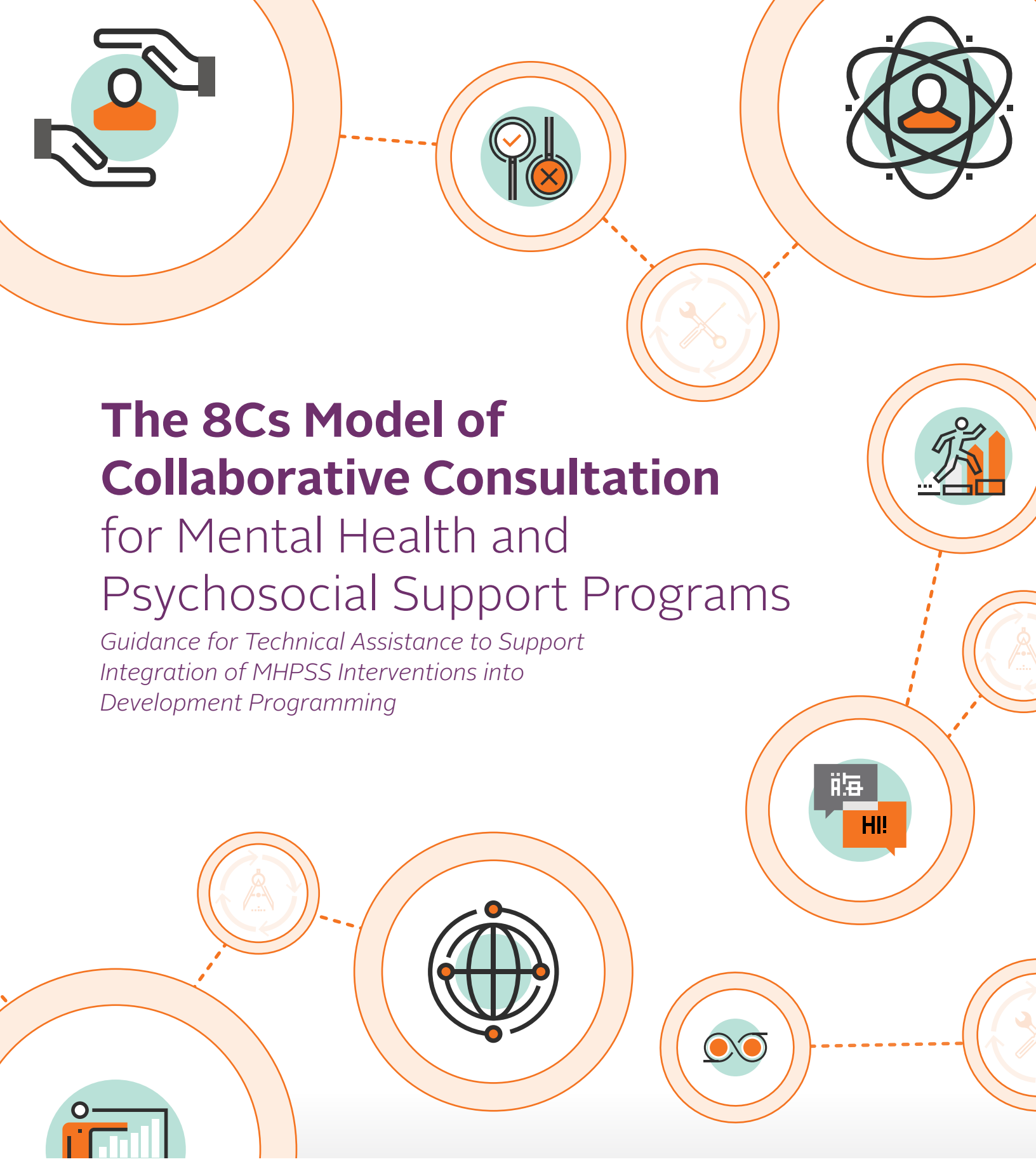

The 8Cs Model of Collaborative Consultation for Mental Health and Psychosocial Support Programs

Guidance for Technical Assistance to Support Integration of MHPSS Interventions into Development Programming

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fhi360

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This document is an interactive PDF. Navigate between pages and sections by clicking on text links, buttons and icons.

AT A GLANCE

The 8Cs Model of Collaborative Consultation technical guidance document contains a wealth of information and resources for further exploration. It is composed of several distinct sections that help the user take one step forward in their efforts to integrate MHPSS into other health and development programs.

In the initial pages of the document, the reader learns more about the evolving world of MHPSS and why the 8Cs Model is helpful in making sense of that world. The reader is also introduced to who this model is for and how users can most effectively operationalize the concepts and tools included in this technical package. Additionally, foundational resources that should be reviewed by those wishing to use the 8Cs skillfully are introduced along with cross-cutting principles, including "do no harm."

Next, the reader is introduced to eight domains (the 8Cs) one by one. In each of the Cs, the reader better understands what to ask during the design or implementation of any MHPSS program, why these are the right questions to ask, and where to find more information on each.

A practical worksheet to help technical advisors operationalize the 8Cs is followed by key terms in the glossary and a list of key resources. (The practical worksheet is also available in Word to support its usability.)

At the end of the document are several annexes on topics that require deeper exploration, including screening, validation, and adaptation of tools, and exemplary case studies that explore the application of the 8Cs in specific settings. These case studies are included to describe unique circumstances, needs, and opportunities specific to different types of programs and include practical examples of the application of the 8Cs.

Finally, those using the 8Cs Model are invited to use a supplemental resource, the **MHPSS Resource Navigator**, to further explore a range of existing interventions and assessment tools currently available for local adaptation and use when applying the 8Cs Model.

TABLE OF CONTENTS

ACRONYMS

ART	Antiretroviral therapy
CBT	Cognitive behavioral therapy
CSO	Civil society organization
EQUIP	Ensuring Quality in Psychological Support
GBV	Gender-based violence
HCW	Health care worker
IASC	Inter-Agency Standing Committee
ICD-11	11th International Classification of Diseases
IMC	International Medical Corps
INGO	International nongovernmental organization
KP	Key population
LGBTQ+	Lesbian, gay, bisexual, transgender, and queer people and those of other diverse sexual orientations and gender identities
LMICs	Low- and middle-income countries
M&E	Monitoring and evaluation
MH	Mental health
mhGAP	WHO Mental Health Gap Action Program
MHPSS	Mental health and psychosocial support services
MOH	Ministry of health
MSP	Minimum service package
NACP	National AIDS Control Programme
NGO	Nongovernmental organization
PFA	Psychological first aid
PHC	Primary health care
PHQ-9	Patient Health Questionnaire 9
PIH	Partners in Health
PLHIV	People living with HIV
PM+	Problem Management Plus
PPE	Personal protective equipment
PSO	Psychosocial support officer
PSS	Psychosocial support
PTSD	Post-traumatic stress disorder
QI	Quality improvement
RCT	Randomized control trial
SOP	Standard operating procedure
TOT	Training of trainers
USAID	United States Agency for International Development
WHO	World Health Organization

INTRODUCTION AND PURPOSE

There is no health without mental health, and yet mental health is more than just the absence of a mental health condition or illness. Mental health conditions are the seventh leading cause globally of disability-adjusted life years and the second leading cause of years lived with disability, with an estimated one in five people experiencing depression at any given time.[1] The 2019 Global Burden of Disease report shows that mental disorders remain among the top 10 leading causes of burden worldwide, with no evidence of reduction since 1990.[2] This burden, including bidirectional, comorbid physical and mental health conditions, affects outcomes across every sector (education, livelihoods, justice system, etc.). However, services that promote mental health, prevent mental and psychosocial distress, and treat mental health conditions remain limited, especially in low- and middle-income countries (LMICs).

Since 2019, the global COVID-19 pandemic has disrupted every facet of human life and has been nothing less than a global collective trauma causing ripples of collective grief and distress. The pandemic has had profound impacts on mental health to an extent that research is only beginning to quantify, with unforeseen secondary and tertiary effects in many other sectors of civil society like the workforce and commerce, education, and broader public health and health systems. Yet, the pandemic has created an important sense of urgency and prioritization for mental health promotion and access to mental health services. Most countries are currently struggling to meet the demand for MHPSS services due to direct or indirect consequences of the COVID-19 pandemic.[3]

In any setting, both chronic stress and intermittent crises can compromise mental health and well-being for individuals, communities, and populations. In most settings, mental health services are usually limited even before crises and, when emergencies such as natural disasters, conflict or violence, or infectious disease outbreaks do occur, access and availability of already sparse services are impaired. Historically, mental health services in humanitarian or disaster response

settings were fractured, haphazard, and limited to basic "first aid" approaches. In the public health and development sector, mental health and psychosocial support services (MHPSS) are often siloed, with limited scope and heavy reliance on even more limited specialist services.[3]

Promisingly, the field of MHPSS has advanced considerably in the past few decades; at times, from hindsight about efforts that failed or did not succeed as expected. In response to the insufficient mental health services provided to victims of the 2004 Indian Ocean tsunami, and similar experiences with the challenges of MHPSS programming at the time, the Inter-Agency Standing Committee (IASC) issued the first comprehensive guidance on MHPSS in 2007.[4] However, coordination and evidence-based programming continued to be lacking. Psychological services provided in response to the Haitian earthquake in 2010 were criticized as uncoordinated despite the availability of guidelines for comprehensive mental health services in humanitarian response situations. At the time, few mental health and psychological interventions had been formally evaluated in diverse cultural contexts, low resource settings, or across the full continuum of development and humanitarian settings. Most psychological interventions were still designed for delivery by specialists who needed years of training and had a professional clinical degree in mental health services.

The state of MHPSS programming is much different today. There has been a transformation in approach regarding who can render services and an acknowledgment that mental health care and psychosocial support is everyone's responsibility. Myriad resources building on the 2007 IASC Guidelines are available, with recommendations ranging from how to conduct needs assessments[5] to how to build back better after emergencies.[6] An abundance of both evidence-based practice and practice-based evidence exists.[7] There is also a rapidly growing evidence base demonstrating that when MHPSS services are integrated into other health programming (including, but not limited to, HIV, TB, maternal and child health, cancer, and cardiovascular disease), outcomes in those areas improve.[8] A recent joint recommendation by UNAIDS and WHO emphasizes the importance of integrating HIV prevention, testing, treatment and care, and mental health services for people living with HIV. It provides a compilation of tools, best practices, recommendations, and guidelines that facilitate the integration of interventions and services to address the interlinked issues of mental health and HIV. This publication is intended for global, regional, and national policymakers; programme implementers including at subnational levels; organizations working in and providers of HIV and mental health services; civil society; and community-based and community-led organizations and advocates. Mental health should be a standard consideration in all health care services from primary to specialty care. Every patient encounter can contribute to advancing mental health whether through screening, referral, inclusion of psychological services, or advancement of foundational helping skills such as empathy as a component of every clinical interaction.

Not only have interventions been more widely adapted for diverse settings, but an extensive — and, at times, overwhelming — number of evaluation tools are available to assure quality services. Whereas a quarter-century ago, only a patchwork of mental health specialists was practicing in low- and middle-income countries, several interventions have trained general health care providers and nonprofessionals to deliver psychological support through task-sharing. This has resulted in a more robust workforce of local mental health experts as well as a cadre who are not

specialists but have been trained in basic MHPSS services.[7] However, this can only be continued ethically and sustainably when these workers are adequately equipped to support others, and when these workers are continually supported in their role providing either stand-alone or integrated MHPSS services.

These are all excellent examples of welcome advances in global mental health that have created a new set of challenges — and opportunities — that may lead to "analysis paralysis" in the field when an avalanche of resources and recommendations obscure a clear path forward.

Given the growing availability of MHPSS recommendations, program leaders, implementers, and care providers increasingly understand the value of MHPSS programming but perhaps lack the familiarity, confidence, experience, or support structures to feel empowered to explore resources and are often left with a sense of uncertainty. They may be asking themselves the following questions:

- Given the breadth of resources, where is the best place to start when planning or designing MHPSS services?
- With so many different MHPSS interventions available, how does one choose the best for a specific setting?
- If an "off-the-shelf" resource cannot feasibly be used, what kind of modifications are acceptable to make?
- What tools are appropriate for a particular intervention and/or a population and how should results be interpreted?
- What are the best practices in quality improvement once MHPSS services are started?
- How can sustainability be appropriately considered from the outset?

THE ESSENTIAL ROLE OF PEOPLE WITH LIVED EXPERIENCE

Another transformation in the field is the acknowledgement that people with lived experience of mental health conditions help guide the process of identifying, implementing, and evaluating new and expanded MHPSS services: "nothing about us, without us." However, program leaders and implementers may not be aware how to identify, engage, and equitably and ethically collaborate with people with lived experience. Therefore, support is needed to be sure these collaborative efforts are initiated and successful.

The overall functionality of the health system, including financing and governance, is also an important consideration when planning for sustainability of any MHPSS initiative. By the nature of MHPSS services, dissolution or disruption due to lack of funding or other support may cause significant harm to beneficiaries.

WHAT DOES "MHPSS SERVICES" MEAN?

The term mental health and psychosocial support (MHPSS) services is used throughout this document to refer to a diverse range of services, interventions, approaches, or techniques that aim to address mental health and/or psychosocial well-being. MHPSS are relevant for all areas of development and humanitarian assistance. The differences between mental health (MH) services and psychosocial support (PSS) services are described below.[a]

MENTAL HEALTH (MH)

"Mental health care refers to the treatment of mental health conditions. Mental health programming seeks to address specific mental health, neurological, and substance use conditions. Community- and systems-level approaches may include policy work, capacity strengthening, or social and behavior change communications. Interventions focused on addressing mental health conditions of individuals or small groups may include psychotherapy, psychoeducation, and psychopharmacology. These interventions are often delivered by clinicians, psychologists, or other formally trained mental health providers, including those with expertise in cultural practices of healing."[a(p. 3)]

PSYCHOSOCIAL SUPPORT (PSS)

"Psychosocial support is a continuum of programming that works at different layers of care, including with individuals, families, groups, and communities. Interventions focus on coping and stress reduction; building interpersonal connections; and addressing psychological, social, and spiritual needs of individuals and communities through respectful and caring relationships. These approaches strengthen collective care mechanisms across families, communities, and cultures to affect both individual and collective well-being."[a] PSS content is designed for dissemination to large numbers of people because it is readily understood and can be easily put into practice without close external supervision.

IMPORTANT KEY POINTS ABOUT MH AND PSS:

- Mental health and psychosocial support should be considered complementary and mutually supportive, rather than exclusive or oppositional. Although one program may focus more heavily on one or another type of service, the broader system should offer both for those who need them.
- Many services, approaches, and techniques that are considered MHPSS services can be integrated into existing primary health services (for example, trauma-informed care, motivational interviewing, cognitive behavioral therapy, stress management).
- All individuals can benefit from PSS including those living with MH conditions. Therefore, comprehensive care should always include components of PSS.

a United States Agency for International Development (USAID). USAID's collective action to reduce gender-based violence (CARE-GBV): how to integrate mental health and psychosocial interventions in gender-based violence programs in low-resource settings. Washington: USAID; 2022. Available from: **https://makingcents.com/wp-content/uploads/2021/01/CARE-GBV_04_MHPSS_v6-508.pdf.**

What is the 8Cs Model?

Given the diverse landscape of coordination opportunities, growing body of guidelines and recommendations, and wide array of evidence-based interventions, tools, and evaluation strategies, the **8Cs Model** was developed to guide consultations among technical advisors and program leaders when designing, implementing, improving, or evaluating integrated MHPSS services into new or existing public health, development, or humanitarian programs.

The 8Cs Model provides a road map of the diverse field of resources available to help program managers and others implement new or adapt existing services for greater integration of MHPSS. The model outlines how to consider preexisting criteria across eight general domains (called "the 8Cs") of planning and practice before moving forward and provides recommendations for implementation and evaluation of safe and effective programs.

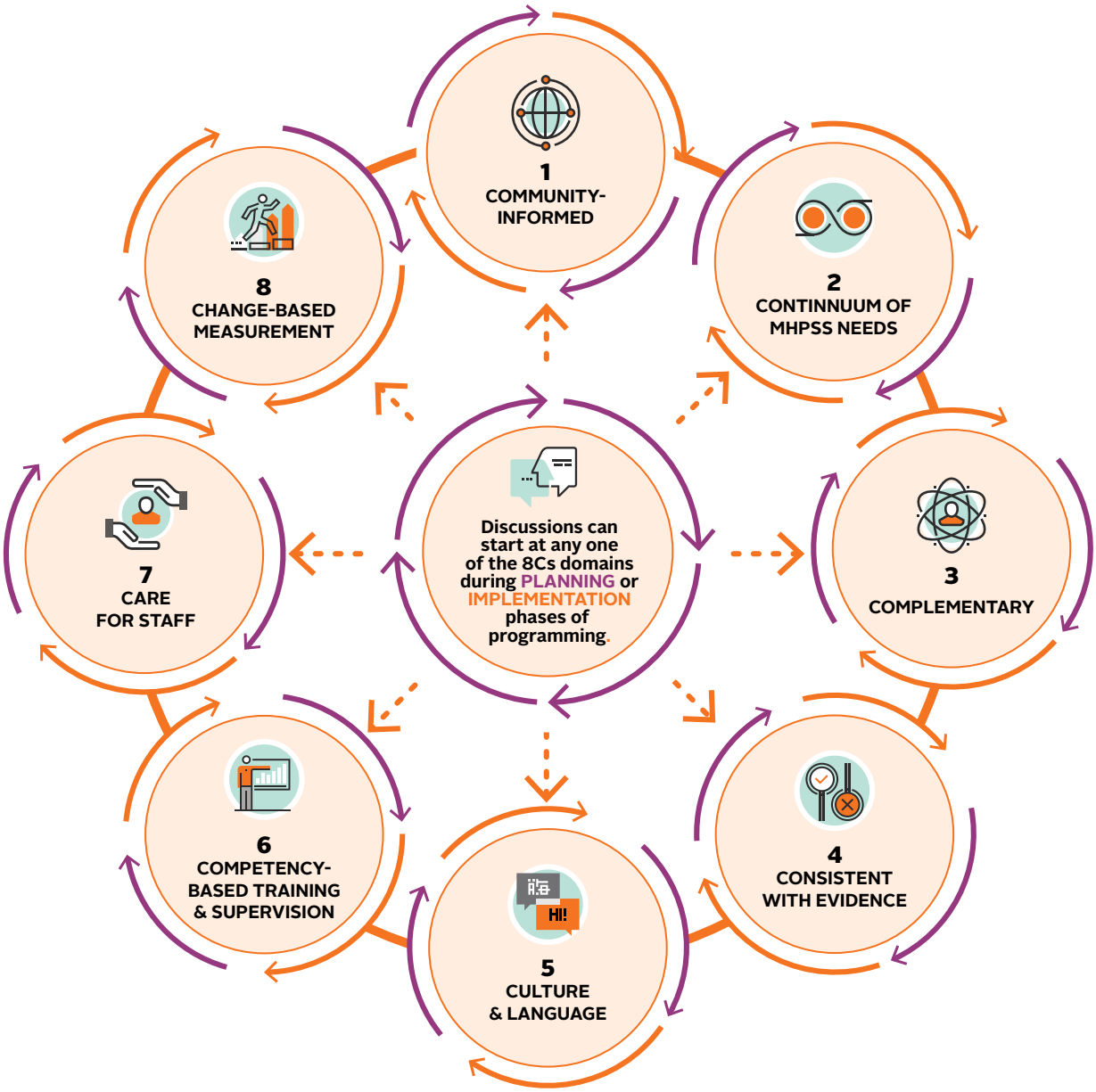
The 8Cs Model is applicable *irrespective of beneficiary or target population*. It is helpful for appraising existing programs for how they may be strengthened, and identifying possible gaps or barriers to address.

The 8Cs Model technical package includes:

- **This 8Cs Model guidance document:** This document introduces the foundational concepts of global MHPSS programming and provides a description of and considerations for eight domains to use for assessing and advising MHPSS programs. Several links in this document will take users directly to key resources and tools for each of the domains. Readers will also find visual aids and infographics to conceptualize the 8Cs Model, and a helpful **8Cs consultation worksheet template** to support collaborative consultations as teams navigate the model. Several references guide users based on the phase of MHPSS programming: design or implementation.
- **Focused annexes for health areas and unique populations:** While the model is designed to be applicable to all beneficiary groups, sometimes unique aspects of specific populations warrant further discussion. Two annexes (one for considerations when working in HIV as a health area, and one for considerations for health workers as the beneficiary population) are included, with additional annexes in progress. Partners are welcome to develop their own focused annex based on material in the 8Cs Model to guide programming in their area of expertise.
- **The MHPSS Resource Navigator:** This web-based interface allows users to search a detailed catalog of available evidence, based MHPSS interventions and assessment tools based on resource type, mental health condition addressed, and intended audience. Users can narrow down their search with some of these basic filters, with more relevant information attached to each resource that may further assist users to find the best tools for their intended goal. This resource navigator may be particularly useful for technical advisors supporting program teams to design, implement, or evaluate health programs that currently have or are seeking to add integrated MHPSS services. While this resource is meant to provide solid guidance in an ever-evolving field, it cannot be considered a static entity or an exhaustive list of possible

resources. It is possible that you may want to use an intervention or assessment tool that has not been included in the Resource Navigator, and this is completely acceptable. You should consider whether the resource you'd like to use has been evaluated and/or validated (and with what population) as well as the credentials of the authors. For example, do the authors come from an organization known in your area to create locally relevant tools and resources? Or, is this an international organization with widely recognized credibility for high-quality programming? If it is not either, consider selecting another intervention. Look to **Domain 5** and the section on Active Ingredients for more ideas on what to use as intervention evaluation criteria.

FIGURE 1. The 8Cs Model for MHPSS Collaborative Consultation



Click on each circle to learn more about each domain

Intended Audience for 8Cs Model

The intended audience of this guidance document is technical advisors supporting teams of people working to implement, integrate, and/or improve MHPSS programming in public health, development, and humanitarian service delivery. Users of the 8Cs Model may include consultants and program leaders at global, regional, and country levels, ideally in a local implementation setting with MHPSS expertise. Experts with an MHPSS background may also find value in the 8Cs Model technical package.

The document can be used as guidance for organizing and conveying information about MHPSS projects to leaders, donors, or other stakeholders. It can also be used as guidance for identifying opportunities and problems and operationalizing solutions for MHPSS services for health care teams, donors, ministries of health (MOHs), and local civic societies. The teams will assist in proposing and evaluating projects on the 8Cs Model to identify what support is needed to meet the recommended criteria across each of the model's eight domains and determine adequate resources to further guide or strengthen the planned program.

