic target: <140/90 mmHg; if tolerated, <130/80 mmHg (older adults: SBP 130–139).
- Combine lifestyle measures with pharmacotherapy based on risk and baseline BP.
- Statin/aspirin only when indicated by individual CV risk or established CVD.

Case Prompts (Short Set)

- Case 1 (39-year-old smoker, BP 145/95): establish diagnosis; further questions; SCORE2 timing; initial non-pharmacological plan (smoking cessation, weight, activity, DASH).
- Case 2 (52-year-old, BP 160/100, NSAIDs & nasal vasoconstrictors): targeted exam/labs; drug-induced HTN; initial therapy and follow-up schedule.
- Case 3 (62-year-old, BP 180/110, long-standing HTN): urgency vs. emergency cues; combination therapy; targets in older adults; adherence & safety.

MCQ – Knowledge Check (10 items)

1) Which BP category aligns with SBP 130–139 or DBP 85–89 mmHg (clinic)?

A) Optimal

B) Normal

C) High-normal

D) Grade 1

Answer: C

2) First-line strategy for most newly diagnosed HTN in primary care:

A) Universal monotherapy

B) Lifestyle + (often) initial dual therapy per guideline

C) Beta-blocker for all

D) ACEi + ARB together

Answer: B

3) Preferred BP target if well tolerated in a middle-aged adult without frailty:

A) <150/90

B) <130/80

C) <120/70

D) <140/90

Answer: B

4) Which combination is guideline-concordant as initial dual therapy?

A) ACEi + ARB

B) ACEi or ARB + CCB or thiazide

C) Beta-blocker + loop diuretic

D) ACEi + alpha-blocker

Answer: B

5) Pregnancy and HTN—acceptable first-line option(s):

A) ACEi

B) Labetalol / Nifedipine / Methyldopa

C) ARB

D) Aliskiren

Answer: B

6) Which medication(s) may raise BP and should be reviewed in HTN work-up?

A) Intranasal vasoconstrictors

B) Chronic NSAID use

C) Some corticosteroids

D) All of the above

Answer: D

7) ECG sign suggestive of LVH includes:

A) QT prolongation

B) Sokolow-Lyon index ≥35 mm (SV1/V2 + RV5/V6)

C) PR depression

D) Low limb-lead voltage

Answer: B

8) Lifestyle intervention with largest average BP impact in obesity:

A) Salt restriction

B) Weight loss

C) Caffeine avoidance

D) Vitamin D

Answer: B

9) Primary prevention with aspirin in uncomplicated HTN:

A) Recommended for all

B) Not routinely recommended; reserve for high/very high risk or established CVD per guidance

C) Recommended only if LDL <2.6

D) Contraindicated in all

Answer: B

10) Statin therapy decision is based primarily on:

A) Patient's age alone

B) SBP at diagnosis

C) Global CV risk and LDL-C target (e.g., SCORE2)

D) Number of antihypertensives

Answer: C

ANNEX 3: Basics of Motivational Interviewing for Smokers (MI)

1. Training Title & Duration

- Title: Communication with People Who Smoke – Principles of Motivational Interviewing (MI)
- Duration: 4 hours (240 minutes)
- Audience: Family doctors, nurses, public health workers, NGO outreach staff
- Format: Blended (interactive mini-lectures, skills practice, role-play, debrief, MCQs)

2. Learning Objectives (with assessment mapping)

By the end of the training, participants will be able to:

1. Explain the prevention framework (primary/secondary/tertiary) in tobacco control. (MCQ)
2. Apply MI core skills (OARS; RULE) to explore ambivalence and elicit change talk. (Observed checklist / OSCE)
3. Use the DTP (Thought–Anxiety–Need) conversation opener to surface beliefs, fears and needs without confrontation. (Role-play)
4. Conduct a brief intervention using the 5A model (Ask–Advise–Assess–Assist–Arrange) and readiness rulers. (OSCE + debrief)
5. Outline pharmacotherapy options (NRT, varenicline, bupropion, cytisine), indications/contraindications and follow-up. (MCQ)
6. Co-create a simple SMART quit plan and arrange follow-up. (Artefact check + OSCE)

Success metrics: Pre→Post MCQ ≥ 20% absolute improvement; OSCE checklist ≥ 80%; ≥ 70% of participants produce a SMART quit plan sample.