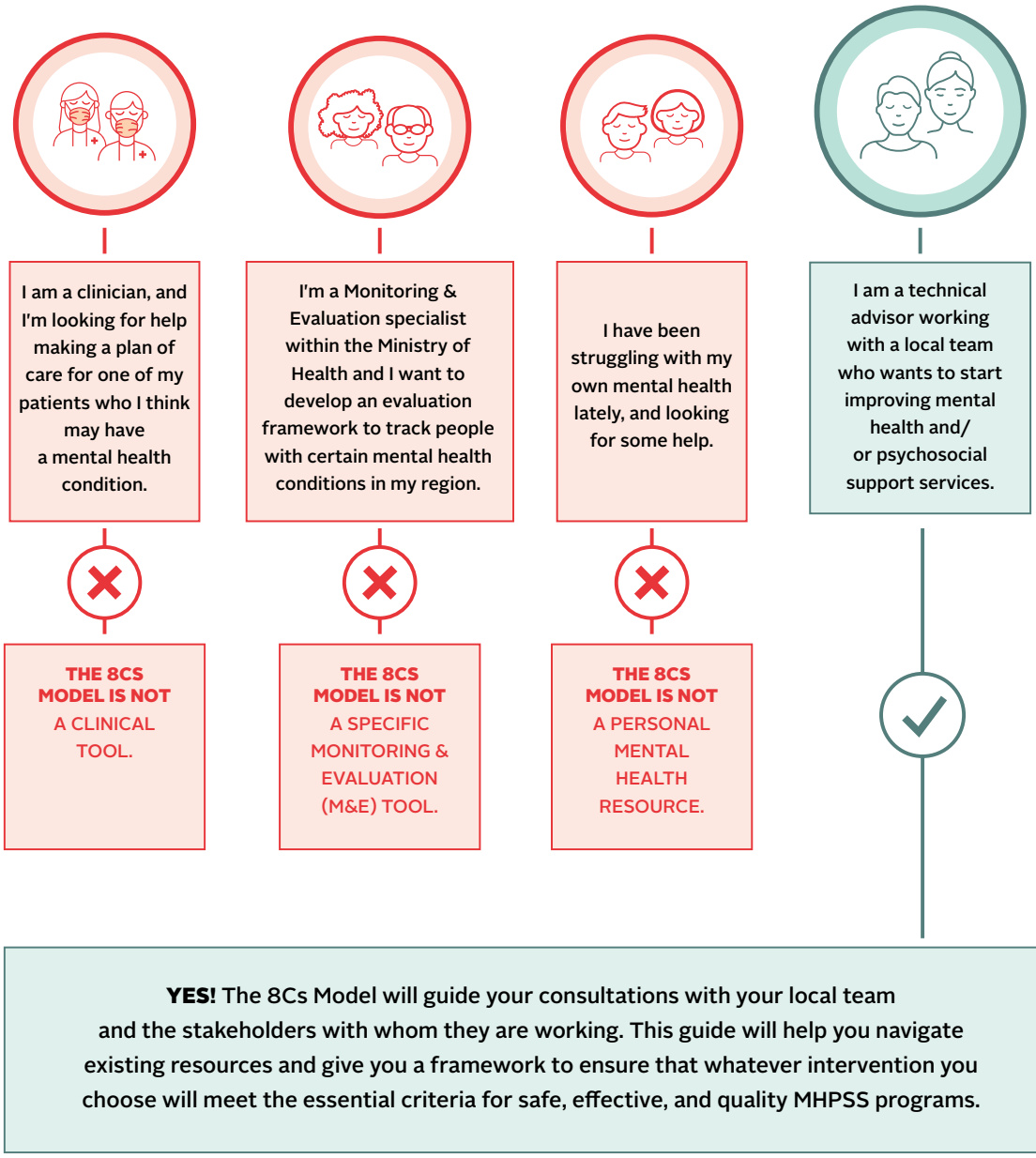
The 8Cs Model is not for everyone! As stated above, it is not a stand-alone document and not an intervention. It is a tool meant to guide the search, selection, and adaptation of the right intervention for a specific setting

IT IS NOT:

- **A clinical tool.** The model should not be used by clinicians or health care workers to guide diagnostic or clinical management plans for individual patients or groups of patients with specific mental health conditions.
- **A specific monitoring and evaluation (M&E) tool.** The model encourages comprehensive M&E and quality improvement (QI) approaches with links to specific resources as part of overall program development or implementation strategy.
- **A personal mental health resource.** The model is designed to help develop programs, not give anyone individual mental health advice. Individuals should seek mental health and/or psychosocial support from a trusted provider or other local resource.

Here are examples of who should not use the model (**Figure 2**). Stop here to see if you should continue, or seek guidance through alternative resources.

FIGURE 2. Who should—and should not—use the 8Cs Technical Package



How to Use the 8Cs

We recommend those intending to use the 8Cs Model familiarize themselves with the concepts, resources, and recommendations included throughout this guidance document. We recommend that the implementing team begin by preparing preliminary information that identifies the intended beneficiary population, intended goal or outcome, and the basic existing assets available to support the intervention.

Then, in consultation with the both the technical advisor and the implementing team, the 8Cs Collaborative Consultation can start at any of the domains and expand to other domains as needed. We have provided a **template** that can be completed during consultations, or you can create your own to capture the most helpful information. This can first be done to document which of the 8Cs components have been addressed and to lay out key questions and concerns by domain. Then, throughout the consultation, recommendations and next steps can be documented for any of the eight "C" domains.

Examples of potential usage:

Example A: The country team for a large international nongovernmental organization (INGO) has identified the need for MHPSS programing because of concerns that health care workers are experiencing psychological distress responding to the latest health crisis in the country. The team has reached out to local mental health specialists, Ministry of Health officials, and their program implementation staff. They have initial commitment from these groups, but the INGO country team staff are unsure where to start in designing their program. At this point, a technical advisor for the INGO could meet with the country team to go through the 8Cs Model to determine what additional information is needed, which potential interventions would fit the needs and context, which evaluation tools would be valid and appropriate for the setting, who could be trained to deliver the intervention and how their competency could be assured, and the key considerations to minimize the risk of harm and potential unintended negative consequences of MHPSS programming.

Example B: An organization has been implementing an MHPSS component in a gender-based violence (GBV) prevention and response program for almost a year, but they have encountered many barriers, such as poorly attended support groups, and are not sure where to start in addressing these barriers. They have reached out to an expert in the country with experience in MHPSS. The expert can use the 8Cs Model to walk through a review of the program to identify which of the 8Cs domains might help to identify and address barriers. The expert can use the 8Cs domains to guide the organization on what actions to take (e.g., engaging different stakeholders, introducing different evaluation tools to check competency and fidelity, or considering other cadres of MHPSS providers and delivering services integrated into different health or social service sectors).

Example C: An INGO working in HIV as a health area is considering a multi-country MHPSS program embedded in antiretroviral therapy (ART) services. They are wondering which aspects of the program can be a one-size-fits-all approach with common components and strategies across countries, and which components would need to be tailored to a given country or specific population. In a workshop with country teams, a technical advisor could use the 8Cs Model, with some specific guidance in **Annex II: Case Study A** to determine how to adapt and implement the program in a feasible, acceptable, and effective manner in the different settings or with different populations.

Who can provide technical assistance with the 8Cs Model?

We recommend that any technical advisor using the 8Cs Model (or person in a similar role providing technical guidance or consultancy) align with the following:

- The individual providing technical assistance should have a level of previous experience with MHPSS programming or services that matches the complexity of the intended project or intervention.
  - For instance, if a technical advisor is providing overall guidance on general program design, then the 8Cs Model will be helpful to guide that design process collaboratively. If the advisor has a lot of program design experience, and that is the intention of the technical assistance, then minimal MHPSS experience may be necessary.
  - However, if the advisor is deeply engaged with technical assistance on decisions about patient flow, clinical decision support, screening and/or working within a specialized area of mental health care (e.g., opioid use disorder, schizophrenia care), then that advisor should use the 8Cs Model to guide programming while relying on what should be a deeper bench of mental health experience, preferably with a clinical background or specialized training in mental health care.
  - The advisor may also recommend recruiting consultants or partners with that expertise if needed; all members of a team of advisors may benefit from contributing to the consultation process. The 8Cs Model can serve as a framework for that multidisciplinary consultation.
  - Internally, a team or organization may determine that they want a higher minimum standard for their technical advisors to provide MHPSS technical assistance. A higher standard will likely result in higher quality for projects with more complexity. However, it may create unintended barriers to integrating MHPSS work in general public health and development programs.
- The technical advisor needs to have a working familiarity with the five foundational resources. **These foundational resources** will inform most interventions, and anyone providing technical assistance should be able to understand, reference, and use them with ease.

"ONE STEP FORWARD"

The goal of the 8Cs is to help technical advisors support program implementers, policymakers, and other people in leadership positions to take "one step forward" in advancing MHPSS services. The longstanding history of stigma against mental health conditions, the lack of resources invested in mental health care, the feeling that other physical health conditions should take priority, the cultural and clinical complexity in accurate diagnosis, and the dearth of clinical experts are all reasons that mental health programming can be dismissed. Therefore, the information provided in the 8Cs is intended to help advisors find at least one action that can be taken in a situation even with a limited amount of resources.

What is one thing that a program manager or policymaker could do to advance the journey toward more MHPSS services? They could raise awareness about the possibilities for mental health integration into existing health services, convene people with lived experience to identify priorities in a particular setting, or set up a volunteer suicide prevention hotline when no other resources are immediately available to expand services. The goal of the "one step forward" approach is also to avoid a misstep. **Problematic first steps include**:

- Initiating screening programs with tools such as the Patient Health Questionnaire 9 (PHQ-9) when the tool has not been validated for local use and there are no places to refer patients needing depression treatment or acute support for suicide risk reduction
- Starting psychosocial support programs at the community level when those delivering services do not have support for their own mental health and psychosocial needs
- Time-limited programs that start patients on medications that may be needed lifelong without a mechanism to support their care going forward

These missteps can set back MHPSS services and create further barriers to moving forward. Ultimately, the test of whether the 8Cs Model is used appropriately is whether a technical advisor collaborates with implementers to advance at least one opportunity for safe and effective MHPSS services for all.

ESSENTIAL RESOURCES TO BE USED IN CONJUNCTION WITH THE 8Cs

This guide is not a stand-alone document or recreation of existing manuals. It is meant to be used alongside other resources, including these five foundational resources that all users of this technical package should be familiar with to move forward with MHPSS programming. It is also important to recognize that while most of these essential resources were developed for MHPSS programming in humanitarian settings, they are broadly applicable and can also be used outside of this context. Technical advisors, in particular, should have a working familiarity with these materials to guide the 8C consultations:

1. **The MHPSS Minimum Service Package (MSP)**
2. **The IASC Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings with Means of Verification**
3. **The WHO/UNHCR Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Humanitarian Settings**
4. **Who is Where, When, doing What (4Ws) in Mental Health and Psychosocial Support: Manual with Activity Codes**
5. **LIVE LIFE: An implementation guide for suicide prevention in countries**

The **MHPSS Minimum Service Package** is a free interactive online resource, as well as a downloadable PDF (79 pages). The MSP provides the highest priority activities for addressing mental health needs in emergency settings and assisting in building intersectoral mental health programs. The MSP describes several core activities as part of the minimum services that should be provided in any MHPSS initiative. The core activities should, in principle, be available and accessible to people in all emergencies, be of high quality, and be provided in an acceptable manner to affected populations. If a core activity is not in place, it should be made available as soon as possible. Use of the MHPSS MSP is expected to lead to better coordinated and more predictable and equitable responses that make effective use of limited resources and thus improve the scale and quality of programming. This will result in substantially better mental health and psychosocial well-being for larger numbers of people. The MHPSS MSP is not a comprehensive list of all feasible or effective MHPSS activities, and thus MHPSS responses should not be limited to MSP activities. Rather, the MHPSS MSP provides a foundation for progressive strengthening and further scale-up of MHPSS activities. The development of sustainable, comprehensive, and inclusive MHPSS systems requires a longer term outlook and investment, with close coordination between humanitarian and development funders, and with respect for the central role of government and local authorities.

The MSP can help guide the country teams in determining which components would be essential in their service package, ensuring that they meet the minimum MHPSS requirements. The MSP includes an actions and activities checklist that MHPSS program coordinators can complete to be sure that all the minimum actions and activities are being conducted. The MSP also includes a gap analysis tool that can be used prior to initiating programs or to track progress of comprehensive programs over time.

The **IASC Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings with Means of Verification** (125 pages) provides an introduction to M&E and the "Common Framework for MHPSS," which is a consensus package of what should be monitored with MHPSS programs and what are acceptable tools (i.e., means of verification) to capture this information. The means of verification are organized by age: what tools are appropriate for 0–5, 6–11, 12–17, 18+). The document includes guidance on collecting MHPSS data, reporting the data, and disseminating the findings. Sample frameworks are provided for different types of MHPSS programs. The Common Monitoring and Evaluation Framework has five goals to which M&E should be tailored:

1. Emergency responses do not cause harm and are dignified, participatory, community-owned and socially and culturally acceptable.
2. People are safe and protected, and human rights violations are addressed.
3. Family, community, and social structures promote the well-being and development of all their members.
4. Communities and families support people with mental health and psychosocial problems.
5. People with mental health and psychosocial problems use appropriate, focused care.

The WHO/UNHCR Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Humanitarian Settings (84 pages) is a resource for needs assessments before beginning programs or when modifying existing programs. The toolkit provides guidance on a host of strategies that emphasize community-based and participatory approaches that involve partnering with beneficiaries and other stakeholders. The toolkit is useful to document existing services as well as identify community priorities. Of note, the toolkit emphasizes identifying services and priorities before doing prevalence studies with standardized self-report tools.

Who is Where, When, doing What (4Ws) in Mental Health and Psychosocial Support: Manual with Activity Codes (20 pages) is a brief resource that supports documentation of existing services and service gaps. Using the 4Ws is vital to prevent duplication and identify what existing services are available before introducing new programs.

The World Health Organization's (WHO) LIVE LIFE: An Implementation Guide for Suicide Prevention in Countries (142 pages) contains information on core pillars of strategies to reduce suicide and descriptions of key interventions for suicide prevention. The core pillars include situation analysis, multi-sectoral collaboration, awareness-raising and advocacy, capacity building, financing, surveillance, and monitoring and evaluation. The key interventions include a range of strategies, such as early identification, assessment, management, and follow-up of anyone who is affected by suicidal behaviors.

Important Considerations & Crosscutting Principles

It is important to recognize that there is no one-size-fits-all solution for implementing and evaluating the MHPSS services, particularly in clinical and programmatic settings. Instead, adaptation of approaches and programs is vital.[9] Building equitable, accessible, and scalable services through the bottom-up approach is part of the solution for these challenges, but there are important — and, at times, complex — ethical and logistical considerations that shouldn't become obstacles to delivering comprehensive, safe, and high-quality MHPSS services. In a peripandemic landscape of shifting fiscal and programmatic priorities, it is important to remember that "one step forward" concept and consider a phased approach based on readiness, acceptability, or other indicator of potential for progress.

Before we introduce the domains within the 8Cs Model, is it important to emphasize that there are crosscutting principles that should be considered throughout all domains and at all stages of MHPSS programming.

Do No Harm

Do no harm is a cross-cutting principle for all aspects of MHPSS programming. The IASC Guidelines define *do no harm* as "avoiding harming MHPSS service users' and care providers' physical, social, emotional, mental, and spiritual well-being." Furthermore, this principle ensures that actions responding to assessed needs are committed to evaluation and scrutiny, support culturally appropriate responses, and acknowledge the power relations between groups participating in or implementing interventions. This principle emphasizes the importance of examining specific ethical considerations, ensuring that the program or activities do not harm individuals. In addition to ethical concerns, this component can protect individuals from retaliation, especially regarding the flow and accessibility of private or personal health information. This principle is inherently tied to sustainability as well. In the midst of competing global priorities in the peripandemic era, what are the potential risks of harm if a program is suddenly defunded, shut down, or interrupted by shifting priorities or new crises? This does not mean that nothing should be done, but it does mean these risks need to be considered and that plans for sustainability and contingency should be built in from the beginning whenever possible.

Common aspects of *do no harm* principles are intentionally reflected in the 8Cs domains, such as:

- Determine the adequacy of exsting referral networks, and strive to establish or shore up inadequate referral networks to link clients to MHPSS specialized services as appropriate (**Domain 3: Continuum of MHPSS Needs**)
- Use validated/vetted curriculum (**Domain 4: Consistent with Evidence Base**)
- Confirm that post-training mentoring and on-the-job supervision can be made available (**Domain 6: Competency-Based Training and Supervision**)
- Roll out regular credentialing, certification credits, or other equivalent continuing education incentives in MHPSS and/or establish a support forum where trained MHPSS staff can exchange problems/solutions (**Domain 6: Competency-Based Training and Supervision**)

- Establish a robust system that allows implementers to monitor progress and rapidly identify adverse events related to the MHPSS services (**Domain 8: Change-Based Measurement**).

Ultimately, this is an overarching principle to keep in mind when planning, implementing, and evaluating any health promotion activity, including MHPSS programs.

Stigma

Addressing mental health stigma is another cross-cutting principle for the 8Cs Model. Individuals with mental health conditions commonly experience stigma and discrimination that serves as a barrier to seeking care, worsening their symptoms and affecting their quality of life. Recently, there have been major developments in addressing mental health stigma. WHO released a mental health report, urging the investing of funds and human resources in different sectors to overcome stigma and meet mental health needs.[7] Furthermore, the Lancet Commission on ending stigma and discrimination in mental health released a report on mental health stigma and recommendations for targeting it on the following levels: international organizations, government, employers, health care and social care sectors, media, people with lived experiences, local communities, and civil society.[10] All care providers, including those rendering MHPSS services, should understand the concept of intersectionality and be prepared to provide non-stigmatizing services to all patients, including key populations and historically marginalized groups. When marginalized communities will be recipients of MHPSS, providers should be sensitized on these communities' historical experiences with MHPSS (e.g., mental health services being weaponized against them, as with "conversion therapy" for lesbian, gay, bisexual, transgender, and queer people and those of other diverse sexual orientations and gender identities [LGBTQ+] or political prisoners) and their unique mental health stressors (e.g., homophobia, transphobia). Furthermore, providers should have a basic understanding of these communities so that clients do not have to teach their providers about themselves (e.g., what it means to be a transgender person), and providers should examine their own potential biases to avoid harming their clients.

While there are multiple elements that should be targeted to address mental health stigma, everyone can start with using non-discriminatory and non-stigmatizing language. For example, The Lancet Commission on Ending Stigma and Discrimination in Mental Health suggests terminology such as "person with lived experience of a mental health condition," "person with a mental health condition," or "person with a psychosocial disability." These are examples of person-first language, which is supported by advocacy groups of people living with mental health conditions. The National Council for Mental Health provides a list of stigmatizing words that should be replaced with more neutral ones (e.g., using "mental health challenge" or "crisis" instead of "mental illness"). The Centers for Disease Control and Prevention offer suggestions for using non-stigmatizing language for communicating with people who have disabilities. Finally, the National Institutes on Drug Abuse (USA) provides a list of terms to reduce stigma when talking about addiction. Language is powerful, and while the resources referenced here advise on terminology in English, speakers of all languages can reflect on common terms in their own language and consider non-discriminatory or non-stigmatizing approaches.

Developmental Lenses & Life Cycle Approaches

Just like physical health, mental health considerations change across the lifespan. This guidance document does not explicitly address considerations unique to pediatric/adolescent mental health, perinatal mental health, or geriatric mental health. However, all programs should seek professional guidance to ensure an appropriate developmental lens when working with beneficiaries across the lifespan — from the very young to the very old.

Mental Health & Medical Emergencies

Individuals experience mental health emergencies just like they experience physical health emergencies. We must be prepared for both. While this topic will be reviewed in **Domain 2: Continuum of MHPSS Needs** and **Domain 5: Contextualization**, no matter what domain your team starts with or focuses on, mental health emergencies need to be understood, recognizable, and planned for. All service providers should be equipped to recognize a mental health emergency and have a plan to connect with a higher level of care if a patient or client exhibits signs of a mental health or medical emergency.

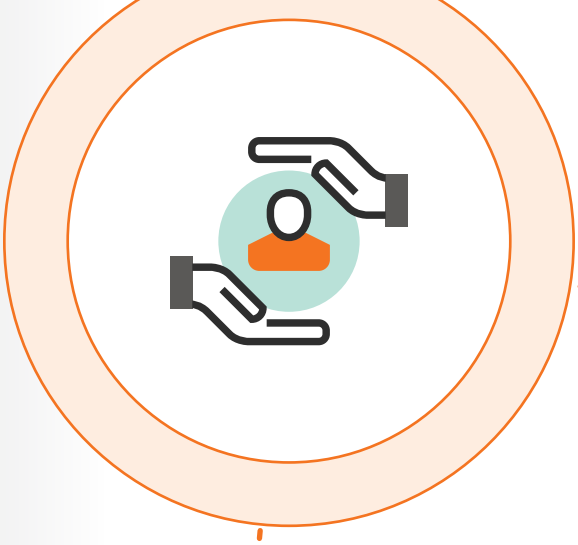
TO SCREEN OR NOT TO SCREEN

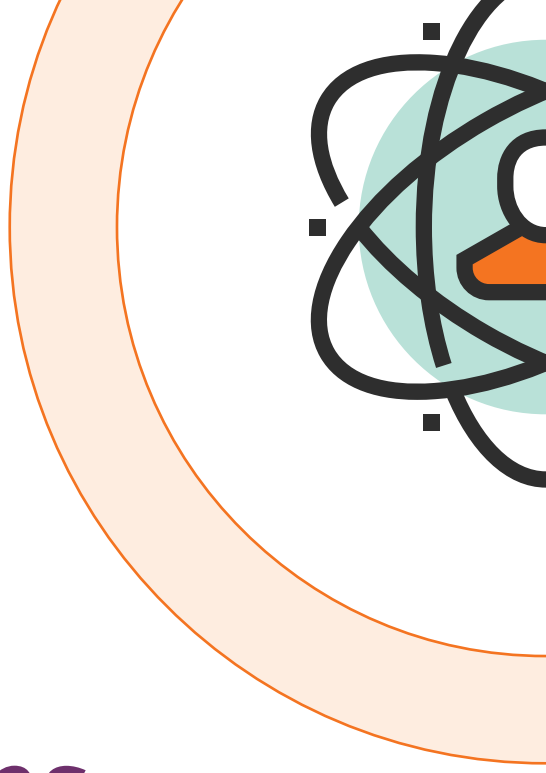
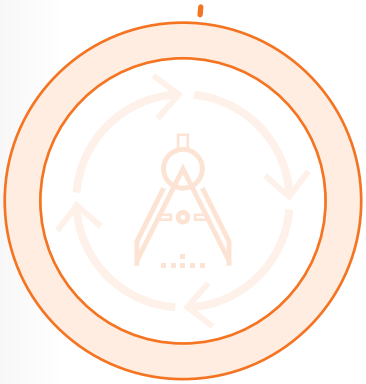
Screening for symptoms of possible mental health conditions is very common in many settings, and screening is discussed several times throughout this document. However, there are advantages, disadvantages and nuances to choosing and using screening tools in an MHPSS intervention.

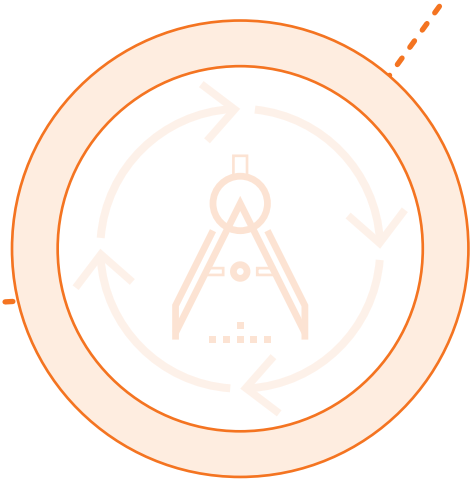
Normative bodies such as the World Health Organization do not have a recommendation on screening members of the general population for mental health disorders. Each implementation team should determine whether screening is the right choice, for whom it is the best approach, and who is interpreting the results for what kind of therapeutic goal or intervention. For more on making this decision, see **Annex I**.

Continuum of Humanitarian & Development Settings

Much of the guidance for MHPSS programming has originated in response to needs during humanitarian emergencies. However, many of the needs and challenges faced in humanitarian settings are also characteristic of general developmental settings, such as the scarcity of mental health professionals. Furthermore, while collective trauma related to disasters and warfare may not be ongoing across development settings, populations in development settings still may experience violence and trauma, and/or the socioeconomic consequences of protracted instability. Consequently, development settings are increasingly experiencing what may be considered “acute-on-chronic” events related to conflict, climate change, and economic instability that create isolated humanitarian crises within chronically low-resource settings. Development settings are also characterized by diverse cultural groups and contextual variation, which necessitates cultural adaptation and accurate language translation for any health service, especially MHPSS services. Members of minority groups, people living with stigmatized health conditions, and women and children are often vulnerable to violence outside the context of humanitarian emergencies. The 8Cs Model and the essential resources referenced throughout this technical package are applicable across all settings, from humanitarian response to long term development agendas.



The 8Cs Descriptions of the Domains

The subsequent sections provide descriptions of the domains, the considerations for design and implementation phases, and annotated lists of key resources for addressing the specific domain. As mentioned above, domains do not need to be addressed in order. However, in a comprehensive review during the design or implementation phase, it can be helpful to address all domains.

DOMAIN 1.
Community Informed

Definition

This domain encompasses community-identified needs and community-informed strategies to address those needs, including the co-design of initiatives with different stakeholders, as well as community-led or informed implementation and evaluation of MHPSS interventions. This domain ensures that the members of a community (including individuals from marginalized groups) can contribute to the identification and prioritization of planning and implementation of strategies aimed at MHPSS service provision. This domain may involve a community of providers, professional associations, MOH influencers, advocacy groups, and patients/clients.

There are a number of tools and resources that exist to conduct a community-informed needs assessment, including the **WHO/UNHCR Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Humanitarian Settings**. This toolkit provides guidance and resources for assessing needs when beginning MHPSS programming. There are resources and recommendations for both qualitative and quantitative needs assessments, with a reference table from this toolkit summarized in Table 1. The IASC Reference group on Mental Health and Psychosocial Support provides a 4Ws tool (Who is Where, When, doing What) that is an ideal first activity to assure that existing services are documented. The 4Ws can assist in mapping the MHPSS activities in humanitarian settings across sectors.