3. Structure and Flow (240 min)

Block	Activity	Minutes	Method
1	Welcome, objectives, baseline self-rating (0–10)	10	Briefing + poll
2	Prevention framework (primary–secondary–tertiary) in tobacco	15	Guided discussion
3	MI essentials: OARS & RULE	25	Interactive mini-lecture + micro-drills
4	DTP opener: Thought–Anxiety–Need (evocation, not persuasion)	20	Demo + triad practice
—	Break	10	—
5	Working with ambivalence: change talk (DARN-CAT); importance & confidence rulers	20	Skills practice
6	5A brief intervention for smokers; map local SPODO → 5A	25	Demo + checklist
7	Pharmacotherapy quick guide (NRT, varenicline, bupropion, cytisine); indications/CI; IDP-sensitive tips	20	Mini-lecture + Q&A
8	Role-plays (hesitant vs. ready to quit); observer	30	Triads rotate

	checklist		
9	Debrief + Q&A	15	Plenary
10	Post-test (MCQ, 10 items) + self-rating repeat	15	Written
11	Action planning: SMART quit plan template + local referrals	10	Worksheet
12	Feedback: Basket / Pot / Bin; closing	15	Reflection

4. Content Outline

4.1 MI Core (keep language MI-consistent)

- OARS: Open questions; Affirmations; Reflective listening; Summaries.
- RULE: Resist the righting reflex; Understand motivations; Listen with empathy; Empower autonomy.
- Avoid 'persuasion' → use evocation & shared planning. Replace 'but' with 'and/at the same time'.

4.2 Conversation Openers – DTP (Thought–Anxiety–Need)

- Thought: “What do you think about your smoking right now?”
- Anxiety: “What concerns do you have about quitting?”
- Need: “What would you like from me today?”
- Skills: reflections, normalization, summaries. Keep it non-confrontational.

4.3 Brief Intervention – 5A (SPODO ↔ 5A mapping)

Standardise on 5A, while acknowledging local SPODO terms. Mapping below:

SPODO (local)	5A (standard)	Brief description
S – Ask	Ask	Status, pattern, history; consider FTND/HSI; CO monitor if available.
P – Advise	Advise	Clear, personalised recommendation to quit; link to values/health.
O – Assess	Assess	Readiness: importance & confidence rulers (0–10); stage of change.
D – Assist	Assist	Set quit date; triggers & coping; involve supports; pharmacotherapy if indicated.
O – Organise	Arrange	Schedule follow-up (1–2 weeks); relapse-prevention check-ins.

4.4 Pharmacotherapy (brief, guideline-concordant)

- NRT: patch, gum, lozenge, spray, inhaler; combination NRT (long + short acting) often most effective.
- Varenicline: partial agonist; reduces cravings and reward; follow local guidance.
- Bupropion: reduces cravings; check contraindications.
- Cytisine: partial agonist; availability varies; follow local protocol.
- Contraindications/precautions (examples):

- Bupropion: seizure risk, eating disorders, MAOI use, severe cirrhosis.
- Pregnancy/Breastfeeding: first-line is behavioural support; consider short-acting NRT under medical supervision.
-Psychiatric comorbidity: MI especially helpful; pharmacotherapy tailored to guideline and patient context.

- Follow-up: monitor side effects, adherence; titrate; relapse plan.

4.5 Tools & Scripts

- Readiness rulers (importance & confidence, 0–10): "Why not a lower number?" to elicit change talk.
- SMART Quit Plan: date, triggers, coping strategies, supporters, rewards.
- Very Brief Advice script (30–60 sec): Ask → Advise → Act/Assist → Arrange.
- Trauma-informed tips in IDP settings: choice, pacing, safety; avoid shaming; normalise setbacks.