DO NO HARM

One of the temptations when initiating programs is to start by assessing the prevalence of mental health conditions using psychiatric self-report tools such as the Patient Health Questionnaire (PHQ-9). However, the International Medical Corps guidance on integrating mental health into primary care clearly states "Do not conduct surveys on the prevalence of mental health conditions (that is, psychiatric epidemiology)" as a first step in developing MHPSS programs. Instead, the first steps should be building partnerships, identifying existing services, and strengthening services. Documenting prevalence with psychiatric clinical screening tools at the outset creates several potential harms. First, documenting prevalence before appropriate landscaping of existing services risks identifying people with a likely mental health condition and then having no place to refer them for services. This can violate trust with communities, stigmatizing populations and worsening psychological distress by telling people they have a mental health condition without having the appropriate services to support them. In addition to determining which services are available, efforts should be made to determine the quality and safety of those programs before making large-scale referrals. Moreover, gathering prevalence data before conducting awareness-raising campaigns and stigma-reduction efforts may lead to inaccurate data and low participation rates in screening activities. To prevent potential harm, this community-informed domain emphasizes documenting the availability and quality of existing resources and the community-based priorities for MHPSS. This should precede introducing clinic-based or community-based screening efforts.

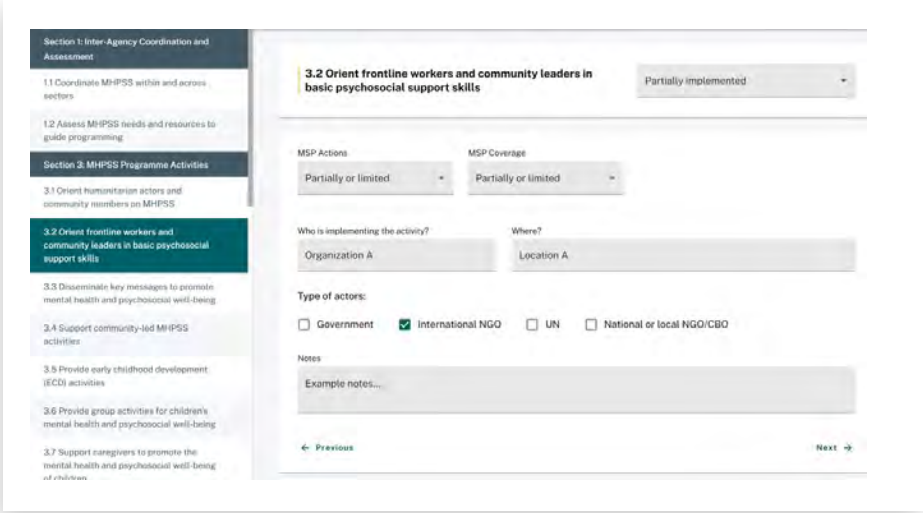
After conducting the 4Ws activity, check the quality of existing services identified. The most important domains to initially document using Annex 3 of the document (page 13) are clinical management of mental health conditions by non-specialists and specialists (Code 9 and 10) and psychological interventions (Code 8). This is vital because these represent places for referrals as other services are developed.

The 4Ws tool can be useful for the following:

- Providing a big picture of the size and nature of the MHPSS response
- Identifying gaps in the MHPSS response to enable coordinated action
- Enabling referral by making information available about who is where, when, doing what
- Informing appeal processes (e.g., consolidated appeal process [CAP])
- Improving transparency and legitimacy of MHPSS through structured documentation
- Improving possibilities for reviewing patterns of practice and for drawing lessons for future response

From the WHO/UNHCR Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Humanitarian Settings, Tools #4 and #5 should be used next to do site visits for health institutions and primary health care services. The other components of the 4Ws can be very informative. However, when resources are limited, the 4Ws activity and the health care setting assessments are the recommended minimum steps before moving forward with other activities.

FIGURE 3. Screenshot of MHPSS MSP Gap Analysis tool



Another foundational resource is the Gap Analysis tool in the **MHPSS MSP**. This is an online interface for a comprehensive documentation of what activities are being implemented in a particular setting (Figure 3). The MHPSS MSP Gap Analysis is comprehensive and provides a rich description of what is ongoing and planned. That said, when time and resources are limited, completing the 4Ws and health care settings assessments may be a more feasible first step.

When identifying tools, read the column "why use this tool" and select a tool that aligns with your purpose.

TABLE 1. A quick guide to identifying mental health tools from WHO/UNHCR Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Humanitarian Settings

TOOL #	TITLE	METHOD	TOOL USE	PAGE
For coordination and advocacy				
1	"A quick guide to identifying mental health tools" adapted from the 4Ws: Who is Where, When, doing What in MHPSS	Interviews with agency program managers	For coordination through mapping what mental health and psychosocial supports are available	30
2	WHO-UNHCR Assessment Schedule of Serious Symptoms in Humanitarian Settings (WASSS)	Part of a community household survey (representative sample)	For advocacy, by showing the prevalence of mental health problems in the community	34
3	Humanitarian Emergency Setting Pereived Needs Scale (HESPER)	Part of a community household survey (representative sample) Or, exceptionally (in acute, major emergencies) as a convenience sample	For informing response, through collecting data on the frequency of physical, social, and psychological perceived needs in the community	41
For MPHSS through health services				
4	Checklist for site visits at institutions in humanitarian settings	Site visits and interviews with staff and patients	For protection and care for people with mental or neurological disabilities in institutions	42
5	Checklist for integrating mental health in primary health care (PHC) in humanitarian settings	Site visits and interviews with primary health care program managers	For planning a mental health response in Primary Health Care	47
6	Neuropsychiatric component of the Health Information System (HIS)	Clinical epidemiology using the HIS	For advocacy and for planning and monitoring a mental health response in PHC	53
7	Template to assess mental health system formal resources in humanitarian settings	Review of documents and interviews with managers of services	For planning of (early) recovery and reconstruction, through knowing the formal resources in the regional/ national mental health system	55
For MPHSS through different sectors, including through community support				
8	Checklist on obtaining general (non-MHPSS specific) information from sector leads	Review of available documents	For summarizing general (non-MHPSS-specific) information already known aout the current humanitarian emeregency (to avoid collecting data on issues that are already known)	59
9	Template for desk review of pre-exisiting information relevant to MHPSS in the region/country	Literature review	For summarizing MHPSS information about this region/ country already known before the current humanitarian emeregency (to avoid collecting data on issues that are already known)	60
10	Paticipatory assessment: perceptions by general community members	Interviews with general community members (free listing with further questions)	For learning about local perspectives on problems and coping to develop an appropriate MHPSS response	63
11	Paticipatory assessment: perceptions by communiity members with in-depth knowledge of the community	Interviews with key informants or groups		70
12	Paticipatory assessment: perceptions by severly affected people	Interviews with severely affected people (free listing with further questions)		74

Considerations

QUESTION 1. In what ways have community needs informed development of this program?

Programs should be informed by a **community-based needs assessment** to ensure that community priorities will be the focus of the MHPSS intervention. These can be more or less formal. For example, a community leader may raise concerns about the mental health of people living with HIV in the community. Formal community needs assessments may not be feasible, but many approaches to assessing community needs do not require extensive resources. Below are commonly used steps for community needs assessments; the resources available should dictate the extent and comprehensiveness of the process. Additional examples of approaches with varying budgets can be found in the case studies presented in Annex II and Annex III.

- **Planning the assessment:** Community is usually defined by a behaviors or type of population. Individuals within the community share values, beliefs, and customs; therefore, it is essential to define the community and identify different cultural groups within that community. The planning step also consists of determining the community components that need to be assessed (e.g., burnout in health care providers in a regional hospital), questions to be asked, methods of data collection, and key informants.
- **Conducting the assessment:** Community needs assessment can be done, virtually or in-person, by conducting interviews, focus groups, or surveys; participating in listening sessions of local community gatherings and forums; or engaging in direct or participatory observation.
- **Reviewing and rating the data collected:** This step involves developing ways to understand the data, such as creating a rating scale with the local team.
- **Recording and reviewing the consolidated data:** Next, enter, aggregate (if possible), and summarize the data.
- **Creating an action plan:** Based on collected data, this step involves identifying and prioritizing the community needs and developing strategies together with the community to address those needs.

QUESTION 2. In what ways has the community participated in co-designing the program?

For successful, sustainable programs, it is vital to incorporate community-based co-design, which involves community members in the needs assessment process and creation of strategies, ensuring that community participation is encouraged but not mandatory and avoiding the burdening of the affected population. Consider including people with lived experiences from the community in the co-design process.

If guidance is needed on co-design, then a participatory approach to create problem-solving strategies is recommended. This approach is when community members are considered equal contributors. Co-design allows problems and strategies to be seen through the lens of community members. For community co-design, Tools #10–12 of the MHPSS Toolkit are recommended. These tools are used for learning about local perception of problems and coping to develop an appropriate MHPSS response.

QUESTION 3. In what ways has the program been implemented in collaboration with the community?

In addition to community involvement in the process of needs assessment, it is essential to ensure community-based intervention implementation. This component involves having effective leadership and competent staff to implement and monitor mental health well-being programs. While program implementation depends on each strategy, three main issues should be prioritized:

- **Sustainability:** Integrating programs into existing structures — such as using existing staff to implement, relying on infrastructure already in place (including physical spaces that ensure confidentiality), and existing interactions with clients (e.g., group outreach in communities versus individual client sessions at a clinic) may be beneficial in ensuring sustainability. Structures of MHPSS program management are usually very weak on national and local levels; therefore, it is important to ensure that communities and local teams lobby policymakers to include mental health in the structural, financial, and policy plans for any health system.
- **Vulnerability:** The most vulnerable groups in the community should be considered, such as women, socially excluded groups, migrants, displaced persons, and prisoners. Implementers usually need to look for these populations to understand their unique needs and include them in the programs.
- **Advocacy:** Individuals who have mental health conditions can become advocates for change.

KEY CONSIDERATIONS

COMMUNITY-INFORMED MHPSS PROGRAMS	
PLANNING PHASE	Obtaining input from a diversity of stakeholders is important at the planning phase. Collaboration with people with lived experience of mental health conditions is vital for assurance that programs address what matters most. Programs should be informed by potential beneficiaries as well as people in policymaking roles and clinical providers who may shape the success and sustainability of the programs.
IMPLEMENTATION PHASE	Ongoing input from community stakeholders can improve program implementation. Community stakeholders may be the first to identify why programs are not as successful as desired or how they could be more successful. During implementation, it is helpful to get input from beneficiaries and those providing services.

NOTES

DOMAIN 2.
Continuum of MHPSS Needs

Definition

This domain stresses the importance of a multi-layered, coordinated approach in MHPSS programs to support people with varying levels of MHPSS needs. Effective program implementation requires participation at all levels: basic services and security; community and family support; focused, non-specialized support; and specialized services. The IASC MHPSS intervention pyramid indicates layers of complementary supports to meet the different needs within communities during emergencies (Figure 4).

All these layers are important to address needs of different people in a community and ideally should be implemented concurrently.

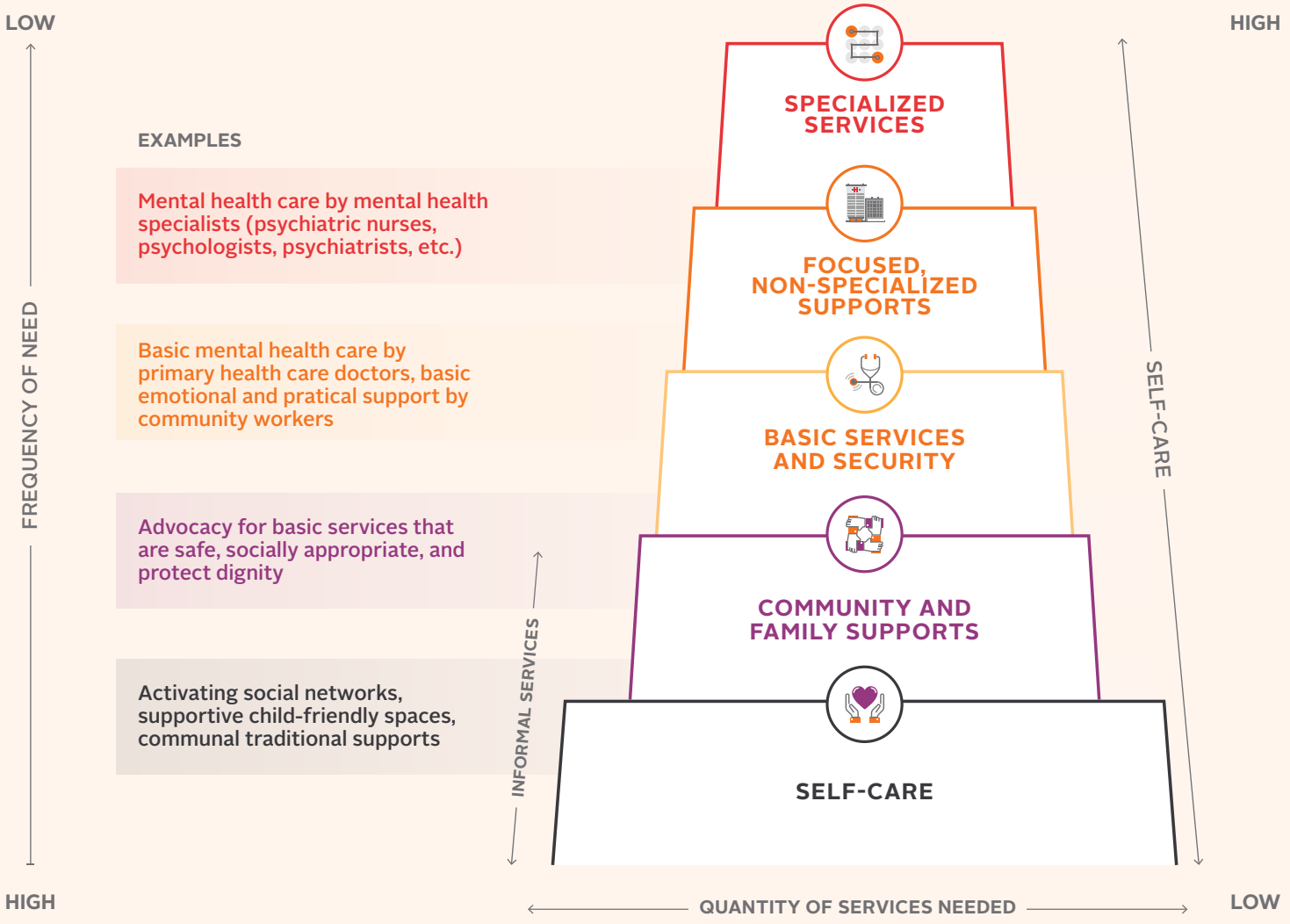
Self-Care: Self-care recognizes individuals as active agents in their own health and health care and includes a wide range of interventions that can be performed with or without the support of formal health care service providers. Self-care interventions are things any individual can do for themselves or their dependents to promote their own health and well-being; they include participation in basic healthy behaviors such as nutrition, physical activity, adequate sleep, social connections and adherence to medications or other health regimens. All individuals can engage in self-care to the best of their abilities at all levels of the service pyramid as a basic intervention, or a component of higher levels of service delivery.

Community and family supports: This layer focuses on a smaller number of individuals who can successfully maintain their mental health and psychosocial well-being if they receive assistance from key community and family supports. An example could be activating social networks by assisting in identifying and involving family members, providing supportive parenting programs or educational activities.

DO NO HARM

It has been encouraging to see the growing interest in MHPSS services in recent years. One challenge that may compromise safety, quality, and efficacy of those services is a focus on lower tiers of the MHPSS pyramid. A common challenge is when programs such as Psychological First Aid, mental health awareness programs, or other community-based general psychosocial services are implemented without higher intensity services available when a person with a higher level of mental health needs is identified. In settings where there are no services for psychiatric emergencies (e.g., suicidality, acute psychosis, substance intoxication, or withdrawal) and no services for ongoing treatment of serious mental health conditions, basic psychosocial services may risk identifying individuals in need of this care and not being able to support them. This puts psychosocial service providers at risk because they are expected to take on care they are neither trained in nor have the resources to provide. A strategy to mitigate this risk is to combine growth in basic psychosocial services along with strengthening of emergency referrals and services. Therefore, for all programs, MHPSS technical advisors should help teams develop strategies to identify and strengthen upper tier services on the MHPSS pyramid.

FIGURE 4. Optimization of MHPSS Services: *adapted from the IASC MHPSS Intervention Pyramid and the WHO Service Optimization Pyramid*



Basic services and security: This layer focuses on essential physical needs, such as food, water, shelter, basic medical care, and control of communicable diseases. The MHPSS response could be advocacy for basic services that are safe and appropriate, and tracking their impact on mental health and psychosocial well-being.

Focused, non-specialized supports: This layer focuses on an even smaller number of people who require more targeted individual, family, or group interventions. The individuals who provide such services are trained and supervised; however, they may not have specialized training. Examples of such interventions could be basic mental health care provided by the primary care physician, nurses, community health workers, case managers, and skilled peer supporters.

Specialized services: The final layer focuses on individuals who require additional assistance because of their difficulty functioning independently even after receiving the supports in other layers. Specialized services should always be available in the case of an emergency, such as acute psychosis or suicidality. This layer includes psychological or psychiatric supports for individuals with severe mental conditions that cannot be addressed by primary care physicians or community health workers. This layer requires the existence of specialized mental health professionals or, at minimum, a mechanism for providing specialized training with supervision to primary health care providers or community health workers to manage more acute or emergent cases.

This doesn't mean that one team, or one organization, is responsible for implementing all these layers at the same time! It does mean that implementers should be aware of what's available in the context and proactively work with partners to strengthen the continuum of available MHPSS services.

MENTAL HEALTH STIGMA

- Mental health stigma — or stigma related to experiencing a mental health disorder — is prevalent globally; however, it particularly affects women, LGBTQ+ people, ethnic minorities, and individuals living in low-resource areas.
- Mental health stigma can be linked to other forms of stigma; for example, previous mental health guidance classified homosexuality as a mental health disorder. This classification was used to further marginalize LGBTQ+ people.
- Mental health stigma can become institutionalized, with a lack of funding for mental health within a health system.
- Mental health stigma may prevent patients from disclosing their conditions to the provider and can worsen the treatment outcomes for their presenting physical health problem.

More information about the IASC MHPSS pyramid layers and strategies that should be implemented, and components that should be avoided, can be found in the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings (page 12).

Considerations

QUESTION 1. Does the program address or acknowledge all tiers of the MHPSS pyramid?
It is important to **cover the MHPSS pyramid** by reviewing mental health needs for each layer and considering changes in the existing health system one stage at a time to address the full spectrum of MHPSS needs.

The WHO Mental Health Policy and Service Guidance Package. After reading this module, countries may wish to focus on specific aspects of mental health covered in other modules. As MHPSS services are established at different tiers of the pyramid, they should be informed by **landscaping activities** (see description of 4Ws above), ensuring that the existing MHPSS programs are not re-established but integrated. For example, if the community reports that a suicide hotline would be useful, there is no need to create a new line if a high-quality national suicide prevention hotline already exists and provides non-stigmatizing care to the focus population. Alternatively, if no such service is available, investigate if there are any other systems in place that could assist the community in parallel as other resources are assembled to cover all tiers of the pyramid (e.g., a mental health support WhatsApp group moderated by trained providers).

The Partners in Health (PIH) Mental Health Value Chain is a list of key elements for providing quality care to mental health patients. The Value Chain assists in program planning and implementation across PIH sites. The Value Chain ranges from health facility to community level, focusing on crisis response, prevention, case-finding, assessment, treatment, follow-up, and reintegration.

QUESTION 2. What intensive services are available or need to be established for mental health emergencies?
At a minimum, all programs should include intensive services for mental health emergencies on-site or provide for safe linkage to specialized care services where available (e.g., direct, facilitated referrals with close safety monitoring). All programs should have procedures in place to identify service users at risk for suicide, ensure their immediate safety, and offer supportive supervision to the staff. The WHO Live Life report provides guidance on identifying, assessing, and intervening for people at risk of suicidal behavior. There are also details on systems strengthening to support suicide prevention.

QUESTION 3. What services are available or will be established to provide treatment for mental health conditions?
The **treatment of mental health conditions** should be culturally adapted and ensure confidentiality for diagnosis and medical history, particularly for marginalized communities (e.g., people living with HIV). When developing services, consider reviewing local health data (if available) to understand the prevalence of the mental health condition(s) you aim to address.

WE HAVE TO TALK ABOUT SUICIDE

As of 2021, suicide was the fourth leading cause of death for younger people (15–29 years old). The LGBTQ+ community, refugees, migrants, indigenous people, the elderly, and prisoners are at higher risk of suicide than the general population. Furthermore, 77% of suicide attempts are estimated to be in LMICs.[a] While most countries are working to reduce suicide rates and encourage conversations, in some places, these conversations are considered controversial. Suicide assessment may have implications such as criminalization. As of 2021, there were 20 countries that considered attempted suicide a criminal offense. Such implications further deter individuals from seeking mental health support. See **the Suicide Decriminalization Report** by United for Global Mental Health for further details.

Talking about suicide is an essential component of any MHPSS program that has resources in place to assist individuals in crisis:

- Asking about suicidal thoughts is encouraged if it is done with compassion; this does not increase the likelihood of committing suicide. On the contrary, it opens the space for conversation.
- Even if someone denies having suicidal thoughts, it is important to notice non-verbal cues that may help identify whether they are being honest (e.g., avoidance of eye contact).
- If a client indicates that they have suicidal thoughts, it is essential to connect them to a resource that can keep them safe, professionally assess risk, and competently handle a mental health emergency.

[a] World Health Organization (WHO). Suicide. 2021.
Available from: https://www.who.int/news-room/fact-sheets/detail/suicide

Other tools like treatment checklists, assessments, locally adapted procedures, examinations, and collaborative referral processes can enhance service quality and impact.

Consider using the **MhGAP Toolkit** to promote an extension for the MHPSS services in primary care and community settings. **Specialists are necessary in the MHPSS program** to ensure the minimum available on-site emergency services are supervised. It is possible that the supervisors are not available around the clock; however, they should be reachable by telephone if there is an urgent case in the clinic (e.g., suicidality) that is beyond the scope of the individuals delivering the MHPSS service.

RESOURCES FOR ALL TIERS:
Illustrative approaches to address the IASC continuum of needs

SELF-CARE:

Self Care can occur in many ways, and is ultimately an individual's decision about what brings them a sense of well-being. The cornerstones of self-care include adequate nutrition, movement, rest and sleep, and fostering emotional connection, but there are many other resources that promote other self-care skills like stress management and mindfulness.

Doing What Matters in Times of Stress: An Illustrated Guide: The guide aims to equip people with practical skills to help cope with stress. A few minutes each day are enough to practice the self-help techniques. The guide can be used alone or with the accompanying audio exercises. It is available in multiple languages, with audio files available on the WHO website to guide learning on some of the techniques described in the guide.

Informed by evidence and extensive field testing, the guide is for anyone who experiences stress, wherever they live and whatever their circumstances. It also serves as the guiding document for **Self-Help Plus (SH+)** (hyperlink, see below), WHO's 5-session stress management course for large groups of up to 30 people delivered by supervised, non-specialist facilitators who complete a short training course.

COMMUNITY AND FAMILY SUPPORTS:

This layer of interventions provides additional support for a cohort of the population who are able to maintain their mental health and psychosocial well-being if they receive help in accessing key community and family supports. In emergency situations, this may include services like family tracing and reunification, assisted mourning and communal healing ceremonies. In general settings, this may include mass communication on constructive coping methods, supportive parenting and childcare programs, formal and non-formal educational activities, livelihood activities and the activation of social networks, such as through women's groups and youth clubs. These resources are crucial and should be community led and/or informed whenever possible to best meet the unique needs of a particular population.

BASIC SERVICES AND SECURITY:

Psychological First Aid (PFA) – PFA is an initial disaster response intervention to promote safety, stabilize survivors of disasters, and connect individuals to help and resources. PFA involves the following themes:

- Providing practical care and support that does not intrude
- Assessing needs and concerns
- Helping people to address basic needs (e.g., food and water, information)
- Listening to people but not pressuring them to talk
- Comforting people and helping them to feel calm

- Helping people connect to information, services, and social supports
- Protecting people from further harm to the greatest extent possible

PFA can be delivered by volunteers, mental health workers, and disaster responders in one session. PFA has demonstrated success as an effective strategy to provide psychological support to earthquake survivors in **Haiti** and fieldworkers assisting Syrian refugees in **Lebanon**.