5. Assessment

- Pre/Post MCQ (10 items): target ≥ 20% absolute gain.
- OSCE mini-scenario: OARS, DTP, 5A, pharmacotherapy offer; pass ≥ 80%.
- Artefact: at least one SMART quit plan per participant.
- Optional follow-up (4–8 weeks): self-reported quit attempt or reduction in cigarettes/day.

6. Supporting Materials

- Slides: Motivational Interviewing for Smokers (PPT).
- Handouts: 5A cheat-sheet; DTP prompts; SMART quit plan (A4).
- Quick reference: Pharmacotherapy one-pager (indications/CI + dose sketch per local protocol).
- Observer OSCE checklist (1 page).

7. Sample Case Prompts (role-play)

- Ambivalent 45M with hypertension, ~10 cig/day: concerns about weight gain; DTP + rulers; Assist with combo NRT.
- Ready 29F, 3 months postpartum: 5A; breastfeeding-safe approach; define support network.
- Stressed 52M, shift worker: night-shift triggers; plan for breaks; screen bupropion contraindications.

Appendix A – SMART Quit Plan (Template)

- Quit date: _____
- Main triggers (situations/people/feelings): _____
- Coping strategies (what I will do instead): _____

- Supporters (names/roles): _____
- Pharmacotherapy (if any): _____
- Follow-up appointments (dates): _____
- Rewards for milestones (1 day / 1 week / 1 month): _____

Appendix B – Observer Checklist (OSCE mini-station) – 10 items

- Uses open questions (OARS – O).
- Provides at least one affirmation (OARS – A).
- Reflects and summarises key statements (OARS – R/S).
- Avoids the righting reflex; demonstrates empathy (RULE).
- Applies DTP opener appropriately (Thought, Anxiety, Need).
- Elicits change talk and explores ambivalence (DARN-CAT cues).
- Implements 5A correctly (Ask, Advise, Assess, Assist, Arrange).
- Offers appropriate pharmacotherapy or explains why not.
- Co-creates a SMART plan (quit date, triggers, coping, supports).
- Arranges specific follow-up (time-bound).

Scoring: 1 point/item; pass ≥ 8/10.

ANNEX 4: Detecting and Managing Depression (mhGAP-aligned)

Module Title

Detecting Depression: Recognition, Assessment, and Initial Management (Part 1 & Part 2)

Note: The earlier metaphor "How to Uncover a Spy" may be retained as a subtitle if desired, but a neutral, clinical title is recommended.

Target Group

Medical students, interns, family doctors, primary-care nurses, NGO outreach staff (10–20 participants).

Total Duration

5 hours total, delivered as two 2.5-hour blocks:

- Part 1 (2.5 h): Recognition & Assessment
- Part 2 (2.5 h): Management & Follow-up

Learning Objectives (measurable)

1. Screen adults for depression using PHQ-2 / PHQ-9 and interpret results (OSCE checklist ≥80%).
2. Conduct suicide risk screening and implement immediate safety steps (brief safety plan, urgent referral criteria).
3. Differentiate depression from grief, bipolar disorder (mania), and common medical causes (e.g., hypothyroidism, anaemia, B12 deficiency).
4. Deliver brief psychosocial interventions (psychoeducation, behavioural activation, problem-solving) and outline basic pharmacotherapy principles per mhGAP.
5. Create a follow-up plan with monitoring indicators (repeat PHQ-9, functional status).

Assessment Mapping

- Knowledge: 10-item MCQ (pre/post), target ≥20% absolute improvement.
- Skills: OSCE mini-station (screening + suicide questioning + safety plan), target ≥80%.
- Attitudes: Reflective exercise (Basket / Pot / Bin).

PART 1 — Recognition & Assessment (150 minutes)

Materials: slides, short video/personal story (e.g., "Black Dog" or rights-cleared alternative), printed PHQ-2/PHQ-9 forms, OSCE mini-checklist, flipchart.