FOCUSED, NON-SPECIALIZED SUPPORTS:

MhGAP: The WHO Mental Health Gap Action Program, or mhGAP, consists of interventions for the prevention and management of priority mental, neurological, and substance use disorders, identified based on evidence about the effectiveness and feasibility of scaling up these interventions in low- and middle-income countries. These priority conditions include depression, psychoses, self-harm/suicide, epilepsy, dementia, disorders due to substance use, and mental and behavioral disorders in children and adolescents. The mhGAP-Intervention Guide (mhGAP-IG) is a resource to facilitate the delivery of the mhGAP evidence-based guidelines in non-specialized health care settings. The mhGAP approach has been shown to be effective to increase physician knowledge in mental health and self-efficacy in primary care settings in **Tunisia**, and to decrease the number of referrals to other specialists, in addition to reducing negative attitudes toward mental health conditions. Furthermore, mhGAP was implemented in **Mexico** in the primary care setting and showed effectiveness in increasing the knowledge and readiness for identification and management of depression and suicide.

Problem Management Plus (PM+): The manual describes a scalable psychological intervention called Problem Management Plus (PM+) for adults experiencing distress as part of communities exposed to adversity.[11] Aspects of cognitive behavioral therapy (CBT) have been changed to make them feasible in communities that have few specialists. To ensure maximum use, the intervention is developed in such a way that it can help people with depression, anxiety, and stress, regardless of whether exposure to adversity has caused these problems. It can be applied to improve mental health and psychosocial well-being no matter how severe people's challenges. Typical trainings are 10 days long, delivered by a trained facilitator, with weekly supervision for a period after the trainings conclude. Trials in Pakistan and Kenya have shown individual PM+ benefit for depression and functioning. Trials in **Pakistan** and **Nepal** have shown benefits of group PM+ for general psychological distress.

SPECIALIZED SERVICES:

Skills Training in Affective and Interpersonal Regulation (**STAIR**) is an intervention that mainly focuses on post-traumatic stress disorder (PTSD) symptom reduction. This intervention is delivered by mental health professionals and takes about eight hours to complete. The results of a randomized control trial (RCT) done with **U.S. veterans** indicated that the STAIR intervention has shown success in reducing PTSD symptoms and depression and improving emotion regulation.

KEY CONSIDERATIONS

CONTINUUM OF MHPSS NEEDS	
PLANNING PHASE	When designing programs, it is important to consider the range of the MHPSS pyramid. Even if programs are mostly targeting basic psychosocial services, individuals may be identified who need treatment for a diagnosable mental health condition, and individuals with mental health emergencies (e.g., suicidality) need to be referred to services. While we know many MHPSS referral networks are suboptimal, there are evidence-based approaches to ensure completion of a referral. Designing an MHPSS program that only has basic psychosocial supports without operational referrals is unsafe and unethical. At a minimum, programs should have an operational referral system in place for mental health emergency needs. Importantly, the population for whom the MHPSS services are developed should feel safe and welcome using any services available via referral.
IMPLEMENTATION PHASE	After programs have been initiated, it is important to evaluate whether the proposed referral pathways are operational and successful. Are individuals at the middle and bottom tier of the IASC pyramid getting appropriate screening and referrals for high-level, intensive, or emergency services when required? How can connections across the pyramid continuum be improved? These challenges are often due to fundamental systems issues that may seem beyond the scope of your intervention, but even small progress rooted in awareness of an aspirational system can be valuable.

NOTES

DOMAIN 3.
Complementary

Definition

This domain aims to identify settings and areas for integrating MHPSS program activities into existing or established programs or systems of care. Integration can occur at different levels: Some programs may be entirely integrated into existing services; other programs may integrate screening or proactive detection into existing programs and refer to stand-alone services. The degree of integration and aspects of which parts are integrated will vary. However, MHPSS activities that are entirely stand-alone, from detection to service provision to follow-up, are at risk of poor sustainability and limited impact. It is ideal if MHPSS services are at least partially integrated, and most community-needs assessments reveal which types of existing programs could be good targets for integration. This domain also focuses on the adaptation and integration of programs into existing services to ensure sustainability, rather than "reinventing the wheel" or establishing duplicative services.

One example of an effective strategy for complementarity is **Integrating Mental Health into Primary Care**, which includes an integration toolkit developed by the International Medical Corps (IMC). This guide introduces the essential ingredients to strengthen mental health systems within the context of health system development. This 8Cs document should be used alongside the MHPSS Minimum Service Package, particularly when implementing minimum components to take care of staff. The six steps of the IMC strategy for integration of mental health care into existing services are as follows:

1. **Ensure stakeholder engagement and conduct a baseline situational analysis** — Gather information about the context such as national policies pertaining to mental health, staff capacities in the country, current provision of care, and attitudes around mental health.
2. **Build capacity of primary health care and other staff to provide mental health care** — Use findings from the situational analysis, feedback, and experiences to adapt the mhGAP training

DO NO HARM

Before integrating mental health services into other programs, two issues need to be addressed. First, the scope of providers of other services (e.g., peer helpers, primary care workers, community health workers) to take on mental health services should be checked. Any cadre taking on mental health services needs time to provide MHPSS services, to receive adequate training and supervision, and to support their own mental health (see 8Cs Domain #7: Care for Staff). Adding mental health services to the responsibilities of burdened care providers puts their well-being at risk and puts their beneficiaries at risk of inadequate care that could worsen their mental health. It would be unethical and irresponsible to mandate inclusion of mental health services with no mechanisms to provide adequate time, financial resources, and staff to addess mental health care. Second, when integrating new services, it is vital to set up working referral systems so that community health workers, primary care workers, and other providers have access to specialist and emergency services when needed (see 8Cs **Domain 2** for more on assuring the continuum of MHPSS services).

materials to the local context. Where available, local specialists and psychiatrists should be identified and involved in policy efforts for building local capacity. Assure there is a referral mechanism in place.

3. **Provide clinical and community level interventions for people with mental illness** — Facility level interventions provided by trained health care staff consist of assessment, diagnosis, and management of mental health conditions; psycho-education for patients and family members; and psychotropic medication.
4. **Ensure holistic integration by strengthening referral mechanisms, adherence to treatments, and medication supply** — Efforts should be conducted to improve the functioning of integrated mental health services through standardized forms, care and referral pathways, appropriate space for services, and psychotropic medication supply. This may also require partnership at national and supranational levels to support procurement and stable supply of essential psychiatric medicines.
5. **Engage in networking, coordination, and advocacy** — Partnerships at various levels enable effective coordinating mechanisms that promote transparency and regular flows of information and referral between stakeholders to meet the basic mental health needs of the population.
6. **Support sustainability of mental health services integration** — This promotes sustainability and long-term development. Continuous policy dialogue with government and key stakeholders is necessary to solve issues such as the supply of medicine, supervision, and annual planning.

Considerations

QUESTION 1. What elements of MHPSS services are currently integrated or could be integrated versus stand-alone, and what are opportunities for further integration?
Mental health programs that are separate from other services or free-standing in a disconnected way have several drawbacks. First, stand-alone mental health services (e.g., going to the outpatient department of a psychiatric hospital) can be experienced as stigmatizing and may deter people from seeking care. Second, stand-alone programs are often less effective because mental health needs occur alongside physical, social, economic, and protection needs. If these needs are not addressed as mental health services are provided, this may impede recovery and the ability to achieve well-being. Third, the global shortage of mental health specialists means that limiting delivery of services to mental health professionals will be grossly inadequate to meet global needs.

Integrated programs not only benefit mental health needs, they also improve the outcomes of the services in which they are delivered. Integrating mental health care into HIV care programs has the potential to reduce risk-taking behaviors associated with HIV transmission, increase testing, promote medication adherence and viral load suppression, and ultimately contribute to epidemic control. Similarly, mental health services integrated into maternal and child health programs can improve reproductive health outcomes, improve child health and development, and promote

engagement in educational and economic empowerment activities for mothers. Integration of mental health services also reduces health systems costs and broader societal costs.

QUESTION 2. What are strategies for integration?

There are several concepts and strategies for integrating MHPSS into existing services, such as training social workers, teachers, human resource workers, community health workers, primary care workers, and other care providers. Non-mental health professionals can be trained to improve the detection of mental health needs, provide basic psychosocial support, and accompany clients as they navigate referral processes. People with limited mental health training can be embedded into existing programs. And, where resources allow, mental health specialists can be embedded into service provision in other health and social service domains (for example, by sharing a specialist's time across sites/sectors).

FOLLOWING ARE A FEW ADDITIONAL CONSIDERATIONS.

The **simplicity of program activities/interventions**: This component refers to implementing programs in which others can be easily trained, which avoids burdening communities already struggling to maintain existing activities. The simplicity of training individuals on MHPSS delivery should improve the institutional flow, allowing reach to different parts of the community/ organizations.

For more information about integrating mental health services into health systems, please see **WHO's Improving Health Systems and Services for Mental Health**. This guide introduces the essential ingredients for strengthening mental health systems within the context of health system development. Note that for MHPSS services, as for many other health areas, an overarching health systems strengthening lens must be used to identify and leverage critical health system enablers for quality and sustainability programming.

PRACTICE TRANSFORMATION

"Practice transformation" is more than just capacitation and mentorship for providers; it is being recognized as an important aspect of redesigning service delivery models to support sustainable integrated behavioral health care in LMICs. While practice transformation approaches are contextual and may depend on the maturity and readiness of a health system, key areas include patient engagement (e.g., patient advisory committees, community-led monitoring), team-based care at facilities, care coordination mechanisms, practice flow improvements, population management considerations, and quality improvement. Many of these key strategies of practice transformation align with the domains of the 8Cs model but refer to strategies at the facility or service delivery level, aiming for mental/behavioral health integrated into general primary care services.

EXAMPLES OF SUCCESSFUL INTEGRATION OF MHPSS INTO EXISTING SERVICES:

- **Friendship Bench**: This mental health intervention that originated in Zimbabwe focused on reducing the treatment gap for common mental health conditions. The program delivery method is individual sessions with some group meeting circles, six 45-minute structured sessions that are delivered weekly by health workers known as "grandmother health providers." The intervention has been implemented in **Zimbabwe** among people living with HIV and adapted in **Vietnam** to treat mental health conditions for people living with HIV and AIDS who were on methadone maintenance treatment.
- **Thinking Healthy**: This intervention was one of the first to implement evidence-based cognitive behavioral therapy techniques recommended in the mhGAP and delivered by community health workers to reduce rates of perinatal depression.

For programs working in the area of GBV, please see **Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action** and **Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence: A Clinical Handbook**. If there is a lack of GBV programs, please see **How to support a survivor of gender-based violence when there is no GBV actor in your area**.

KEY CONSIDERATIONS

COMPLEMENTARY AND INTEGRATED MHPSS PROGRAMMING	
PLANNING PHASE	Building upon the findings of needs assessments and landscaping activities, identify which aspects of MHPSS programming can be integrated into other health, social, educational, and economic services. Components such as identification of people in need of MHPSS services may need to be integrated across an array of sectors; this prevents having a single entry point into MHPSS care.
IMPLEMENTATION PHASE	After services have been initiated, there is often differential uptake across sectors. Integration in some sectors may be more successful than others. Determine what makes integration successful in a particular sector, then try to replicate those elements in other sectors. Alternatively, referrals to sectors where integration is more successful may be appropriate.

NOTES

DOMAIN 4. Consistent with Evidence Base

Definition

This domain emphasizes the importance of utilizing evidence-based practice when implementing an MHPSS program. The entirety or components of the intervention and tools should be selected based on the evidence. It should also account for the unique beliefs, values, and cultural identity of each context in which the program is implemented. Finally, MHPSS programming should integrate assessment, evaluation, and monitoring processes.

Evidence-based interventions are strategies that are proven to work at some level.[12] Despite improvements in the past few years, there remains a wide gap between research and practice, which affects care received by MHPSS service users and exposure to avoidable harms such as going through treatments that may generate adverse effects.[13, 14] Evidence-based interventions may reduce harm and promote positive treatment outcomes for MHPSS service users, generate new knowledge, and facilitate clinical decision-making for health care providers.[14]

Active ingredients are also called "mechanisms of change" or "common practice elements." They refer to the components of the intervention that ultimately led to the desired outcome. Understanding active ingredients, such as behavioral activation or cognitive reframing, can support adapting and implementing effective programming.

DO NO HARM

Fortunately, there is a growing body of evidence-based interventions in MHPSS. The first risk of harm in this domain is to implement an intervention that is not supported by evidence. New interventions should be tested under appropriate conditions, where safety of those providing services and those receiving services is closely monitored, and there is an approach to demonstrate the benefit of the new intervention over other interventions that have shown benefit in similar settings. A second risk of harm comes from how existing evidence-based interventions are implemented. Often, there is pressure to shorten training and supervision, or to abbreviate interventions. If an intervention was shown to be effective when primary or community health workers were trained for 10 days and then received weekly supervision, it cannot be assumed that the same intervention will be effective with only five days of training and monthly supervision. Inadequately trained providers may introduce more harm than benefit. (The 8Cs Domain #6 has more information on how to assess competency of providers delivering MHPSS services.) Additionally, when components of an evidence-based intervention are removed, the intervention may not be effective or may introduce harm. For example, at first, health care workers and community providers may be uncomfortable screening for or discussing suicide risk. However, if a component around suicide risk reduction is removed from an intervention, this may reduce the benefit of the services and not give providers the appropriate tools and training to manage a vital component of MHPSS care.

Evidence-based MHPSS interventions

There are many MHPSS interventions that have been shown to be effective, but some well known interventions have more supporting evidence than others. Two such interventions — Self Help Plus and Common Elements Treatment Approach - are described in detail below. It is important to note that evidence-based interventions may vary in feasibility, intensity, and resource requirements. The evidence supporting a particular intervention should be considered in the context of all of the other factors discussed in the other domains of the 8Cs to determine the best intervention for your particular setting.

EXAMPLES:

- **Self-Help Plus (SH+)** is WHO's five-session stress management course for groups of up to 30 people. It is delivered by supervised, non-specialist facilitators who complete a short training course and use pre-recorded audio and an illustrated guide to teach stress management skills. The course is suitable for adults who experience stress, regardless of their country of residence and other circumstances. The format of SH+ makes it well suited for use alongside other mental health interventions, as a first step in a stepped care program, or as a community intervention delivered alongside broader community programming. This intervention has shown success in improving psychological health and well-being in humanitarian settings in countries like Uganda.
- **Common Elements Treatment Approach (CETA)** is a transdiagnostic intervention developed to improve mood and anxiety symptoms and is commonly used in LMICs. This intervention is usually delivered in six to 12 hour-long sessions and can be provided individually or in groups. Intervention administrators can be non-professionals or individuals with mental health backgrounds. The results of this intervention have shown improvement in overall well-being for survivors of torture and militant attacks in **Iraq** and in youth in **Somali** refugee camps, and a reduction of symptoms of internalizing, externalizing, and PTSD.

Considerations

QUESTION 1. What MHPSS interventions and validated assessments have evidence to support their effectiveness for the selected MHPSS condition and population?

In order to determine what MHPSS interventions could be used for specific populations, refer to the MHPSS Resource Navigator. This is an interactive, web-based tool that uses filters to search through evidence-based MHPSS interventions as well as validated tools for screening and measurement. Of note, most of the MHPSS interventions and tools are free, but some have a licensing fee, proprietary training fee, or other costs, which are noted when possible. The filters are designed to find the right tool when you may only know a few beginning requirements of your "ideal" intervention, like the mental health condition you'd like to address or the beneficiary population you are hoping to serve.

Examples of some of the most used MHPSS interventions are in **Key Resources**. These examples were chosen as simple and effective strategies to provide mental health support in various settings (e.g., humanitarian emergencies). The MHPSS Resource Navigator provides users with elements that are essential to choosing the right intervention for a specific population. One should consider target population and mental health condition, training duration, and other elements based on available resources.

QUESTION 2. What active ingredients does the intervention have?

Active ingredients and mechanisms of change refer to the specific components of an intervention that drive clinical impact. They serve as potential targets of known efficacy that an intervention can be built or adapted around. In short, the active ingredient of an intervention targeting a specific condition compels a team to ask the question of "What works, for whom, when, and how?"

For example, behavioral activation is a common therapeutic approach that is shown to be effective in many interventions aiming to improve depression and/or anxiety symptoms. Behavioral activation is a highly individualizable plan of care, but the basic tenet of behavioral activation is to interrupt the pattern of avoidance and withdrawal that is typically associated with depression by intentionally performing behaviors that activate a person's sense of meaning, resulting in a positive feeling even if they don't feel like it at first! Over time, the change in behavior creates enough positive reinforcement in the brain and the body that the symptoms of withdrawal and avoidance begin to improve. Behavioral activation has a robust evidence base for being an active ingredient in interventions addressing depression, and it seems that the active ingredient of behavioral activation lies not just in people getting up and doing things when they don't feel like it, but rather intentionally finding meaning and connection between the action, the thoughts, and the feelings.

In an implementation setting, providers may be able to adapt approaches to behavioral activation to their cultural or linguistic context, so long as the active ingredient, in this case, awareness and reinforcement of the connection between intentional action, thoughts, and feelings is not removed from the intervention.

The Wellcome Trust has spearheaded a massive research initiative to identify and refine the most effective active ingredients in MHPSS interventions, particularly those that aim to address the most common mental health conditions like anxiety and depression. Some of them are listed here, divided into six general categories. A project team may use these components to either search for or plan adaptation of a specific intervention:

ACTIVE INGREDIENTS TO PREVENT OR TREAT YOUTH ANXIETY AND DEPRESSION REVIEWED BY WELLCOME-FUNDED TEAMS (2020-2021)

Behaviors and activities

- Behavioral activation: increasing engagement with positive activities
- Collaborative goal setting and tracking
- Engagement with the arts
- Exposure: facing one's fears in a planned manner
- Physical activity: more bodily movement
- Problem-solving
- Relaxation techniques: better stress response via relaxation
- Remote measurement technologies: use of remote technologies to monitor changes in biology, behavior and environment relevant to the problems
- Self-disclosure: sharing information with others about personal experiences and characteristics

Beliefs and knowledge

- Agency: developing a sense of agency through social action
- Cultural connection: connection with one's own culture
- Mental health literacy
- Sense of mattering
- Sense of purpose
- Self-evaluation: improved view of self
- Spiritual and religious beliefs

Brain/body functions

- Circadian rhythms: better sleep-wake cycles
- Gut microbiome: improving gut microbiome function
- Hippocampal neurogenesis: growth of new neurons in the hippocampal region of the brain
- Omega-3 supplements
- Reduced levels of inflammation in the body
- Selective serotonin reuptake inhibitors: use of antidepressants

Wellcome selected these active ingredients based on the quality of the submitted proposals, the teams' expertise, and the need to ensure that a diverse range of ingredients were considered. This is not a comprehensive list to all possible active ingredients. Categories used are imperfect and merely for ease of navigation.

https://cms.wellcome.org/sites/default/files/2022-11/Mental_Health_Active_Ingredients_table_Nov22.pdf

Foundational helping skills, also known as common factors or core skills, also have a robust evidence base. This term refers to the interpersonal provider competencies needed to build an empathetic, respectful, and trustworthy relationship with clients. In addition to targeting treatment- or condition-specific mechanisms of change, foundational helping skills are an evidence-based component that should be, as the name implied, considered foundational to any intervention. Examples of foundational helping skills include effective communication, demonstrating empathy, and promoting hope for recovery. Foundational helping skills have been widely established as an essential and universal prerequisite for the delivery of effective psychological care and identified as a core competency for all health workers in the **WHO Global Competency Framework for Universal Health Coverage** for the health sector. Competent use of these skills by providers improves treatment outcomes for people accessing all fields of health services, from surgery to mental health services, and use of these skills has been shown to support greater treatment compliance outside of mental health, for example, with HIV treatment adherence.

All interventions need to include effective use of foundational helping skills alongside condition-specific or treatment-specific components. More information on training in foundational helping skills is found in a later domain on competency-based training and supervision.

KEY CONSIDERATIONS

COMMUNITY-INFORMED MHPSS PROGRAMS	
PLANNING PHASE	When planning interventions, be sure to select from existing evidence-based practices or components of those practices. Based on the conditions of interest, the time available for services, and who is available to be trained, one can then select which evidence-based intervention would be most appropriate.
IMPLEMENTATION PHASE	After evidence-based interventions are in place, it is important to evaluate whether they are having the intended effect associated with expected outcomes. Measuring the mechanisms of change, in addition to outcomes, is helpful to determine if and how an intervention is working.

NOTES

DOMAIN 5.
Culture, Language, and Contextualization

Definition

This domain involves the acknowledgment of cultural values, norms, beliefs, and preferences of a specific location or population, through tools, assessments, and strategies for cultural adaptation and translation, taking into account multiculturalism and intersectionality. In addition, this domain includes elements that may affect the implementation of a mental health intervention, such as health care structure, space, privacy considerations, mandatory reporting laws, or lack of agreement on licensure requirements (of waiving that requirement), and potential malpractice that could lead to lawsuits.

DO NO HARM

When mental health assessments and interventions are not culturally and contextually adapted, they risk exposing those providing interventions and those participating in programs to harm. Most clinical psychiatric screening tools, such as the PHQ-9, overestimate the prevalence of mental health problems by 20–40% even when using an adapted and validated version. When a version that has been transculturally translated and validated is used, there can be even higher inaccuracy. Therefore, cultural adaptation and validation is vital whereever possible. Similarly, when interventions are not adapted appropriately, there is a risk of increased stigma for those participating in the program. The services also may be less effective.

Considerations

QUESTION 1. Have the MHPSS interventions and materials used been culturally adapted, translated, and contextualized? If not, how will they be translated and adapted?

All MHPSS interventions and materials should be culturally adapted, translated, and contextualized. This allows for identification of culturally specific risk and protective factors and improves the effectiveness of the intervention. **Systematic cultural adaptation, translation, and contextualization** ensure that the materials used for the intervention are correctly translated and use culturally appropriate concepts. **The mhCACI framework** provides an example of a 10-step process used in Nepal to adapt a Group PM+ intervention involved 10 steps:

1. Identify mechanisms of action
2. Conduct a literature desk review for the culture and context
3. Conduct a training of trainers
4. Translate intervention materials
5. Conduct an expert read-through of the materials
6. Qualitative assessment of intervention population and site
7. Conduct practice rounds
8. Conduct an adaptation workshop with experts and implementers
9. Pilot test the training, supervision, and implementation
10. Review through process evaluation

One of the main reasons for cultural adaptation and contextualization is that, due to cultural

norms and perceptions, different cultures may understand and express their mental health symptoms in different ways.

Contextualization and adaptation should also consider the potential impact of leveraging digital health tools and other technology-based platforms to engage clients, navigate access issues, and supplement in-person service delivery. Of course, this depends on the readiness of the community, the readiness of existing service providers to incorporate digital solutions, and local telecommunications infrastructure, but it is another factor to consider when seeking to optimize adaptation of an intervention to the local context.

QUESTION 2. How has the MHPSS intervention been validated for specific contexts and populations?

Before an MHPSS intervention or its tools, measurements, assessments, and evaluation are used, it is essential to ensure that they have been adapted to local culture and language and are reliable and valid for specific contexts and populations. The best way to learn about MHPSS intervention adaptation in different countries is through a literature review. **UNICEF Measurement of Mental Health Among Adolescents at the Population Level** provides a step-by-step process for trans-cultural translation, adaptation, and validation of MHPSS assessments.

It is not sufficient to translate the MHPSS intervention to a different language; the focus should be on ensuring that the intervention is culturally compatible and compelling. These components are described in the "Culture and Language" section below and in the following article: **Development of the mental health cultural adaptation and contextualization for implementation (mhCACI) procedure: a systematic framework to prepare evidence-based psychological interventions for scaling.** Please see Annex I for additional guidance on validation and adaptation of screening and/or assessment tools.

QUESTION 3. What will be put in place to reduce and prevent stigma?

Mental health stigma must be considered for MHPSS intervention planning and implementation. According to the literature, mental health stigma is associated with delayed help-seeking behavior and treatment, which tends to result in poor outcomes, barriers to access to care, and human rights violations.[15]

While exploring reduction and prevention of stigma is specifically included in **Domain 5** of the collaborative consultation, it is a crosscutting principle that should be considered throughout the development or implementation of any MHPSS intervention.

Culture has a strong influence on stigma, and largely determines what is considered socially acceptable behavior. Culture and language also influence explanations of what causes mental illness and how mental illnesses can be or should be treated.[16] Stigma and discrimination against people living with mental health conditions has been documented in cultures throughout the world. Globally, research has demonstrated widespread human rights violations of people living with severe mental illness.[17] Understanding personal,

familial, and cultural beliefs about mental illness can be important for successful treatment and communication.

One of the key factors for targeting mental health stigma and discrimination is social contact — direct or indirect contact with individuals who have experienced mental health conditions. Interventions tackling stigma through social contact can connect health care providers and people with lived experiences mainly through education (i.e., raising awareness about stigma and recognizing people with lived experiences).

To address the gap between the individuals in need of mental health support and individuals who can provide such services, more MHPSS interventions are being embedded into mental health services in the primary care setting. However, health care settings may present some challenges due to the lack of training for health care providers on MHPSS, which could lead to experiences of stigma by individuals seeking mental health support. It is essential that MHPSS interventions are done in a space that is not stigmatizing, taking into consideration cultural context, mental health stigma, and stigma against a specific population or community.

Promoting high-quality, non-stigmatizing care in an integrated setting can mitigate the risks of stigma related to mental health as well as other health areas that may be stigmatized, like HIV, TB, and reproductive/sexual health.[21, 22] Therefore, embedding mental health services into HIV, sexual and reproductive health (SRH), or maternal and child health (MCH) services, not; or accepted community systems of care (community health clinics, schools, community social centers) rather than stand-alone mental health clinics can limit stigma. Using language that is culturally acceptable to talk about mental health problems (e.g., "stress") and avoiding terms that are derogatory (e.g., "crazy," "challenged," "disordered") can also reduce risk of stigma and encourage help-seeking. To learn more about cultural factors and mental health stigma and ways to address them, see Reducing the stigma of mental health conditions with a focus on low- and middle-income countries. Finally, the **Lancet Commission on ending stigma and discrimination in mental health recently released key recommendations.**

A more recent approach toward understanding culture and stigma has emerged from the field of medical anthropology, known as the *moral understanding of experience*. This is the idea that cultures are likely to stigmatize behaviors that threaten *"what matters most"* to them. What matters most may vary between cultures, and even between subcultures within cultures. This may explain why different professions and roles within a society have different types and severities of stigma; each profession or role creates its own unique subculture within a general cultural group. This is why the understanding and perpetuation of stigma may differ in the cultural practices of, say, health professionals, law enforcement officers, teachers, religious leaders, and other community members. The combined cultural expression(s) of stigma in any community can both affect and be affected by structural factors that shape how social, political, economic, and policy norms may perpetuate stigmatizing practices and behaviors. Recently, interventions to reduce stigma have employed a what matters most framework, rather than solely focusing on changing cultural beliefs or trying to promote one view of mental health literacy.[18,19] Researchers in low- and middle-income countries have developed a what matters most framework that incorporates different aspects of culture and structural stigma, and guides intervention design and implementation.[20]

QUESTION 4. How will the legal requirements and restrictions related to MHPSS services be addressed?

Considering different ways to **protect** the MHPSS intervention delivery staff from **potential lawsuits (such as licensure, malpractice, and billing)** may benefit not only the personnel but also the service users. Concerns about potential neglect may affect the end users' trust while working with the MHPSS staff.

Determining if a license is needed to provide MHPSS services is essential to avoid potential lawsuits for malpractice. For instance, consider collaborating with government agencies, ministries of health, and local professional societies to determine licensure requirements or actions for waiving such requirements to protect trainees and their supervisors legally, or partner with government institutions to operate under their umbrella of laws and regulations. Furthermore, consider whether there should be a fee for MHPSS services and what it should be.

Understanding what constitutes misconduct (such as sexual relationships with a client), setting clear guidelines on what services will be provided, and practicing self-care to prevent burnout from personal and professional stressors might be a starting point for avoiding malpractice.

QUESTION 5. What mandatory reporting laws do the MHPSS intervention implementers need to be aware of?

This consideration primarily refers to mandatory reporting laws for abuse. While many Western countries have laws designed to protect individuals against abuse, other countries may not have such a system in place. Mandatory reporting requirements dictate that an individual in a service provision role (most commonly a health care provider, educator, or social worker) who has a reasonable concern that abuse has taken place or is taking place is legally required to report their concern to the appropriate authority for further investigation. Mandatory reporting requirements most commonly refers to abuse of children, the elderly, or vulnerable people (such as individuals with severe mental health conditions or intellectual disabilities). Such abuse violates human rights, and in some countries, failure to report is considered a crime.

Additional guidance regarding mandatory reporting for specific vulnerable populations includes:

- **Children:** There is no consensus for mandatory reporting of child abuse among different countries. To learn more about children's protection against sexual violence, please see **Child Sexual Abuse Material: Model Legislation and Global Review.**
- **Elderly:** More information about WHO's actions against elder abuse can be found in **A Global Response to Elder Abuse and Neglect: Building Primary Health Care Capacity to Deal with the Problem Worldwide: Main Report**.
- **Individuals** who communicate plans to self-harm or hurt others may be included in mandatory reporting requirements, though specific protocols or action plans may depend on the professional risk assessment of these individuals, and the available resources to keep them and others safe.

- **Individuals** who report experiencing violence, including gender-based violence, may trigger mandatory reporting.

Another consideration involves national reporting laws related to mental and behavioral health that may negatively affect MHPSS service users. For example, some countries have criminalized substance use, and providers are mandated to report illegal substance use to the police. In these situations, MHPSS assessments and programs may decide not to ask about certain types of substance use to avoid violating legal requirements, or providers should have specific training about what type of information is reportable and how to counsel their clients on mandatory reporting laws before any personal information is divulged. Criminalization of homosexuality, suicide attempts, and mandatory reporting laws regarding criminal behavior are other examples of legal issues to consider in developing MHPSS services.

KEY CONSIDERATIONS

CULTURE, LANGUAGE, AND CONTEXTUALIZATION	
PLANNING PHASE	Materials need to be culturally adapted and translated. Simple forward and back-translation procedures can contribute to materials that are unacceptable, inaccurate, and stigmatizing. Standardized qualitative methods should be used to systematically adapt and translate materials that will be understandable, relevant, acceptable, and comprehensive. Existing stigma may be a barrier to implementation, and beneficiaries may encounter new stigma through programming. Therefore, mechanisms need to be put in place to reduce and prevent stigma and monitor for adverse events. Legal requirements and restrictions should be identified before implementing programs. Policies on who can provide MHPSS services — ranging from psychological treatments to dispensing psychiatric medications — vary from country to country. Mandatory reporting laws related to detection of child maltreatment, GBV, and other issues also need to be accounted for in the design phase and articulated to service users when explaining any limitations in confidentiality.
IMPLEMENTATION PHASE	Difficulties in implementation can arise from how materials are adapted and translated. When barriers are encountered, you may need to further modify the adaptations and translations. Impediments in implementation are often due to stigma at the facilitator level or reluctance to use services at the participant level. Adding anti-stigma programs to existing services may improve the uptake and benefit of services. During implementation, barriers may arise due to legal requirements and restrictions that necessitate adaptation of the program and coordination with legal bodies. Programs should also regularly monitor whether mandatory reporting requirements are being clearly communicated, implemented, and followed up.

NOTES

DOMAIN 6.
Competency-Based Training and Supervision

Definition

In order to address the treatment gap created by the insufficient number of mental health professionals and a growing number of individuals seeking mental health support, WHO proposed an approach of task-sharing or task-shifting to increase service capacity.[23] This approach refers to training lay health workers or non-specialized individuals such as nurses, teachers, and social workers to deliver mental health assistance. Such an approach has shown high success rates in a number of countries.[7,13] Training non-professionals in a task-sharing approach can also be utilized in support group facilitation as a way to improve mental health conditions and reduce stigma. A task-sharing approach requires consideration of both competency-based training and supervision. A recognized and supported infrastructure for competency-based training and supervision offers a range of benefits beyond safer task-sharing or task-shifting. Competency can be standardized and staff can be continuously supported with standardized goals and clear pathways to achieving those goals. This creates legitimacy among MHPSS services and promotes a culture of quality and excellence among service providers.

- **Competency-based training:** Participants should acquire, remediate, and sustain at least minimum competencies regarding mental health interventions and should be able to demonstrate skills and knowledge to deliver such interventions. Competencies are not static attributes; they require continuous improvement.
- **Supervision:** Supervisors should have the ability to oversee the implementers, ensuring that mental health interventions are appropriate in a specific setting and population and are carried out in the most effective and safe way, with supervisors providing systematic, structured, and high-quality feedback.

DO NO HARM

When providers of MHPSS services are not competent, they risk doing more harm than good for their beneficiaries. Whereas specialists in MHPSS typically have extended training programs and a process of going through licensure or certification, the growing trend toward task-sharing involves training for brief periods of time (a few days, weeks, or months), and there are often not formal certification or licensure processes (to date). Therefore, it is important to have a system in training and supervision to check the competency of those involved in brief training programs to deliver MHPSS services. Assessing potential harmful behaviors on the part of providers allows for correcting these behaviors to reduce risk of harm to beneficiaries. A second area of potential harm related to competency is that introducing competency assessment without resources for capacity building may demoralize and demotivate providers. If an NGO is evaluating competencies of government health workers, for example, then there should be resources available to provide trainings or supervision to address gaps in competency. This can be summed up with the ethos "Don't assess without assisting." Competency assessment should be done in the context of improving skills for MHPSS services.

Considerations

QUESTION 1. What competencies are relevant for the selected MHPSS programming, and how will they be measured?

It might be challenging for governments, NGOs, academic institutions, and the general population to be confident that the non-professionals delivering MHPSS services provide quality care, specifically because professional organizations do not oversee such activities. Competency-based approaches and assessments may address these challenges using benchmark skills to provide supportive and safe care.

Scaling up MHPSS services through primary care can be done by including quality training in mental health in in-service education or employing individuals with lived experience as first-line providers of support. WHO's **World mental health report: transforming mental health for all** may provide additional guidance in providing such care.

Training and supervision for MHPSS need to include mechanisms to help identify when **minimum competency is achieved. Competency is a journey**, not a static and time-bound attribute; therefore, it is essential to determine what minimum competencies should be acquired to provide MHPSS interventions. **Ensuring Quality in Psychological Support (EQUIP)** is a platform that provides free competency assessment tools and resources to support governments, training institutions, and NGOs, both in humanitarian and development settings, to train and supervise the workforce to deliver effective psychological support to adults and children. It also provides guidance for supervision, especially supportive and constructive feedback. This platform has shown success in a number of countries, including **Ethiopia** and **Nepal**.

There are three different types of psychological support competency assessment tools:

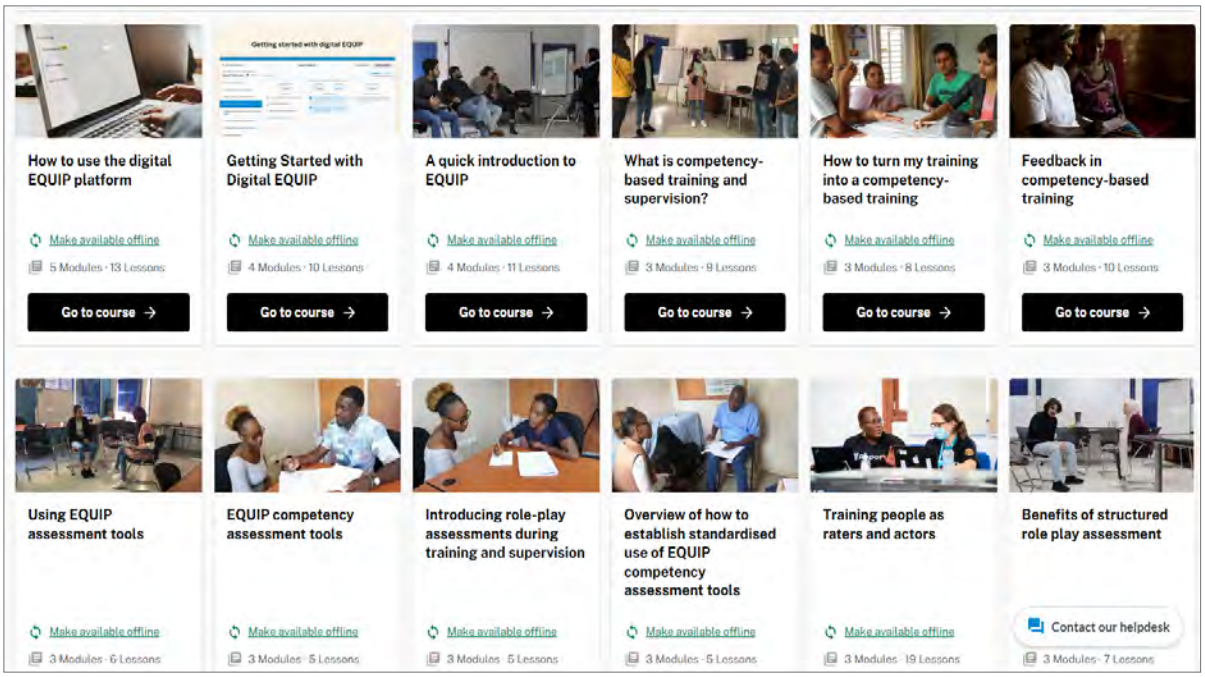
- **Enhancing Assessment of Common Therapeutic factors (ENACT):** A foundational helping skills assessment tool for non-specialist and specialist helpers delivering psychological support
- **Assessment of Competencies Tool (GroupACT):** A group-based common competencies assessment tool for non-specialist helpers working with groups
- **WEACT:** A common competencies assessment tool for non-specialists and educators delivering care to child and adolescent populations

These assessment tools can help remediate, achieve, and sustain minimum competency by using the EQUIP platform. The platform is an online resource that is also available in an offline format. It includes a series of courses introducing competency-based training and describing how to design a competency-based training. Assessment tools are available to evaluate a range of competencies such as foundational helping skills for adults, for children, and for working with groups. Intervention-specific skills include problem-solving, behavioral activation, cognitive techniques, and trauma-informed strategies. Competency evaluations can be set up in the platform and ratings entered directly; then visualizations are provided to summarize key strengths and areas for improvement for individuals and teams.

In addition, these assessments help inform trainers and supervisors about their trainees' progress and areas for improvement. EQUIP users typically pair the competency assessment tools with a brief role-play (which resembles an interaction of a helper and a person using the service) before, during, or after training and supervision. To learn more about the EQUIP platform, please refer to **Ensuring Quality in Psychological Support (WHO EQUIP): developing a competent global workforce**.

Organizations may feel hesitant to start using a competency-based approach. Although competency-based training has tremendous potential to yield safer and more effective care, there may be reluctance among organizations that perceive barriers to adopting a new training methodology. The EQUIP training modules are built specifically to address these types of questions and to provide a quick start to introducing competency-based elements.
The screenshot depicts the courses that are available through EQUIP to introduce a competency-based approach (Figure 5). The module "How to turn my training into a competency-based training," is a quick guide to adapting existing trainings with minimal additional resources and effort.

FIGURE 5. Screenshot of courses available on the WHO EQUIP platform



QUESTION 2. How will supportive supervision be implemented?

The **supervision** of staff who deliver MHPSS services must be adequate, providing individuals with essential resources and **support** when they are faced with difficult or unfamiliar cases. Even with limited human resources in MHPSS delivery settings, it is important to have a supervisory role, particularly in acute emergencies, so it is clear what steps to follow under different circumstances

(e.g., when someone has suicidal ideation, has experienced GBV, or has been diagnosed with HIV). Please see **Domain 3** for more information.

In addition, **Domain 7** describes supportive supervision as a component of care for caregivers. Supportive supervision not only promotes high-quality MHPSS services for beneficiaries, the mentorship, support, and confidence that comes from developing these skills may serve as a protective factor against stress, moral injury, and burnout among service providers.

Commonly used staff support programs include:

- **Stress First Aid (SFA)** – This is a framework of practical actions to help reduce the likelihood that stress reactions will develop into more severe or long-term problems. SFA offers flexible options for addressing stress reactions. It can be used for self-care, to help co-workers with stress reactions, or to help people seek other types of support. SFA can be delivered in an eight-week period by volunteers elicited by unit leads or by so-called SFA champions. This framework has been implemented mainly in the United States.
- **Basic Psychosocial Skills - Guide for COVID-19 Responders** – This free self-paced resource for COVID-19 responders focuses on teaching basic psychosocial skills for supporting others through interactions and self-care.

KEY CONSIDERATIONS

CULTURE, LANGUAGE, AND CONTEXTUALIZATION	
PLANNING PHASE	Training and supervision programs need to be designed so that MHPSS facilitators achieve and maintain minimum competency for safe and effective delivery. When designing programs, the minimum competency requirements should be outlined, as well as systems to evaluate competency in a standardized fashion.
IMPLEMENTATION PHASE	Competencies should be regularly evaluated during implementation. If minimum competencies are not being achieved, this should be addressed by modifying training and supervision. In addition, selection procedures for MHPSS facilitators can be altered if information is generated on which competencies affect implementation skills.

NOTES

DOMAIN 7.
Care for Staff

Definition

This domain covers care for the well-being of staff, considering mental/physical health, and ethical, economic, and occupational components of their work, and providing supportive supervision and adequate resources for service providers to do their jobs. Health care professionals may face unique challenges when caring for patients, particularly in low-resource areas. The COVID-19 pandemic has exacerbated those challenges, exposing health care providers to mental and physical exhaustion due to loss of patients and colleagues, continuous risk of contracting the virus, and putting in many extra hours in understaffed or under-resourced clinical settings to manage the influx of patients. Such exhaustion is called burnout and is defined as "a syndrome resulting from chronic workplace stress that has not been successfully managed," according to the 11th International Classification of Diseases (ICD-11). Burnout may involve the following elements:

- Feelings of energy depletion or exhaustion
- Increased mental distance from one's job, or feelings of negativism or cynicism related to one's job
- Reduced professional efficacy

Though the ICD-11 describes burnout as an occupational experience and not a medical condition, it involves many mental health components; unaddressed burnout can develop into individual mental health challenges. According to studies that looked into health care workers' (HCW) mental health conditions and burnout, the most commonly experienced conditions were anxiety, depression, sleep disorders, substance use, and somaticization.[24] In addition, other studies reported fatigue, stress, PTSD, decreased self-esteem, and lack of efficacy (particularly for women). As a consequence, burnout — especially among the health care workforce — may affect quality of service and attention to detail, lead to increased medical errors, and deepen psychological distress, which eventually worsens burnout.[25] Since burnout is associated with a number of mental health conditions, it can be stigmatized, particularly when experienced by HCWs. While these examples highlight the experience of burnout and mental health challenges among the health care workforce in the context of the COVID-19 pandemic, burnout affects many people in caring professions; burnout can be experienced by anyone and is not unique to HCWs.[26] Therefore, it is practically and ethically essential to consider care for staff when designing or implementing any health-related intervention.

DO NO HARM

As described in prior sections, it is crucial that addition of MHPSS services include support for staff delivering those services. Lack of support risks both their mental health and well-being and those of program beneficiaries. Before implementing programs, assure that staff have protected time for supportive supervision, that they are not simply expected to add tasks on top of their full-time duties, and that appropriate resources are made available to operationalize care for staff in the programmatic setting.

Considerations

QUESTION 1. What resources need to be put in place for staff safety when delivering MHPSS services?

This component refers to the **understanding of minimum safe working conditions** and **raising awareness** among employees not only about chemical, biological, or other types of hazardous substances but also about psychological hazards for health care workers. There have been several recent publications to advocate for mental health as one of many components of occupational health and safety, and to guide policymakers and other leaders across industries to actualize these recommendations

- See the announcement from WHO for **Healthy, safe and decent working conditions for all health workers, amidst COVID-19 pandemic**.
- For more on the global, regional, and national norms for health protection in the workplace, please see **International minimum requirements for health protection in the workplace**.
- Please read the following article to learn about mental health challenges in the COVID-19 pandemic for health care workers: **Prioritizing the Mental Health and Well-Being of Healthcare Workers: An Urgent Global Public Health Priority**.
- The Resilience Collaborative, from the Johnson & Johnson Center for Health Worker Innovation, has published **Building Health Worker Resilience: A Toolkit to Protect Against Burnout on the Front Lines**. Like the 8Cs Model, it helps implementers navigate the evidence to choose appropriate interventions. It also provides a framework to distinguish individual, interpersonal, and organizational factors that may serve as targets for intervention.
- Screening for mental health concerns and knowing which individuals require MHPSS assistance may not be beneficial without adequate resources to then render appropriate care. **Assuring that staff have the resources needed to safely deliver MHPSS services** may improve the effectiveness of the intervention. **The SAFE (Supporting Adolescents and their Families in Emergencies) Resource Package** can strengthen the capacity of fieldworkers to deliver assistance in acute emergencies for adolescents.

QUESTION 2. How are compensation decisions made? What are local dynamics regarding compensation for MHPSS service staff? Is current compensation considered fair? Has fair compensation been considered for MHPSS service staff?

Fair compensation may be one of the key elements to keep individuals engaged and motivated to do their work, particularly in challenging times, such as a pandemic. In addition, it is crucial to avoid "task-dumping" on the staff that is already overburdened with tasks, particularly without recognition and reward for their hard work. To learn more about compensation in a global context during the pandemic, please visit **Global Wage Report 2020–21: Wages and minimum wages in the time of COVID-19.**

QUESTION 3. Will there be a mechanism by which staff delivering MHPSS services can give feedback to improve their working conditions and/or the quality of the project?

Besides cultural and societal causes of burnout, there are a number of structural and organizational components that may contribute to burnout, such as excessive workloads, insufficient number of employees who could share that burden, administrative issues, lack of organizational support, and, in the health care field, potential exposure to illness due to lack of personal protective equipment (PPE). Structural and organizational burnout could be reduced by providing family support (if resources allow), such as childcare facilities, transportation, mental health support, and available PPE. MHPSS staff need to have an opportunity to provide feedback on such matters to prevent burnout and promote mental well-being. Mapping out ways to provide feedback and ensuring no possibility of retaliation is essential. For example, consider adding comment boxes or anonymous electronic surveys where staff could leave anonymous suggestions and creating regular times when those comments would be reviewed weekly, biweekly, or monthly. Suggestions could be discussed in meetings, allowing staff to express their opinions about changes.

KEY CONSIDERATIONS

CARE FOR STAFF	
PLANNING PHASE	Identify the working conditions of people delivering MHPSS services and determine how these can be made to protect the safety and well-being of staff or optimized to promote well-being.
IMPLEMENTATION PHASE	Document the physical and psychological safety of staff and identify remediation mechanisms to improve safety measures. Identify current compensation practices and determine policymakers or other stakeholders who may need to be engaged to improve compensation.

NOTES

DOMAIN 8. Change-Based Measurement

Definition

Change-based measurements are tailored to assess the implementation of a program and its change, such as the expected impact and potential harms and benefits, as well as dissemination and sharing for adaptation.

A change-based evaluation focuses on measuring what matters most to the community. **The IASC Common Monitoring and Evaluation Framework for MHPSS in Emergency Settings** proposes strategies to measure six impact indicators with the overarching goal to improve mental well-being and reduce suffering:

- **Functioning** – inability to do daily activities (may vary in different cultures)
- **Subjective well-being** – indicators of well-being that could be measured, such as feeling calm, safe, strong, hopeful, capable, rested, interested or happy, and not feeling helpless, depressed, fearful, or angry
- **Social behavior** – behaviors that might be affected by other members in the community, such as altruistic actions and violence
- **Social connectedness** – quality and number of social connections that individuals have or perceive having
- **Ability to cope with problems** – particularly for those individuals who suffer from mental health conditions or psychosocial issues
- **Disabling distress and/or presence of mental, neurological and/or substance use disorders or symptoms.**

Based on the objectives of different mental well-being strategies, appropriate indicators and measurement tools should be selected.

While the MHPSS navigator does not include M&E tools, assessment scores can be used as part of a larger monitoring and evaluation plan to measure change over time among beneficiaries. For example, using the PHQ-9 before a beneficiary participates in an intervention, and then using the assessment again after the beneficiary has completed the intervention, can produce data that can be analyzed to estimate the impact of that intervention on depressive symptoms.

DO NO HARM

Risks of harm for measurement have been introduced in prior domains. As a reminder, there are several key issues. First, prevalence studies in clinical or community settings should not be conducted before services are put in place. Second, measurement should be culturally adapted and validated to optimize the accuracy of information provided. Ultimately, bad data are worse than no data because of the potential to misallocate resources or mislead program managers, clinicians, and policymakers. Other concerns are that measurements focus on priorities highlighted by the community.