Time	Content	Method
10'	Icebreaker: one word for current mood + one source of joy; mix seating	Pairs / group reshuffle
5'	Ground rules (confidentiality, respect, participation)	Group agreement on board
10'	Pre self-rating (0–10) & 10-item pre-MCQ	Written
15'	Story/video + debrief; person-first language, anti-stigma	View + guided reflection
20'	Core features of depression; functional impairment; public health burden	Interactive mini-lecture

Time	Content	Method
25'	Screening: PHQ-2 → PHQ-9; culturally sensitive openings; open vs. closed questions	Demo + triad practice
15'	Suicide item (PHQ-9 Q9): normalised asking, direct questioning, immediate steps	Role-play + safety cheat-sheet
25'	Differential: grief, bipolar (mania signs), medical causes (TSH, CBC, ferritin/B12, glucose), meds	Case-based discussion
5'	Transition / energiser	—

Quick Reference — Tools

- PHQ-2: 2 questions; if score ≥3 → administer PHQ-9.
- PHQ-9: severity + monitoring; item 9 = suicide ideation → immediate risk assessment and safety steps.
- Suicide Safety Mini-Protocol (primary care): 1) ask directly; 2) acute risk → emergency pathway; 3) brief Safety Plan (triggers, coping, contacts, crisis lines); 4) means-restriction counselling; 5) follow-up within 24–72 h.

PART 2 — Management & Follow-up (150 minutes)

Time	Content	Method
10'	Icebreaker: "Safe place" brief imagery	Guided exercise
40'	Psychosocial interventions: psychoeducation, behavioural activation, sleep hygiene, problem-solving, MI basics	Poster rotation + mini-demo
30'	Pharmacotherapy basics (mhGAP): SSRI first-line; onset/latency; side-effects; pregnancy/lactation; older adults	Mini-lecture + 5-item quiz
20'	Role-play: initiating psychosocial intervention	Triads + observer checklist
20'	Follow-up planning: repeat PHQ-9, adherence, adverse effects, "red flags"	Small-group plan build
10'	Post-MCQ + post self-rating	Written
20'	Feedback: Basket / Pot / Bin	Reflective circle

Trainer notes: In IDP and trauma-exposed settings, use trauma-informed communication (choices, pacing, safety, shame-avoidance). Benzodiazepines are not first-line; antipsychotics only with clear indications and close follow-up.

Dementia Module — "Fog on the Horizon": Screening and Initial Management (210 minutes)

Learning Objectives

1. Perform brief cognitive screening using Mini-Cog or GPCOG; rule out delirium with 4AT (or CAM).
2. Plan initial work-up: history, physical, labs (CBC, TSH, B12 ± folate, glucose, electrolytes; LFT/RFT); imaging indications (focal signs, abrupt onset, etc.).
3. Address BPSD with non-pharmacological strategies first; support caregivers and plan respite/education.
4. Uphold dignity and rights; avoid physical/chemical restraints; if used in emergencies, keep minimal duration and document.

Time	Content	Method
10’	Memory-cards icebreaker	Game
10’	Ground rules	Group
5’	Self-assessment (tree drawing)	Self-rating
40’	Introduction: what dementia is; prevalence; family burden; legal/ethical basics	Lecture + personal story
10’	Break	—
40’	Assessment: Mini-Cog/GPCOG; 4AT for delirium; baseline labs; late-life depression differentiation	Video + algorithm
20’	Break	—
30’	Role-play: assessment + caregiver interview	Triads + checklist
10’	Q&A	Plenary
5’	Self-assessment repeat (tree)	Self-rating
15’	Feedback: Basket / Pot / Bin	Reflective circle
5’	Closing	—

Quick Aids (Clinician Reference)

- Mini-Cog: 3-word recall + clock draw; abnormal if 0 words recalled, or 1–2 words with abnormal clock.
- 4AT (delirium): alertness, AMT4, attention, acute change/fluctuation; score ≥4 → probable delirium.
- Baseline labs: CBC, TSH, B12 (± folate), glucose, Na/K, Ca, LFT/RFT; HIV/syphilis when indicated.
- BPSD – non-pharm first: identify triggers (pain, constipation, sleep loss), structure environment, routine, validation techniques.
- Pharmacological options: only when necessary, short duration, low dose, close monitoring (e.g., severe psychosis/agitation with risk).