Considerations

QUESTION 1. How will potential harms and benefits of the MHPSS programming be measured? MHPSS interventions should not put people at risk physically, mentally, socially, materially, emotionally, or legally or cause further harm by violating human rights or impairing decision-making (intentionally or unintentionally).[27]

Establishing the ethical principles (i.e., what is right or wrong) that will guide the programming is key to intentionally adhering to the principle of "do no harm." **Measuring potential harms and benefits** is part of the monitoring and evaluation process. To learn more about indicators that could help identify potential harms, please see the **IASC Common Monitoring and Evaluation Framework for MHPSS Programmes**, which proposes a framework of six key areas to conduct ethical mental health and psychosocial research in emergencies. The recommendations are the following:

- **Purpose and benefits**: This includes selection of an appropriate research question that could help cover the gaps in knowledge, assessment of risks and benefits, and dissemination.
- **Analysis of ethical issues**: If possible, the research proposal should go through an ethical review.
- **Participation**: Research should include an informed consent process; provide opportunities to contribute to research design and conduct; and require a fair selection process.
- **Safety**: Ensure that the reporting for vulnerability and protection needs is in place, protect confidentiality, and include accountable staff selection and training.
- **Neutrality**: Provide appropriate access to and exit from a research site; include declaration of interests and role of funding.
- **Study design**: Choose the most appropriate and acceptable methodology for the selected research question.

QUESTION 2. How will the mechanisms of change/fidelity/competency be measured?

Monitoring and evaluation are important components to determine if the program is delivering the desired results. M&E can demonstrate positive and negative changes and suggest considerations for future research. Please keep in mind the following components for **assessments**:

- **Mechanisms of change** are frequently reported for MHPSS interventions in terms of the theoretical and operational processes for the achieved outcome. Identifying such mechanisms may narrow the gap between research and practice. To learn more about mechanisms of change, please see **Mechanisms of change for interventions aimed at improving the wellbeing, mental health and resilience of children and adolescents affected by war and armed conflict: a systematic review of reviews** and **Development of the mental health cultural adaptation and contextualization for implementation (mhCACI) procedure: a systematic framework to prepare evidence-based psychological interventions for scaling**.
- **Fidelity** is the extent to which delivery of an intervention adheres to the protocol or program model initially developed.[28] Fidelity is the main indicator of internal validity. To learn more about

fidelity, please see the following article: **Fidelity Criteria: Development, Measurement, and Validation.**

- **Competency** is the ability to demonstrate treatment-specific and foundational skills of MHPSS interventions (such as cognitive techniques and being empathetic).[29] For more on competency assessment, please see **Domain 6. Competency-Based Training and Supervision** in this document.

QUESTION 3. How will the implementation of the MHPSS program be measured?

There are many challenges and barriers to implementing and evaluating MHPSS interventions in LMICs and scaling them to a national level. Even evidence-based interventions scaled beyond the original effectiveness of RCT may not be successfully implemented in different countries and settings and may produce a different set of outcomes. **Scaling up mental health care and psychosocial support in low-resource settings: a roadmap to impact** proposes a minimum standards framework that provides step-by-step guidance on evidence-based interventions delivery at scale with measurable indicators. The roadmap narrows the gap between research and practice and describes the following minimum set of criteria that needs to be plotted for scalability:

- Relevance
- Effectiveness
- Quality
- Feasibility

There are different ways to measure MHPSS intervention implementation, process/monitoring data, and evaluation data/outcomes. The **RE-AIM framework** has been widely used for planning and evaluation of evidence-based interventions that use qualitative and/or quantitative data. The framework consists of the following elements:

- **Reach**: Participation and representativeness of the target population for the intervention (aggregated individual measure – end users of the initiative)
- **Effectiveness**: The positive and negative effects of the program (aggregated individual measure)
- **Adoption**: Uptake or institutionalization of the intervention in agencies and settings (organizational level measure)
- **Implementation**: The extent to which the intervention is implemented as intended in the real world (aggregated individual and organizational level measure)

- **Maintenance**: The extent to which the intervention and the benefits it generates are sustained over time (aggregated individual and organizational level measure)
- Furthermore, the PIH **Monitoring, Evaluation, Quality Improvement and Targeted Research to Support Site Goals** provides an extensive list of essential MHPSS M&E components, such as M&E process map and strategies, sample key indicators, quality improvement measures, and examples of effective M&E processes.

More information on community-based needs assessment, program implementation, and evaluation can be found in **Setting up community mental health (CMH) programmes**. Finally, there are many free, culturally adapted assessment tools that can be used to measure mental health conditions. Many of these tools can be found in the **MHPSS Resource Navigator**

KEY CONSIDERATIONS

CHANGE-BASED MEASUREMENT	
PLANNING PHASE	Measurement systems need to be integrated into M&E to address intended outcomes and potential harms, track mechanisms of change, monitor fidelity and competency, and record implementation metrics. All tools need to be culturally adapted and translated to appropriately measure the intended domain.
IMPLEMENTATION PHASE	During implementation, the feasibility and actionability of the data collection process should be reassessed regularly. Is information reliably being generated, and is this then available in a timely manner to those who can act upon it?

COMMONLY USED ASSESSMENT TOOLS

COMMONLY USED MENTAL HEALTH TOOLS	▪ **The Patient Health Questionnaire** (PHQ) is an instrument for screening, diagnosing, monitoring, and measuring the severity of depression. ▪ The **General Anxiety Disorder** (GAD-7) tool is used to screen and measure symptom severity for the most common anxiety disorders. ▪ The **Hospital Anxiety and Depression Scale** (HADS) is a 14-question instrument that measures anxiety and depression.
COMMONLY USED FUNCTIONING TOOLS	▪ **World Health Organization Disability Assessment Schedule 2.0** (WHODAS 2.0) is a 36-item measure that assesses disability in adults ages 18 years and older.
COMMONLY USED DISTRESS SCALES	▪ **PSYCHLOPS** asks respondents to indicate the problem that bothers them the most. This tool assesses mental health outcomes and quality of life.
BURNOUT	▪ **The Burnout Assessment Tool** (BAT) is a new self-report questionnaire to measure burnout. The BAT can be used individually for burnout assessment as well as collectively in organizations for screening and identifying those with elevated burnout levels. Also, the BAT can be used for benchmarking, that is, for determining the level of burnout relative to a representative sample of the workforce. Finally, the general version of the BAT can be used for assessing and monitoring those who are currently not working, for example, in the context of a treatment, counseling, or return-to-work program. In addition to the full version of the BAT with 23 items, a shortened version with 12 items is available. ▪ The **Maslach Burnout Inventory** (MBI) measures burnout based on WHO and ICD-11 definitions. Please note this tool is not free. ▪ The **Copenhagen Burnout Inventory** has three scales that measure different dimensions of burnout: personal, work-related, and client-related. ▪ The **Professional Quality of Life (ProQOL)** tool measures the effects of working with individuals who have experienced trauma and consists of compassion satisfaction, burnout, and compassion fatigue sub-scales. ▪ The **Stanford Professional Fulfillment Index** (PFI) assesses burnout using professional fulfillment, work exhaustion, and interpersonal disengagement sub-scales. ▪ The **Job Content Questionnaire** (JCQ) tool assesses social and psychological characteristics of jobs.
QUALITY OF LIFE	▪ The **World Health Organization Quality of Life Questionnaire-Brief Version** (WHOQOL – BREF) is an assessment of quality of life using physical health, psychological health, social relationships, and environment sub-scales. ▪ The **World Health Organization Five Well-Being Index** (WHO-5) is an assessment of current well-being.
SELF-ESTEEM	▪ The **Rosenberg Self-Esteem Scale** measures positive and negative feelings about the self.
SUBSTANCE USE	▪ The **Alcohol, Smoking, and Substance Involvement Screening Test** (ASSIST) offers early identification of substance-use-related health risks and substance use disorders in primary health care, general medical care, and other settings. ▪ The **Alcohol Use Disorders Identification Test** (AUDIT) is a tool to screen for unhealthy alcohol use.
SOCIAL SUPPORT	▪ The **Multidimensional Scale of Perceived Social Support** (MSPSS) is a scale that measures perceived adequacy of social support from three sources: family, friends, and significant others.

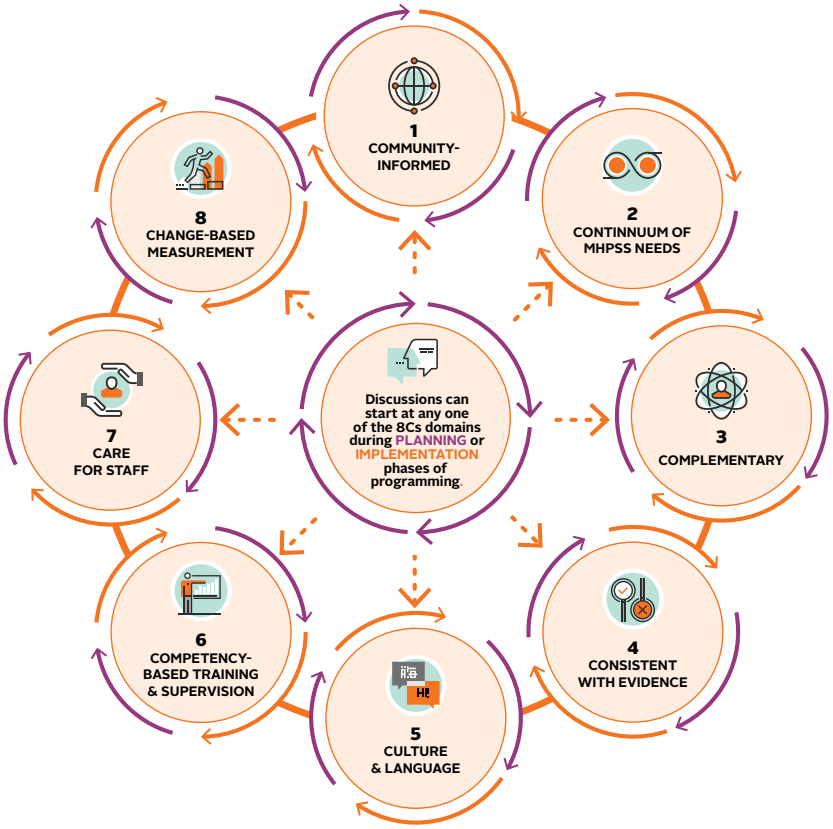
NOTES

The 8Cs
Collaborative Consultation Worksheet

8Cs COLLABORATIVE CONSULTATION WORKSHEET

The 8Cs Collaborative Consultation Worksheet is designed to help users operationalize the 8Cs Model (at right) by structuring and capturing a dialogue in which important topics are identified and recommendations are summarized for each of the 8Cs. This worksheet may also capture areas where additional information should be gathered as an immediate next step. It gives a brief definition of each domain, the key considerations to explore, and a place to document concerns and recommendations. It essentially becomes a "to do" list for the technical advisor and program teams collaborating on the MHPSS program.

This workheet can be used for consultations during the design phase and the implementation phase, and the considerations can be tailored to the stage of programmatic work. Any format can be used for such consultations; for this reason, the worksheet is provided as a Word document to facilitate easy adaptation.



While using the worksheet, keep in mind these crosscutting principles that should be upheld across all domains, and may be explored more deeply in any of them:

- Follow "Do No Harm" principles.
- Address mental health stigma.
- Ensure an appropriate developmental lens when working with beneficiaries across the lifespan.
- Understand, recognize, and plan for mental health emergencies.

Refer to the technical guidance document for additional details, essential resources, and extended explanation of the concepts included in this worksheet.

8 C DOMAIN	CONSIDERATIONS	NOTES
1. COMMUNITY-INFORMED Identifies community-informed needs and strategies to address those needs, including the co-design of initiatives with different stakeholders and the implementation and evaluation of mental health and psychosocial support (MHPSS) interventions.	▪ How have community-identified needs informed the development of the program? ▪ In what ways has the community participated in co-designing, implementing, and evaluating the program? Can this be further strengthened?	Discussion Points, Concerns:
		Discussion Points, Concerns:
2. CONTINUUM OF MHPSS NEEDS Stresses the importance of a multi-layered, coordinated approach in any MHPSS program. Effective program implementation requires participation at all levels/tiers: basic services and security; community and family support; focused, non-specialized support; and specialized services.	▪ Has program design been informed by landscaping activities to identify service gaps? ▪ What intensive services are available for mental health emergencies? ▪ Are there specialists available to provide treatment for severe mental health conditions? ▪ What are the existing referral pathways? How can they be improved to further enhance linkages?	Discussion Points, Concerns:
		Discussion Points, Concerns:

8 C DOMAIN	CONSIDERATIONS	NOTES
3. COMPLEMENTARY Aims to identify opportunities for MHPSS service integration into existing structures or programs to ensure sustainability, instead of re-establishing existing programs.	▪ What elements of the MHPSS program are integrated into a broader health or development program? Or, if none, what elements could be integrated into what kinds of existing programs or structures? ▪ Are the integration strategies for MHPSS programs or interventions feasible? Acceptable? Sustainable?	Discussion Points, Concerns: Discussion Points, Concerns:
4. CONSISTENT WITH EVIDENCE BASE Promotes evidence-based practice when implementing an MHPSS program. The entirety or components of the intervention and tools should be selected based on the evidence.	▪ What is the evidence base for the MHPSS intervention? ▪ What are the active ingredients/ mechanisms of change for the intervention? ▪ If evidence of the chosen intervention is limited, how might you approach adaptation of evidence-based tools?	Discussion Points, Concerns: Discussion Points, Concerns:

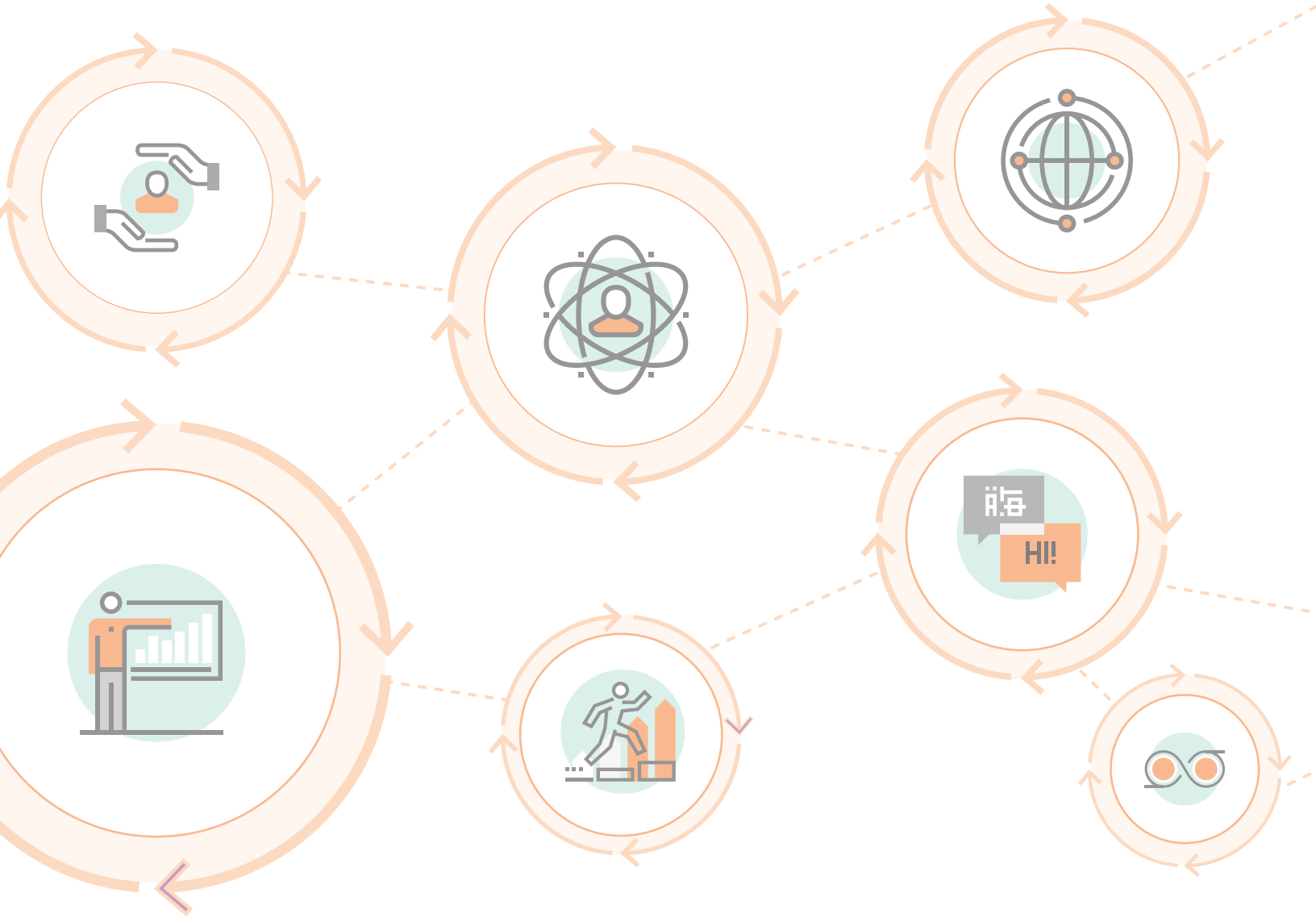
8 C DOMAIN	CONSIDERATIONS	NOTES
5. CULTURE, LANGUAGE, AND CONTEXTUALIZATION Acknowledges cultural values, norms, beliefs, and preferences of a specific location or population, through tools, assessments, and strategies for cultural adaptation and translation, taking into account multiculturalism and intersectionality. Considers myriad practice environmental factors that may affect a mental health intervention, such as health care system structure, and legal frameworks that determine important elements such as mandatory reporting laws, licensure requirements, and malpractice regulations.	▪ Are the MHPSS interventions and materials used appropriately adapted, translated, and contextualized to a specific culture or setting. If not, how can this be done? ▪ Has the MHPSS intervention and/or assessment been validated for a specific context, setting, and/or beneficiary population? ▪ What are the legal frameworks governing the intended setting, and are all stakeholders aware of key legal issues that may affect the MHPSS program? ▪ What measures are in place to prevent or mitigate mental health stigma and how do these reflect understandings of mental health and mental health conditions locally?	Discussion Points, Concerns: Discussion Points, Concerns:
6. COMPETENCY-BASED TRAINING AND SUPERVISION *Training*: Participants acquire, remediate, and sustain minimum competencies regarding mental health interventions and demonstrate skills and knowledge to deliver such interventions. *Supervision*: Trained leaders are positioned to supportively supervise implementers, ensuring interventions are carried out in an effective and safe way; provide systematic, structured, quality feedback.	▪ What competencies are relevant for the selected MHPSS program, and how might they be measured? ▪ Are the MHPSS implementers aware of and equipped with the tools to ensure minimum standards for safe and effective strategies? ▪ How will supportive supervision be implemented?	Discussion Points, Concerns: Discussion Points, Concerns:

8 C DOMAIN	CONSIDERATIONS	NOTES
7. CARE FOR STAFF Care for the well-being, mental, and physical health of those who are providing care or implementing the intervention is considered. This includes considerations for ethical, economic, and occupational components of their work, and provision of supportive supervision and adequate resources to complete their duties.	▪ Do staff have the necessary resources to safely deliver service? If not, why not? What can be optimized? ▪ Has fair compensation been considered? ▪ Is there a mechanism whereby MHPSS program staff can offer feedback on the conditions of their work or other needs that affect their safety, health, or well-being? ▪ Is support available to promote well-being and avoid burnout? ▪ Is there access to a higher level of mental health care for those who require it?	Discussion Points, Concerns: Discussion Points, Concerns:
8. CHANGE-BASED MEASUREMENT Measurements tailored to assess the implementation and its change, such as the expected impact of a program, and assessment of potential harms and benefits. A change-based measurement for MHPSS programs should ideally focus on what matters most to the community.	▪ How are the potential harms and benefits of programs being ethically measured? ▪ Are the mechanisms of change/fidelity/competency measured? If so, how? If not, how could this information be collected? ▪ Is the implementation of the MHPSS program measured against minimum standards/criteria?	Discussion Points, Concerns: Discussion Points, Concerns:

CLOSING

With the information presented in this guidance document and the supplementary materials, you are ready to engage in a dialogue about MHPSS programming and service integration. Regardless of your background or previous experience with MHPSS work, you are now equipped with the rationale for why MHPSS integration is so important to achieve progress in other health areas, the essential foundational documents developed by the experts in global mental health, and a framework to ask the right questions and guide a dialogue with your collaborators to plan, implement, or improve MHPSS programming in any setting, for any beneficiary population.

The 8Cs Model represents one step forward in making MHPSS programming less overwhelming and therefore more accessible — conceptually and operationally — for people around the world who want and need this type of technical support. There are, of course, many more steps to take to achieve our goals of health, but because there is no health without mental health, we must consider how an MHPSS lens can enrich our work. We hope the 8Cs Model makes that path clearer and easier to walk as we work toward these goals together.



GLOSSARY

NAME	DESCRIPTION
Acute psychiatric or mental illness	Mental health condition, or an exacerbation of an existing condition, that has a sudden onset of acute symptoms and is usually short in duration. When a patient requires acute mental health care, they have high levels of need and are often in crisis, and thus anxious and vulnerable.
Anxiety	Apprehensiveness or anticipation of future danger or misfortune accompanied by a feeling of worry, distress, or somatic symptoms of tension. The focus of anticipated danger may be internal or external.[A]
Burnout	Feelings of energy depletion or exhaustion; increased mental distance, or feelings of negativism or cynicism related to one's job; and reduced professional efficacy.[A]
Cognitive behavioral therapy	Type of mental health treatment that combines cognitive and behavioral therapies.
Depressive disorder	Characterized by depressive mood (e.g., sad, irritable, empty) or loss of pleasure accompanied by other cognitive, behavioral, or neurovegetative symptoms that significantly affect the individual's ability to function. A depressive disorder should not be diagnosed in individuals who have ever experienced a manic, mixed, or hypomanic episode, which would indicate the presence of a bipolar disorder.[A]
Fatigue	A feeling of exhaustion, lethargy, or decreased energy, usually experienced as a weakening or depletion of one's physical or mental resources and characterized by a decreased capacity for work and reduced efficiency in responding to stimuli. Fatigue is normal following a period of mental or physical exertion but sometimes may occur in the absence of such exertion as a symptom of health conditions.
Functional impairment	Limitations due to the illness; usually referenced when individuals who have a certain disease may not carry out certain functions in their daily lives, referred to as "disability" by WHO.[B]
General psychological distress	Refers to non-specific symptoms of stress, anxiety, and depression.[C]
Inpatient health care	Usually refers to care rendered in a hospital or other facility to patients who require admission to manage their symptoms. Inpatient care can be short or extended, depending on the patient's need and the availability of mental health resources in the community (outside of the facility).
Post-traumatic stress disorder (PTSD)	It may develop following exposure to an extremely threatening or horrific event or series of events. It is characterized by the following: re-experiencing the traumatic event or events in the present in the form of vivid intrusive memories, flashbacks, or nightmares.[A]
Primary health care	Whole-of-society approach that aims to improve national health systems to bring health and well-being services to the communities.[D]
Psychosis	A mental health condition that is characterized by loss of contact with reality through delusions, hallucinations, incoherent speech, exhibiting inappropriate behavior, and other symptoms.[E] Psychosis can be caused by organic or psychiatric pathologies.
Quality of life	Individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards, and concerns.[F]

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C Viertiö S, Kiviruusu O, Piirtola M, Kaprio J, Korhonen T, Marttunen M, et al. Factors contributing to psychological distress in the working population, with a special reference to gender difference. BMC Public Health. 2021; 21: 611.

D World Health Organization (WHO). Primary health care. n.d. [Accessed 2022 Dec 28]. Available from: **https://www.who.int/health-topics/primary-health-care#tab=tab_1.**

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GLOSSARY

NAME	DESCRIPTION
Resilience	Ability of individuals, communities, and states and their institutions to absorb and recover from shocks while positively adapting and transforming their structures and means for living in the face of long-term changes and uncertainty (OECD).[G]
Self-care	Way of caring for oneself by being aware, in self-control, and self-reliant to achieve, maintain, or promote well-being.[H]
Social support/social networks	Social resources perceived by an individual.[I]
Specialized health care	A type of health and well-being services that require additional training in a specific medical field.
Supportive supervision	Intervention that aims to strengthen the health care system and improve the quality of services provided by the staff.
Trauma-informed care	Practices that promote a culture of safety, empowerment, and healing.
Well-being	A state of happiness and contentment, with low levels of distress, overall good physical and mental health and outlook, or good quality of life.[J]

G Organisation for Economic Co-operation and Development (OECD). Risk and resilience. [Cited 10 Jan 2023]. Available from: **https://www.oecd.org/dac/conflict-fragility-resilience/risk-resilience/**

H Martínez N, Connelly CD, Pérez A, Calero P. Self-care: A concept analysis. Int J Nurs Sci. 2021 Sep 5; 8(4): 418-425. doi: 10.1016/j.ijnss.2021.08.007.

I Zhou ES. Social Support. In: Michalos AC (eds) Encyclopedia of Quality of Life and Well-Being Research. Berlin: Springer, Dordrecht; 2014. Available from: **https://doi.org/10.1007/978-94-007-0753-5_2789.**

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KEY RESOURCES

The following table is a consolidation of the key resources referenced throughout the guidance document. You will notice that several resources are repeated in multiple domains. These resources are foundational resources that are applicable across multiple domains. All users of the 8Cs Model should be comfortable with the Foundational Resources and how they can be applied in nearly any MHPSS intervention or program.

RESOURCE	DESCRIPTION
DOMAIN 1. COMMUNITY INFORMED	
IASC: The 4Ws in Mental Health and Psychosocial Support Programming: Manual with Activity Codes	The 4Ws (Who is Where, When, doing What) can assist in mapping the MHPSS activities in humanitarian settings across sectors.
The IASC Common Monitoring and Evaluation Framework for MHPSS in Emergency Settings	Guidance on MHPSS program design, assessment, monitoring and evaluation, and research. This resource is applicable across multiple domains of the 8Cs Model.
Community Needs Assessment Participant Workbook	Information on how to conduct community-based needs assessment
Community-Led Monitoring Technical Guide	Information on community-led indicators
DOMAIN 2. COMPLEMENTARY	
The IASC Common Monitoring and Evaluation Framework for MHPSS in Emergency Settings	Guidance on MHPSS program design, assessment, monitoring and evaluation, and research. This resource is applicable across multiple domains of the 8Cs Model.
Gender-Based Violence Resources: Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action Health care for women subjected to intimate partner violence or sexual violence: A clinical handbook How to support a survivor of gender-based violence when there is no GBV actor in your area	Guidelines, tools, pocket guide, and additional resources for working with gender-based violence in humanitarian settings

RESOURCE	DESCRIPTION
DOMAIN 3. CONTINUUM OF MHPSS NEEDS	
IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings	The IASC Guidelines serve as a foundational resource applicable across multiple domains of the 8Cs Model.
MHPSS Minimum Service Package (MSP)	The MSP builds on existing MHPSS standards and tools to create a single, easy-to-follow intersectoral package. It is applicable across multiple domains of the 8Cs Model.
LIVE LIFE: An implementation guide for suicide prevention in countries	The guide is for all countries, with or without a national suicide prevention strategy; national or local focal points for suicide prevention, mental health, alcohol, or NCDs; and community stakeholders with a vested interest or who may already be engaged in implementing suicide prevention activities.
MhGAP Community Toolkit	The toolkit provides guidance for program managers on how to identify local mental health needs and tailor community services to match these needs. It offers practical information and necessary tools for community providers to promote mental health, prevent mental health conditions, and expand access to mental health services.
Improving Health Systems and Services for Mental Health	WHO guidance introducing the essential ingredients for strengthening mental health systems within a context of overall health system development
Mental Health Policy, Plans and Programmes	WHO module providing detailed information about the process of developing policy and implementing it through strategic plans and programs
WHO 2022 World Mental Health Report	Drawing on the latest evidence available, this report showcases examples of good practice from around the world, and voicing people's lived experience, it highlights why and where change is most needed and how it can best be achieved. This resource is applicable across multiple domains of the 8Cs Model.
Suicide Decriminalization Report	Global report from United for Global Mental Health on the state of suicide as a criminal offense and points of advocacy to influence policy, improve access to care, and reduce risk of morbidity, mortality, and stigma
Suicide Risk Assessment Guide SAFE-T (Suicide Assessment Five Step Evaluation and Triage) for Clinicians	These suicide risk assessment resources were developed to assist clinicians in all areas but especially in primary care and the emergency room/triage area to make an assessment and care decisions regarding patients who present with suicidal ideation or provide reason to believe that there is cause for concern.
HHS Roadmap for Behavioral Health Integration	Roadmap from the United States Department of Health and Human Services for integration of behavioral health services to meet the demand for mental health care in the U.S.

RESOURCE	DESCRIPTION
DOMAIN 4. CONSISTENT WITH EVIDENCE BASE	
FHI 360 MHPSS Resource Navigator	This interactive resource uses filters to guide users through an extensive catalog of evidence-based MHPSS assessments and interventions. This resource is applicable across multiple domains of the 8Cs Model.
Development of the mental health cultural adaptation and contextualization for implementation (mhCACI) procedure: a systematic framework to prepare evidence-based psychological interventions for scaling	This resource is applicable across multiple Domains in the 8Cs Model. It provides an evidence-based approach to cultural adaption and contextualization to implement mental health interventions. This article explains a 10-step process used in Nepal to adapt a mental health intervention called Group Problem Management Plus (PM+) using a systematic framework.
What science has shown can help young people with anxiety and depression	This resource can guide readers to learn more about the state of the science in relation to what works in preventing or treating youth anxiety and depression across a range of topics and disciplines.
DOMAIN 5. CULTURE, LANGUAGE, AND CONTEXTUALIZATION	
Development of the mental health cultural adaptation and contextualization for implementation (mhCACI) procedure: a systematic framework to prepare evidence-based psychological interventions for scaling	This resource is applicable across multiple domains in the 8Cs Model. It provides an evidence-based approach to cultural adaption and contextualization to implement mental health interventions. This article explains a 10-step process used in Nepal to adapt a mental health intervention called Group Problem Management Plus (PM+) using a systematic framework.
The Lancet Commission on ending stigma and discrimination in mental health	This Lancet Commission report brings together evidence and experiences of the impact of stigma and discrimination and successful interventions for stigma reduction.
UNICEF Measurement of Mental Health Among Adolescents at the Population Level	There is a gap in validated tools and prevalence data for measurement of adolescent mental health conditions at the population level. UNICEF, with the support of experts, is leading an effort to develop a data collection tool to capture information on adolescents' mental health at a population level in LMICs. This resource is applicable across multiple domains in the 8Cs.
Reducing the stigma of mental health disorders with a focus on low- and middle-income countries	This paper explores various aspects of stigma toward mental health with a focus on LMICs and assesses measures to increase help-seeking and access to and uptake of mental health services.

RESOURCE	DESCRIPTION
DOMAIN 5. CULTURE, LANGUAGE, AND CONTEXTUALIZATION	
Child Sexual Abuse Material: Model Legislation and Global Review	This groundbreaking report, often referred to as ICMEC's Rule of Law project, analyzes child sexual abuse material (CSAM) legislation in 196 countries around the world, and offers a "menu" of concepts to be considered when drafting anti-CSAM legislation.
A Global Response to Elder Abuse and Neglect: Building Primary Health Care Capacity to Deal with the Problem Worldwide: Main Report	WHO, with partners from all continents, conducted this study in order to develop a strategy to prevent elder abuse within the primary health care context.
DOMAIN 6. COMPETENCY-BASED TRAINING AND SUPERVISION	
WHO 2022 World Mental Health Report	Drawing on the latest evidence available, this report showcases examples of good practice from around the world, and voicing people's lived experience, it highlights why and where change is most needed and how it can best be achieved. This resource is applicable across multiple domains of the 8Cs Model.
Ensuring Quality in Psychological Support (EQUIP) Ensuring Quality in Psychological Support (WHO EQUIP): developing a competent global workforce	A platform that provides users with essential assessment tools can help remediate, achieve, and sustain minimum competency, and inform trainers and supervisors about their trainees' progress and areas for improvement. Competency-based training and supportive supervision is inherently part of caring for staff and should be applied to Domain 7: Care for Staff as well.
DOMAIN 7. CARE FOR STAFF	
The Mental Health and Psychosocial Support Minimum Services Package (MHPSS MSP)	The MSP builds on existing MHPSS standards and tools to create a single, easy-to-follow intersectoral package. It is applicable across multiple domains of the 8Cs Model.
WHO Guidelines on Mental Health at Work WHO Policy Brief on Mental Health at Work	The WHO guidelines on mental health at work provide evidence-based recommendations to promote mental health, prevent mental health conditions, and enable people living with mental health conditions to participate and thrive in work.
Health Care Worker Resilience: A toolkit to protect against burnout on the front lines	One of many resources from The Resilience Collaborative, this provides a comprehensive framework for evidence-based strategies that can be adapted for local settings.
International Minimum Requirements for Health Protection in the Workplace	Global, regional, and national norms for health protection in the workplace

RESOURCE	DESCRIPTION
DOMAIN 7. CARE FOR STAFF	
Global Wage Report 2020–21: Wages and minimum wages in the time of COVID-19	Reviews compensation patterns and points for advocacy across different countries
The SAFE (Supporting Adolescents and their Families in Emergencies) Resource Package	Supporting Adolescents and their Families in Emergencies (SAFE) is a protection and psychosocial support program model to strengthen the capacity of front-line actors — including caregivers — so that adolescent girls and boys (ages 10-19) are safer, more supported, and equipped with positive coping strategies in acute emergencies.
WHO calls for healthy, safe and decent working conditions for all health workers, amidst COVID-19 pandemic An intervention package for supporting the mental well-being of community health workers in low- and middle-income countries during the COVID-19 pandemic Service user and caregiver involvement in mental health system strengthening in low- and middle-income countries: Systematic review	Additional publications supporting the evidence base and call to action to protect and promote the mental health and well-being of service providers and those providing care to beneficiaries
DOMAIN 8. CHANGE-BASED MEASUREMENT	
IASC Common Monitoring and Evaluation Framework for MHPSS Programmes IASC Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings: With means of verification (Version 2.0) IASC MHPSS M&E Framework MOV Toolkit	This guide lists indicators that could help identify potential harms, proposing a framework of six key areas to conduct ethical mental health and psychosocial research in emergencies. This resource is applicable across multiple domains of the 8Cs Model.
Monitoring, Evaluation, Quality Improvement, and Targeted Research to Support Site Goals	Elements of monitoring, evaluation, quality improvement, and research cut across every phase of the implementation matrix and value chain. This resource from Partners in Health offers guidance and useful insights for data collection for mental health programming and how to use this data to improve program processes.
RE-AIM Framework	The RE-AIM Framework was developed to measure the success of translation or dissemination of interventions from the original effectiveness research to wide-scale intervention in multiple intervention cycles and/or at multiple locations.

RESOURCE	DESCRIPTION
DOMAIN 8. CHANGE-BASED MEASUREMENT	
Mechanisms of change for interventions aimed at improving the wellbeing, mental health and resilience of children and adolescents affected by war and armed conflict: a systematic review of reviews	This review aimed to identify mechanisms of change in successful psychosocial interventions in order to inform existing interventions and highlight research gaps.
Implementation Science Methodologies and Frameworks	This resource from the Fogarty International Center describes tools to frame research using validated implementation science methodologies and frameworks, and engage communities, policymakers, and program-implementers in identifying locally relevant research questions that are responsive to local health priorities.

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ANNEX I: To screen or not to screen?

This section offers an expanded discussion of the advantages, potential pitfalls, and points of consideration regarding the use of screening tools in MHPSS programming. This particular issue – and therefore this section – will continue to evolve as global mental health programming advances. Therefore, this section should be considered a "living discussion," and will be continuously revisited and updated as new evidence and real-world experience becomes available.

SCREENING TO IDENTIFY RISK OF IMMINENT HARM

In the case of imminent risk for harm to self or others — including suicidality, homicidality, intimate partner violence, and substance use emergencies — screening can be conducted **even if conditions such as validation or local adaption of assessments have not occurred.** However, there still must be somewhere to refer individuals who are at imminent risk of harm, especially suicidal harm. The mhGAP-IG suicide module can be used to train providers to recognize cases of suicidality. But first, the **WHO Live Life guidance** should be used to gain a systems perspective that will facilitate an effective intervention for patients who are at risk for harm.

Screening for mental health conditions is a common way to identify individuals accessing health or care services who may be experiencing a mental health condition. Screening tools can often quickly identify emergencies, for example, when an individual may be at imminent risk of hurting themselves or someone else. Screening tools can also be completed repeatedly to monitor for improvement or deterioration of a patient with a known mental health condition. An "assessment tool" may also be referred to as a "screening tool," and typically refers to a standardized set of questions that an individual can answer either on their own (self-administered) or with the help of someone who has been trained to administer the screening.

However, screening is not always recommended. It has important limitations and potential disadvantages. Thus, is it important to thoughtfully consider whether to screen for mental health conditions, when to screen, and what type of screening tool to use. Normative bodies such as the World Health Organization do not have a recommendation on screening members of the general population for mental health disorders. Each implementation team should determine whether screening is the right choice, for whom it is the best approach, and who is interpreting the results and for which type of therapeutic goal or intervention.

Considerations and tips for using mental health screening tools

Screening can be an excellent tool for getting the right patients to the right care in a manner that is relatively quick and low-cost. This is only possible when those using the screening tools understand how to identify the right version of the right tool, how to effectively use these tools as one part of making a diagnosis, and how to interpret the scores.

Understanding the difference between a mental health condition, symptoms of a physical illness, and a period of short-term distress or unhappiness requires looking beyond screening results and having a conversation with the client.

- **Screening tools are not diagnostic tools.** They alert a provider to spend time assessing the client further, but they do not provide definitive proof of a mental health condition. This is important because screening tools may seem like an appropriate way to initiate referrals from a lower level provider to someone with more experience, but in fact, they are just the start of a conversation. Many conditions and life experiences can lead a patient to complete a screening tool in a way that would create a falsely high score (e.g., recent physical illness, acute grief, low literacy). Referring a person to services that they do not need can burden the client and may cause them to believe that they have a mental health condition when they are going through a normal emotional experience, such as grief, and this can also overburden the health system. This does not mean that illness, acute grief, and other experiences cannot lead to or coexist with mental health conditions. Understanding the specifics of a client's experience is needed to use the nuance required to assess whether the results of a screener indicate a mental health condition that requires professional support, or whether they indicate the ordinary ups and downs of life. To avoid misusing screening tools as diagnostic tools, providers must receive competency-based training and clear protocols and pathways for referral to specialists.
    - *Example: The PHQ-9 is a common screening tool for depression. It asks about a patient's experiences over the past two weeks. A provider is preparing to meet a new patient, and the nurse informs her that the patient's PHQ-9 was high with a score of 18. The provider enters the exam room, and upon their initial discussion, the provider learns that the patient is recovering from the flu, and indeed, over the past two weeks, felt generally down, slept too much, did not eat enough, had trouble focusing, and felt lethargic almost every day. She is feeling much better now. The patient is not depressed — she is just recovering from a nasty illness!*

- **Whenever possible, use a validated tool.** Using a screening tool effectively requires that this tool is adapted for the local setting. Therefore, a screening tool should not be introduced until it has been validated or appropriately adapted using a reliable methodology.

To find a validated tool for your context:

- Confirm with your team and key stakeholders what you intend to screen for, and for what purpose.
- Find out which screening tools are in use in your current work setting. What do they screen for, how were they selected, and how are they used? If there are not any, why not?
- If this process does not uncover a validated tool that can assess the condition you would like to assess, use the MHPSS Resource Navigator or conduct a brief literature search. See Ali et al. (2016) for a systematic review of studies that have validated screening tools used to assess common mental health disorders in LMICs.[1]
- If you learn that there is a validated tool, always check that the version in the language you need has also been validated. There may be multiple language options for a screening tool, but they may not all be validated. This can be done by contacting the study author if the information is not available on the source website.

When a validated version of the tool you would like to use is not available, consider the following **optional** alternatives:

- Use a different tool that has been validated locally to screen for the same condition. For example, your program would like to use the PHQ-9 to screen clients in a local primary care clinic for depression, but it has not been validated in the local language. Check whether other tools that screen for depression, such as the Kessler 6, have been validated in your setting or language. *Using an alternative tool that is validated in your context is always preferrable to using a tool that has not been validated.*
- If no alternative tools are available, consider doing a rapid cultural adaptation process so that the tool is comprehensible and acceptable in the cultural context.
  - See Figure 1 for the 10-step mental health cultural adaptation and contextualization for implementation (mhCACI) adaptation process, and for additional guidance on this process, see examples such as van Ommeren et al. (1999)[2] and Kohrt and Kaiser (2021)[3].

While using locally validated tools is ideal, alternatives that are costly or unduly time consuming should not be utilized to the detriment of program implementation. These alternatives should be considered as options only, and not required.

- If resources and time are available, a validation study can be completed after a cultural adaptation process.
  - For examples, see Kohrt (2016)[4] and Carvajal (2023)[5]. Consider partnering with a researcher or local professional or academic associations for this process if you choose to pursue it.
- If no validated tools are available and there are no resources to pursue a rapid cultural adaption process or validation study, consider the following:
  - Reassess your intentions for screening or your approach or timeline to the project. For example, if there are no tools that have been validated to screen for depression in your beneficiary population, but there are tools to screen for somatization or distress, consider shifting your screening strategy provided there is a qualified clinician to professionally assess clients who screen positive.
  - If no validated alternatives exist and your screening strategy cannot shift, you may consider an alternative tool that has been validated in a similar population, or a translated but unvalidated tool, but proceed with caution when interpreting the results. Until a tool has been locally validated, any cut-off scores established in other languages or for other settings should be used with caution (e.g., a cut-off of 10 or more on the PHQ-9 may be too high or too low in another setting to accurately identify who needs services). As stated above, there are many alternatives to this situation.

FIGURE 1. The 10 steps of the mental health cultural adaptation and contextualization for implementation (mhCACI) procedure

"Because of the high burden of untreated mental illness in humanitarian settings and low- and middle-income countries, scaling up effective psychological interventions requires a cultural adaptation process that is feasible and acceptable. The mhCACI is a 10-step adaptation process that incorporates changes into both content and implementation strategies, with a focus on local understandings of distress and treatment mechanisms of action".

1. Identify mechanisms of action
2. Conduct a literature desk review for the culture and context
3. Conduct a training of trainers
4. Translate intervention materials
5. Conduct an expert read-through of the materials
6. Conduct a qualitative assessment of intervention population and site
7. Conduct practice rounds
8. Conduct an adaptation workshop with experts and implementers
9. Pilot test the training, supervision, and implementation
10. Review through process evaluation=

Sangraula M, Kohrt BA, Ghimire R, Shrestha P, Luitel NP, Van't Hof E, et al. Development of the mental health cultural adaptation and contextualization for implementation (mhCACI) procedure: a systematic framework to prepare evidence-based psychological interventions for scaling. Glob Ment Health (Camb). 2021 Feb 19;8:e6. doi: 10.1017/gmh.2021.5. PMID: 33996110; PMCID: PMC8082944.

- **No tool is 100% sensitive or specific.** Tools that screen for common mental health conditions like anxiety or depression may generate a large percentage of false positives (up to 25–30%). This can be true even when using culturally adapted versions. As described above, these false positives can be multifactorial and should not immediately result in a diagnosis without further discussion with the individual. Screening tools can also result in false negatives. If an individual has reported no signs or symptoms of the condition being screened for but demonstrates visible signs of the condition and/or reports concerning clues while in consultation with the health care provider, a provider may opt to repeat the screening tool with the patient or at least ask the patient about the discrepancy.
- **When possible, rule out organic causes of reported symptoms.** When a trained provider is considering a differential diagnosis of a mental health disorder for any patient, it is important to remember that most guidelines recommend ruling out "organic" or physiologic causes of the signs or symptoms that support the tentative diagnosis. For example, other conditions that mimic signs or symptoms of depression include anemia, hypothyroidism or other endocrine disorders, sleep apnea, and medication side effects. If able, the clinician should consider other possible differential diagnoses to the best of their ability to safely manage the condition of the patient.
- **Consider the possibility that everyone may screen "positive" — then what?** In some settings, especially in humanitarian settings or with marginalized groups, the majority of people completing a screening tool for common mental health conditions like depression or anxiety may screen positive. In these settings, screening tools may not help to identify those with the most need. They may identify mental health emergencies, but they may also create unintended consequences if there are not enough resources to effectively assess and manage every person that screens positive.
- **Sometimes doing nothing is preferable to causing harm.** When there is no one available who can assess and/or manage an individual with a positive screening tool, either on-site or within a reasonable period for referral, the individual does not benefit from screening. Therefore, screening should only be done in settings where there is competent care available and/or a referral network in place for the specific condition being identified. For example, if the only mental health services available require in-patient treatment at a psychiatric hospital, it is not appropriate for primary care facilities to screen for depression when the primary care facility does not have staff trained to assess and manage the depression.
- **Use caution when screening for trauma.** It is important to note that screening for symptoms of trauma, or post-traumatic stress syndromes (e.g., difficulty sleeping, easily startled, avoidance of certain places and people) is typically more acceptable than screening with a battery of different traumatic exposures (e.g., Have you been sexually assaulted? Were you sexually, physically, or emotionally abused as a child? Have you witnessed someone being killed?). It is not recommended to routinely use trauma exposure checklists unless this is in the context of clinical mental health services with someone specifically trained to administer these tools and provide the needed trauma-informed care. Because of the comorbidity of depression and anxiety with post-traumatic stress disorder (PTSD) symptoms, it is often sufficient to use

depression and anxiety screeners in primary care, then complete a trauma inventory later once someone is in care with a mental health professional trained in trauma survivor support and care. Some programs, such as GBV programming, that take place outside of clinical mental health services can appropriately use trauma exposure checklists, as they are used to provide targeted and relevant services to those experiencing specific traumatic exposures.

ANNEX II: Case Study A: Integrating MHPSS in HIV programs for key populations most affected by HIV

As the 8Cs Model approach is agnostic in relation to population served and type of program in which MHPSS is integrated, annexes on specific use cases are included to describe unique circumstances, needs, and opportunities specific to different types of programs. These annexes include practical examples of the application of the 8Cs for specific populations and programs. This annex focuses on the integration of MHPSS in HIV programs serving key populations most affected by HIV — gay, bisexual, and other men who have sex with men, people who inject drugs, sex workers, and transgender people.

Specific Considerations

There is a Strong Relationship Between HIV and Mental Health Conditions

There is a strong and bidirectional relationship between HIV and mental health conditions. People living with HIV (PLHIV) have a greater burden of mental health conditions such as anxiety, depression, PTSD, and psychotic illness.[6,7] A systemic review and meta-analysis found that PLHIV have a 100-fold increase in suicide death rate compared to the general population.[8,9] In sub-Saharan Africa, 24% of PLHIV were experiencing depression, compared to about 3% of the general population, in 2018 (both rates have increased during COVID-19).[10,11] Medications used to treat HIV can also lead to increased rates of mania, psychosis, and changes in mood.[12,13] Poor mental health is also a risk factor for acquiring HIV.[14] It is associated with reductions in the likelihood of testing, initiating ART, continuing in treatment, and achieving viral suppression.[15,16,17,18,19,20] Finally, mental health conditions are associated with increased mortality among PLHIV.[21,22]

Members of Key Populations have a Disproportionate Burden of Mental Health Conditions

Key populations disproportionately affected by HIV, regardless of HIV status, also bear a disproportionate burden of mental health challenges. For example, lesbian, gay, bisexual, transgender, queer, and intersex adolescents and young people and those of other diverse sexual orientations and gender identities (LGBTQI+) experience higher rates of mental health conditions

than their non-LGBTQI+ peers and are at a disproportionately higher risk of suicide.[23] In a meta-analysis on the mental health of female sex workers in low- and middle-income countries, rates of common mental health conditions were: depression 41.8%, anxiety 21.0%, PTSD 19.7%, psychological distress 40.8%, recent suicide ideation 22.8%, and recent suicide attempt 6.3%.[24] Among people who inject drugs, a systematic analysis found the pooled estimate for current severe depressive symptomology was 42.0%, and for a depression diagnosis was 28.7%. Across the sample, the pooled estimate for suicide attempts was 22.1%[25]

Considerations for Mental Health Integration in HIV Programs Serving Key Populations Individuals

While experiences of stigma, discrimination, and violence are drivers of poor mental health outcomes among many populations, these factors are particularly relevant for key populations (KP) individuals. Members of key populations face higher rates of stigma and discrimination than the general population and experience a disproportionate burden of harassment, violence, and marginalization. These experiences also limit access to mental health care, including when KP members anticipate or experience stigma, which may come from mental health providers themselves.[26] One of the most egregious examples of stigmatizing behavior by mental health providers is the dangerous and harmful practice of conversion therapy — an attempt to change a person's sexual orientation, gender identity, or gender expression.[27] Thus, when mental health providers are engaged, it is important to assess their understanding and ability to serve KP members and to train the providers, as needed, to meet common mental health needs among KP members. These include depression, anxiety, PTSD, and other impacts of trauma, substance use disorders, and issues related to self-stigmatization.