Trainer Pack (Attachments)

- Printable PHQ-2 / PHQ-9 forms.
- One-page Suicide Safety Plan template (triggers, coping, contacts, crisis numbers, means-restriction).
- OSCE checklists: Depression (screening + safety); Dementia (Mini-Cog/GPCOG + 4AT + caregiver interview).
- Dementia care plan mini-template (goals, actions, supports, follow-up).
- Slide deck and MCQ set (10 questions per block).

Summary of Improvements vs. Previous Draft

- Neutral, clinical titles; removed potentially stigmatising metaphor as main title.
- Consolidated timing (exact minutes per block; totals consistent).
- Integrated validated screeners: PHQ-2/9; Mini-Cog/GPCOG; 4AT/CAM.
- Added suicide risk protocol and brief safety plan.
- Expanded differential diagnosis (TSH, B12, meds, grief vs. depression, bipolar screening).
- Prioritised psychosocial strategies; cautious pharmacology aligned with mhGAP.

- Emphasised trauma-informed, IDP-sensitive communication.

ANNEX 5: Evidence-Based Screening: Live Long, Live Well

1) Training overview

Title: Evidence-Based Screening — How to Live Long and Well?
Target group: Medical students, residents, primary care/FPs, young physicians.
Format: Interactive lecture, small-group work, case studies, planning exercise, reflection.
Resources: Projector, slides, flipcharts, markers, screening table handouts, pre/post test, optional digital advisor (e.g., CheckMe or local tool).
Variants: Core (2h) and Extended (4h).

2) Learning outcomes

1. Differentiate primary, secondary, tertiary and quaternary prevention.
2. Explain why routine "check-ups" are not equivalent to screening and may cause harm.
3. List common screening targets and risk factors.
4. Apply international guidance (USPSTF / WHO / EU programmes) and adapt to local policies.
5. Produce a personalised screening plan using a structured table and/or a digital tool.
6. Recognise and communicate overdiagnosis and overtreatment risks.

3) Timetable options

A) 2-hour Core agenda

- Opening & logistics (5')
- Icebreaker: "What makes you unique?" → link to personalisation (7')
- Ground rules on flipchart (5')
- Pre self-assessment (1–10) + expectations (5')
- Mini-lecture: 4 levels of prevention; screening ≠ diagnosis; harm-benefit (15')
- Mini-lecture: What, who, when? (HTN, DM, lipids, CRC, cervix, breast, lung; HIV/HBV/HCV; PHQ-2/9, AUDIT-C, tobacco) (15')
- Activity 1: Screening table (small groups) (10')
- Break (5')
- Activity 2: Case planning (1 complex case) (20')
- Plenary: Quaternary prevention — what not to do (13')
- Post self-assessment + take-home messages (10')
- Q&A + Feedback (Basket/Pot/Bin) (10')

B) 4-hour Extended agenda

- Block 1 (2h): as per Core agenda
- Break (20')

- Guideline face-off (20'): groups use different sources (USPSTF vs EU vs local) on the same case
- Screening planning competition (25'): accuracy, harm-benefit, feasibility
- Digital tool demo or paper decision-tree (20')
- Rubric-based feedback (15')
- Closure: 5-item post-test, summary, next steps for local adaptation (20')

4) Core content (to be localised)

Always align with current national or regional guidelines. The bands below are examples for discussion:

- Hypertension: screen 18+; confirm office elevations with HBPM/ABPM; more frequent checks ≥40 or with risk factors.
- Type 2 diabetes: adults 35–70 with overweight/obesity and/or additional risk factors; FPG/HbA1c ± OGTT per policy.
- Lipids/statin primary prevention: 40–75 based on global CVD risk; lipid profile at baseline; intervals per local protocol.
- Colorectal cancer: commonly 45–75 (USPSTF) or 50–74 (EU programmes); FIT every 1–2y or colonoscopy per programme.
- Breast cancer: USPSTF 40–74 biennial; many EU programmes 50–69 biennial.
- Cervical cancer: primary HPV 25–65 q5y or cytology 21–65 q3y (jurisdiction-specific).
- Lung cancer LDCT: 50–80 with ≥20 pack-years, current or quit <15y ago.
- Infections (HIV/HBV/HCV, STI, TB): risk-based and occupational protocols; consider IDP context.
- Mental health: PHQ-2/9 if system supports follow-up; AUDIT-C; tobacco screening for all adults.
- Quaternary prevention: avoid routine PSA mass screening; avoid routine CXR, abdominal US, ECG in asymptomatic adults without indications.

5) Activities & tools

Screening table template (printable):

ondition	Target population	Method	Interval	Risk factors/Notes	Benefit–harm	Guideline source
Example: CRC	Adults 45–75 (local policy)	FIT / Colonoscopy	FIT q1–2y; Colonoscopy per programme	Family history, IBD	Mortality ↓; risk: perforation, overdiagnosis	USPSTF / EU / Local

Rubric for group plans (0–2 points each): accuracy; completeness; feasibility; benefit–harm balance; local adaptability.

6) Case bank (examples)

- Case A — Male, 35, healthcare worker, smoker, BMI 31, FHx diabetes/prostate cancer: HTN, DM, lipids; HBV booster; TB screening; PHQ-2/9; AUDIT-C; PSA only via shared decision-making (not routine).
- Case B — Female, 65, smoker, T2D + HTN: influenza/pneumococcal/zoster vaccines; CRC; breast; cervix per programme; diabetic complications review; global CVD risk management.

7) Assessment

- Pre/Post self-rating (1–10) + 5-item mini-test (true/false).
- Group plan scored with rubric; feedback focuses on localisation and harm–benefit communication.

8) Key messages

- Good screening saves lives; poor screening causes harm.
- Personalisation over one-size-fits-all check-ups.
- Shared decision-making and transparent benefit–harm communication.
- Always align with up-to-date local guidance.

Appendix — Quick cheat-sheet (example bands; localise)

- BP: adults 18+; confirm with HBPM/ABPM; ≥40 or high-risk — more frequent.
- DM2: 35–70 with overweight/obesity ± RF; FPG/HbA1c.
- Lipids/statin: 40–75 per global risk; revisit intervals locally.
- CRC: 45–75 (USPSTF) or 50–74 (EU) — FIT/colono.
- Breast: 40–74 (USPSTF) or 50–69 (EU).
- Cervix: HPV 25–65 q5y or Pap 21–65 q3y.
- Lung LDCT: 50–80, ≥20 PY, current/<15y quit.
- PSA: not population screening; consider 55–69 shared decision-making.
- HIV/HBV/HCV/STI/TB: risk-based protocols.
- Depression/alcohol/tobacco: PHQ-2/9, AUDIT-C, ask everyone.

References (generic)

- USPSTF — U.S. Preventive Services Task Force recommendations (latest local adoption).
- WHO — Screening and prevention guidance; mental health (mhGAP).
- ECDC / EU country screening programmes.
- National/Ministerial guidelines applicable in your country/region.

Appendix 1 - Literature for Hungarian mental health training

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Co-funded by the European Union

ShowUp4Health is co-financed by the EU4HEALTH Programme of the European Union under the Grant Agreement No. 10112942 (HaDEA). The content of this deliverable represents the views of the author only and is his/her sole responsibility; it cannot be considered to reflect the views of the European Commission and/or the European Health and Digital Executive Agency (HaDEA) or any other body of the European Union. The European Commission and the Agency do not accept any responsibility for use that may be made of the information it contains.