Another way to avoid anticipated stigmatization and to help overcome stigma around seeking mental health support is to collaborate with peers (individuals who are also key population members) to offer psychosocial support. Peers can meet basic mental health needs by providing services such as psychological first aid and help to normalize seeking more intensive mental health care. However, while this is an important approach, peers should not be asked to take on the task of supporting others' mental health without being offered services or resources to meet their own mental health needs and the ongoing support of supervisors to help navigate (or even take over) difficult cases and mitigate burnout or the effects of vicarious trauma (see **Domain 7**).

As with any service for key populations, it is important that KP members are engaged in each phase of designing, implementing, and evaluating integrated MHPSS activities. This will ensure a stronger program design and help preemptively or quickly identify unintended consequences that may cause harm. Ongoing processes such as community-led monitoring can also call attention to the need for access to MHPSS activities and help to ensure that these activities, once implemented, are meeting the perceived needs of key population members, particularly those with lived experience of mental health conditions.

CASE STUDY: Applying the 8Cs to an HIV program for key populations

Background

Each application of the 8Cs is an opportunity to learn how the process works in the real world. This anonymized case study describes the use of the 8Cs process in an HIV program serving key populations in sub-Saharan Africa.

The country-based project team for an HIV program serving KP members and KP members living with HIV wanted to address mental health issues faced by their clients by beginning to screen the clients for mental health disorders in a systematic way.[28] In this program, peer-led HIV services are delivered via outreach mobile clinics, KP-led drop-in centers and public clinics. Services available include HIV prevention (education, condoms and lubricants, pre-exposure prophylaxis [PrEP], gender-based violence [GBV] screening, and referral to post-GBV care), HIV and STI testing, treatment, and viral load monitoring.

WORKING WITH A TECHNICAL ADVISOR TO APPLY THE 8CS MODEL OF COLLABORATIVE CONSULTATION

Initial goal: The country-based project team wanted to address mental health issues faced by their clients. Their initial plan was to screen all clients for mental health disorders in a systematic way so that there would be actionable and useful information that allowed KP individuals in need of MPHSS services to be identified. This would be accompanied by a protocol that clearly described which MPHSS services should be offered and where based on the KP individuals' unique needs. Health care providers, psychosocial support officers (PSOs), and possibly peer outreach workers from the project would be trained on the protocols, tools, and the service package so that they could correctly identify those who need MPHSS care and either provide psychosocial support on site or refer for more intense mental health needs.

However, the team wanted to take this step carefully and consider whether other integration options might also be available to them. They decided to collaborate with a technical advisor to complete the 8Cs process to determine which mental health services should be introduced, how, by whom, and to which clients. The technical advisor reviewed each domain with the country team, asking probing questions to facilitate a dialogue. Below are the questions and responses from the consultation process.

DOMAIN 1. COMMUNITY INFORMED

- **Who are the stakeholders calling for more MHPSS support? Are there MHPSS champions locally?**

  The project team and the civil society organization (CSO) partner note clients' unmet need for mental health care. The need is also expressed by the KP peer networks; they are calling upon service providers to offer this care in a systematic and extensive way.

There is some general interest from the donor, PEPFAR, but this is not specific to the country, and no funding has been made available to address this issue.

- **Are there existing assessments/research about local mental health needs?**

  There is no national mental health strategy, and there are limited data on the mental health burden in the country. The National AIDS Control Programme (NACP) has included some mental health questions in their risk screening for PLHIIV (to determine whether someone is more likely to discontinue treatment), but these questions are not from an evaluated screening tool, and they are not routinely reported by the NACP. Otherwise, the project is not collecting mental health data, and this is not required by the donor, nor recommended by NACP/MOH.

DOMAIN 2. CONTINUUM OF MHPSS NEEDS

- **How well do the mental health services already available (inside the project or via referral) cover the full pyramid of recommended MHPSS services? That is, are there services for those who need less intensive interventions all the way up to those who need emergency services and more specialized care?**

  KP members with a probable mental health condition according to the results of the risk assessment are sent to a PSO as part of the project-supported services. The PSO provides psychosocial support but not in a standardized way and not based on a specific mental health condition (e.g., there is no diagnosis and no specific protocol for major depressive disorder). The PSO can refer a client to specialized services in the government system if they feel this is appropriate, but there is no clear guidance that they follow on when to refer. There are psychiatric units in the national hospital as well as in lower level hospitals where referrals can be made. In case of mental health emergency, KP individuals are referred through a peer navigator to the psychiatric units in the national hospital, as well as in lower level hospitals.

  However, there is not clarity on whether the psychiatric units are offering KP-competent services. There is conflicting information on what relevant services and medications are provided free of charge or out of pocket. There is no specific widely known protocol for how to deal with emergencies such as suicidality. For example, there is no national suicide hotline.

- **From what you have described, all MHPSS services are available at either the least specialized level of care (ART nurse, peer navigator, PSOs) or the most specialized (hospital-based psychiatric care). Is the goal to enhance one of these levels of care or fill in the gaps in the pyramid, for example, by engaging primary care providers (e.g., general practitioners) in MHPSS?**

  There is no goal to build capacity among specialized services within the current scope and resources of the project. We are also not able to build the skills of primary care providers who

are outside of the project. We can build the skills of PSOs, peer navigators, ART nurses, and others within the project.

DOMAIN 3. COMPLEMENTARY

- **How does the project become aware of mental health struggles among clients?**

  There is a national risk assessment for those initiating and on ART. It includes questions about mental health, though these questions are not from a known screening tool. The assessment is offered by ART nurses and peer navigators responsible for a client's ART adherence. The risk assessment is conducted at ART initiation and at every follow-up visit, about every three months.

  In addition, if someone experiences violence, the project provides them with psychological first aid and makes mental health services available to them if they opt for such services.

- **It sounds like the PSOs do most of the psychosocial support. Do PSOs have time available to see more clients?**

  The PSOs are engaged by the project on a part-time basis, and they independently decide how long a client should continue receiving psychosocial support. It is assumed that such a decision is based on the client's needs, but there is no protocol to guide such a decision, neither a system to monitor nor to verify the process. Typically, a client receives two to five one-on-one sessions with the PSO. This ceiling was set to allow the PSO to continue to serve new clients. As there are no mental health targets, generally this service must leverage other funding; hence, staffing for psychosocial/mental health support is typically allocated a small budget.

DOMAIN 4. CONSISTENT WITH THE EVIDENCE BASE

- **Are any specific evidence-based interventions in place?**

  The project trained the PSOs on the WHO training named LIVES (Listen, Inquire, Validate, Enhance Safety, and Support) to support survivors of GBV; and the PSOs have backgrounds in psychosocial support/education. However, the project is not currently using an MPHSS package in terms of training curricula, guides, and tools.

- **What evidence-based interventions are tailored for the KP individuals with whom you work?**

  Nothing has been adapted locally to our knowledge. Given the limited resources of the project, we could strengthen the PSOs' capacity by training them on a validated screening tool (e.g., K6-10 or PHQ-9) to identify KP individuals with mental health conditions. We could also introduce the Problem Management Plus (PM+) manual to offer a low-intensity psychological intervention to KP individuals with stress, anxiety, and depression to improve their mental health and psychosocial well-being.[29]

DOMAIN 5. CULTURE, CONTEXT, AND LANGUAGE CONSIDERATIONS

- **Are existing screening tools available in the local language?**

  The national mental health assessment tool is translated into the local language, which might be useful as a basis for translating other tools, as needed. However, it would be important to understand the process by which the existing language was chosen, how and who made the translation, and whether it is clearly understood by clients and specifically by KPs. Otherwise, we are not aware of screening tools that have been validated locally.

- **Are the local laws related to suicidality, mandatory reporting, and other issues known to the project? For example, when would the existing psychosocial officers have to report to the police?**

  We have not researched these laws. This will be an important next step for our project.

- **Are the local laws related to key populations' behavior, such as people who inject drugs, sex work, same sex relations, trans and nonbinary** identities, or other queer identities known to the project?

  Sex work is criminalized, as are relationships for men who have sex with men (imprisonment up to 14 years). The possession of small amounts of drugs is also criminalized.[30] However, we need information on mandatory reporting to understand whether a mental health provider, at a hospital for example, would be mandated to give authorities information about any of these behaviors if they were shared by a client.

- **Are the local laws related to HIV status known to the project? For example, are there laws requiring PLHIV** who are aware of their status to disclose their status to sex partners?

  No.[31]

DOMAIN 6. COMPETENCY-BASED TRAINING AND SUPERVISION

- **How were the peer navigators trained to address mental health issues?**

  They were only trained to listen empathetically and to suggest that clients with a high score on the risk assessment speak with the PSO.

- **How were the PSOs trained to address mental health issues?**

  There is no standard training for the PSOs (meaning, they do not come in with a specific credential). They are trained to help those newly diagnosed with HIV understand and accept their status and to use LIVES skills for survivors of GBV.

- **Have the competencies of the PSOs been assessed?**

  Their competencies, apart from the ability to use LIVES immediately post-training, have not been assessed against a specific set of skills.

- **Do the PSOs have supervisors who help them manage difficult cases?**

  No.

DOMAIN 7. CARE OF STAFF

- **How are the existing PSOs doing? In particular, how is their own mental health and well-being?**

  Unknown.

- **Could the PSOs be screened for burnout or other mental health issues before adding to their caseloads?**

  This has not been done, but it could be done. It would require discussion with HR and implications related to HR policies.

DOMAIN 8. CHANGE-BASED MEASUREMENT

- **What opportunities are there to show the impact of MHPSS interventions currently in place?**

  There is not a specific MPHSS protocol and package of interventions, nor are mental health data currently collected, and no validated scales are in use. Hence, it is not possible to compare outcomes along the HIV treatment cascade for those who do and do not receive mental health support.

Collaborative consultation recommendations

It is clear there is an urgent need for action to address mental health concerns given that providers, the CSOs, and the KP community have called for such support. However, it is also clear from this collaborative consultation with the 8Cs Model that there is much to learn in order to *do no harm* while adapting to fit the availability of local human and financial resources.

Although the country-based project team originally intended to address mental health issues by

SCREENING ACTIVITIES SHOULD ALWAYS BE COMMENSURATE WITH THE SERVICES AVAILABLE

While selecting a tool for screening may seem like the first step in setting up MPHSS services because it can help identify need (which also supports advocacy), **screening for nonemergency mental health needs should not be done until the availability of services at multiple levels and of competent providers is sufficient.** See more in Annex I: To screen or not to screen.

While in this case, there are psychiatric units available for referral, these should not receive individuals with all mental health conditions. Relying solely upon referral to psychiatric hospitals is potentially harmful because (1) clients with issues such as depression and anxiety may need more than the PSO can provide, but they do not need, and would be harmed by, excessive confinement and isolation from society in a psychiatric unit; (2) the project could be perceived as unsafe by others considering sharing their own mental health struggles because such sharing could result in institutionalization; and (3) there could be harm to the system as it becomes stretched even more thinly trying to support those who do not need this high level of care.

employing a new mental health screening tool, before the program completes more screening and therefore brings more people into MHPSS services, the following components must be in place:

1. Project team (peer navigators, PSOs, nurses) ready to receive those who need both general and specialized mental health care. This requires that there are enough mental health service providers and that these providers have the needed competencies; use validated curricula, guides, and tools; have time to see more clients; receive the support they need from supervisors; and know the specific pathways to higher level support for their clients.
2. MPHSS services that provide different levels of support, including through primary health care health personnel at drop-in centers, are available through the program or through referrals from the program.

To understand whether the above conditions are met, the project staff would need to:

- Assess and strengthen project team (peer navigator, PSO, nurse) competencies (e.g., using the ENACT competency list from the **EQUIP Platform**).
- Ask the project team (peer navigator, PSO, nurse) about their current caseloads and whether these can be expanded. If so, by how much? If not, why not? What are the limiting factors to expanding case load?
- Talk to the project team members (peer navigator, PSO, nurse) about their own mental health and well-being and create structures that shore up the support that PSOs and others receive to address both difficult cases and their own risk of burnout or vicarious trauma (this should include supportive supervision).
- Map the existing MHPSS services to establish the presence or absence of the needed levels of support across the pyramid by using the IASC manual, **Who is Where, When, doing What (4Ws) in Mental Health and Psychosocial Support** (with an emphasis on domains 8, 9, and 10).
- Roll out validated MPHSS trainings to build capacities as needed.

If additional funding cannot be dedicated to the above activities, it may be more appropriate to train existing providers within the project to recognize psychiatric and substance use emergencies since there is no specific protocol to identify such cases. Clients who seem to be having an emergency could be seen at public hospitals by psychiatric care specialists — services already available via the National Mental Health Service at the psychiatric unit of the government hospital. However, this should be done in tandem with a better understanding of the local legal context related to mandatory reporting, an assessment of the KP competency of providers within the National Mental Health Service, and a strengthening of the referral linkages to the national system. If peer navigators will continue to accompany clients to these services, they should also have supportive supervision and the ability to seek support if they need help for their clients or for themselves.

The mhGAP-IG suicide module can be used to train clinical providers to recognize emergencies (it is not intended for use by cadres such as outreach workers without clinical training). But first, the project team should use the WHO Live Life to gain a systems perspective that will facilitate an effective intervention.

ACTIONS: ONE STEP FORWARD

Based on this consultation process, the local team decided that their "one step forward" to facilitate future MHPSS work and minimize risk of harm will be to conduct the following with their limited existing funding:

Conduct competency-based training of project team members such as peer navigators, PSOs, and nurses to identify substance use and/or psychiatric emergencies confidently and competently and safely refer KP individuals to the already identified psychiatric units within the public health system. This will entail training in the following modules of the mhGAP-IG: "Good Clinical Practice" and "Suicide Module." Activity resources will include:

- Coordination meetings with local health administrators and those providing mental health services at the tertiary level
- Reviewing Live Life to determine the appropriate roles for project staff as they relate to identifying and managing suicidality
- Training project coordinators and managers in the EQUIP platform to evaluate the competency of the primary care team to screen for suicide risk and provide support, include developing a safety plan
- Hiring a psychiatrist to conduct a monthly supervision session with the project team offering MPHSS services to psychiatric and substance use emergencies to assure that suicide screening, support, and referrals are happening appropriately and the project team's need for supportive supervision is met

ANNEX III: Case Study B: Integrating concepts of self-care, resilience, and MHPSS needs for health care workers providing mental health services in South Asia

Introduction and background

The term "health care worker" is commonly used to describe individuals who have received specific training and the responsibility to address the health concerns in their communities. Health care workers can include commonly recognized cadres like nurses, doctors, pharmacists, psychologists, and community health workers, but there is a broad range of occupations that comprise the health care workforce. According to WHO, "Health systems can only function with health workers; improving health service coverage and realizing the right to the enjoyment of the highest attainable standard of health is dependent on their availability, accessibility, acceptability, and quality." Despite observing steady increases in the numbers of health care workers since 2016, WHO predicts that the world will need 10 million more health care workers by 2030, primarily in lower- and middle-income countries (LMICs).[32]

The emotional and psychological impact of being in a health care occupation is as significant as it is complex. A career in health care is often referred to as a "calling," and those that enter the industry are often driven by a sense of mission and an authentic desire to help people. This premise can remain true while also acknowledging that people in this line of work face significant stressors by the nature of their role. Health care workers around the world operate in settings that are often stressful and at times traumatic. They not only bear witness to, but often actively manage, situations that represent the worst experiences of people's lives — extreme pain and vulnerability, debilitating illness, tragic loss, and the waves of grief affecting both patients and families. While in many ways, these difficult experiences are part of the job, they are balanced with the joys that come with healing, recovery, birth, and saved lives. Ultimately, this means that there is a baseline experience of stress and secondary trauma that health care workers must continuously manage.

When compounding stressors stack up, without time or resources that offer relief, the effects can become amplified and significantly affect health care workers. The compounding stressors of working in health care may include challenges such as chronic shortages of materials and medications needed to care for patients, chronic staffing shortages resulting in overwork and unsafe patient ratios, unsafe work environments due to lack of basic infrastructure or other protective equipment, delays or disruptions in pay, cultural norms for discussing or prioritizing personal needs, and a range of possible stressors from health care workers' personal lives. There are several terms that reference the effects of these compounding stressors, and it is important to distinguish between each of these phenomena.

Stress: Stress can be defined as any type of change that causes physical, emotional, or psychological strain. Stress is your body's response to anything that requires attention or action. Everyone experiences stress to some degree. The way you respond to stress, however, makes a big difference to your overall well-being.[33]

Burnout: "Burnout is a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed. It is characterized by three dimensions:

- Feelings of energy depletion or exhaustion;
- Increased mental distance from one's job, or feelings of negativism or cynicism related to one's job; and
- Reduced professional efficacy.

Burnout refers specifically to phenomena in the occupational context and should not be applied to describe experiences in other areas of life."[34]

Moral injury, or demoralization syndrome: "Moral injury is understood to be the strong cognitive and emotional response that can occur following events (or structural circumstances) that violate a person's moral or ethical code.

Potentially morally injurious events include a person's own or other people's acts of omission or commission, or betrayal by a trusted person in a high-stakes situation. For example, health-care staff working during the COVID-19 pandemic might experience moral injury because they perceive that they received inadequate protective equipment, or when their workload is such that they deliver care of a standard that falls well below what they would usually consider to be good enough."[35]

Mental health condition, or mental health disorder: "A mental disorder is characterized by a clinically significant disturbance in an individual's cognition, emotional regulation, or behavior. It is usually associated with distress or impairment in important areas of functioning."[36]

Is it important to understand that there is no singular experience that can surmise the psychological and emotional experience of the health care workforce as a whole, and that an individual lived experience must be considered with a nuanced intersectional lens that accounts for the combined complexities of gender, racial/ethnic, socioeconomic, and geographic dynamics.

It is also crucial to highlight that while the COVID-19 pandemic thrust the psychological health of the health care workforce into the limelight, issues relating to overwork, burnout, moral injury, and disproportionate rates of certain mental health conditions have affected health care workers — and therefore the health care system — for decades. The pandemic, however, brought the baseline stress levels of health care workers to a boiling point, with marked increases in self-reported experiences with stress, burnout, and symptoms like anxiety, depression, and post-traumatic stress syndromes.[37] While the waves of COVID-19 patients gasping for oxygen are no longer filling hospitals, the memories of that experience have not faded. Secondary and tertiary effects from the pandemic continue to ripple through the health care workforce,

affecting the availability, quality, and safety of patient care around the globe. Workforce attrition and absenteeism have profound implications for individual patient outcomes as well as a health systems' ability to function.

While research to understand the extent and drivers of health care worker attrition during the COVID-19 pandemic is evolving, emerging evidence suggests that most attrition is related to issues of personal and psychological safety being compromised in the context of organizational, structural, or environmental inadequacies in the work setting.[38] In a groundbreaking publication entitled "Mental Health at Work," WHO presents a cutting-edge review of the extent to which mental health affects and is affected by the work environment across multiple sectors, including health care. This publication, along with a policy brief from the International Labor Organization, also makes clear recommendations for employers and industry leaders to consider mental health an occupational health issue.[39] Ideally, mental health for the health care workforce is protected and improved with a harmonized approach that meets the personal mental health needs of individuals who work in health care, and addresses the structural and organizational factors that create or exacerbate poor mental health in the health care workforce.

Tailoring MHPSS for health workers

Health care workers (HCWs) represent a unique population that, by the very nature of their role in society, have unique mental health and psychosocial needs. There is a significant occupational health element to considering the mental and psychological well-being of this population. Basic safety and protections, fair wage schemes, and reliable access to materials required to care for their patients are examples of basic policy goals that require continuous advocacy and serve as the foundation for a sense of basic safety and well-being for the health care workforce. Planning an MHPSS intervention for health care workers that does not, at a minimum, acknowledge and consider the structural and organizational factors contributing to the sense of workplace stress is not only unethical but may be ultimately futile. It has been posited that structural investments in the health system as a whole should be the primary MHPSS intervention for the health care workforce; while that is a valid perspective for this unique population, it is also important to plan for and protect the MHPSS needs of the individuals that make up this group.

There are also significant cultural elements to consider; "culture" does not only describe a set of norms for a group living in a particular country or region or speaking a common language. Culture can apply to each health facility — or even teams within a facility — born of a mix of personality types, work environment, and leadership/management dynamics. All these elements affect how experiences with stress, burnout, and mental health are expressed, and received, within a team or health facility and should be considered when tailoring a particular program.

Lastly, long-term acceptability and sustainability should be considered with any intervention aiming to address mental health and well-being for health workers. This often includes addressing basic safety issues and structural challenges, as discussed above, in a manner that is sustainable, and often includes engaging with multiple cadres within a health care team, especially those in leadership roles or management roles that have power to exert sustainable culture shifts to

achieve the practice transformation often required to improve experiences with stress, burnout, and mental health.

Example scenario: Applying the 8Cs to integrate MHPSS for health care workers as both providers and beneficiaries

A large NGO has a country office in a small South Asian country with significant funding to address mental health for both the general population and health care workers in the context of the COVID-19 pandemic. They are partnering with several local leaders in the health care field as well as several leaders in psychiatry and psychology from a local professional association and teaching hospital. The primary mechanism of this intervention is training to increase awareness of and capacity in mental health service delivery.

This is an ambitious project, aiming to directly target four unique cadres of health care workers as both participants and beneficiaries of the training:

- General frontline health workers (mainly physicians and nurses) working in area hospitals
- Trained mental health professionals, including psychologists, psychiatrists, and counselors
- Ambulance drivers/emergency medical technicians (EMTs) working in the community
- Staff of a mental health hotline established for the general community

CASE STUDY B: Working with a technical advisor to apply the 8Cs Model for Collaborative Consultation

Initial goal: The country team's initial proposal aims to conduct a series of trainings of trainers (TOTs). These trainers will then replicate the trainings directly to the aforementioned health workers. The objectives of each training module were originally quite vague, and generally referred to a goal of "increasing capacity to provide mental health services."

Ultimately, the goal was to improve the ability of the health workers participating in the training to provide safe and effective mental health care to the general community and increase their own awareness and ability to address their own mental health needs as health care workers.

Program Phase: Implementation/Improvement: The facilitator guides for each TOT module have already been developed by teams of local experts and the logistics of the TOT sessions have been planned. The developed content was shared with the technical assistance team to evaluate using the 8Cs Model and recommend additional improvements to ensure a comprehensive, high-quality training package. The technical advisor reviewed the existing content across each domain with the country team, asking probing questions to facilitate a dialogue and examples of the types of responses that may arise during the consultation.

The following questions and recommendations arose from the 8Cs Collaborative Consultation process, which reviewed and addressed the main issues in all four training modules. In this example scenario, the collaborative consultation was conducted over a series of video conference calls, emails, internal team discussion, and document review.

CROSSCUTTING PRINCIPLES:

The crosscutting principles of the 8Cs Model — "do no harm," addressing stigma, developmental lens and life cycle approaches, and preparing for emergencies — were introduced at the beginning of the consultation and continuously revisited throughout the consultation

DOMAIN 1. COMMUNITY-INFORMED

- **These trainings were developed by leading psychiatrists and psychologists. How were the intended beneficiaries engaged to develop this content?**

  Not directly; the content was developed by professionals who had a working familiarity with the roles and responsibilities of each cadre.

- **Is it possible to include members of each of these cadres in the development of the content, facilitation of the training, or continuous implementation of the principles of the training in the practice setting?**

  Yes, this is possible.

DOMAIN 2. CONTINUUM OF MHPSS NEEDS

- **Linkage to care is key. Can you include more specific information for how each cadre of health worker will be trained on how to link patients (or themselves) to high levels of mental health care when needed? Are there clear referral pathways, or standard operating procedures (SOPs), for referring more complex patients to higher levels of care?**

  Some cadres have clear SOPs, but it may be harder for other cadres to know how to link more complex patients to a higher level of care. This may also affect care-seeking behavior for health care workers' mental health. We can make this clearer.

- **Mental health emergencies, like suicidality, are only addressed in one of these trainings. All cadres should have clear guidance on how to assess a potential mental health emergency, how to link with emergency services, and how to prioritize safety for the client and the care team until the situation stabilizes.**

  Noted; the team will investigate these pathways and develop specific content as well as printable information that participants can carry with them and replicate/disseminate in their regions.

DOMAIN 3. COMPLEMENTARY

- **Have there been similar trainings for these cadres in the past? If so, what can we learn from those (successes as well as challenges)?**

  This is the first training of this kind. Some of the cadres have received some of this content in previous trainings but never in this format or context.

- **What else can employers or other institutions do to make it easier for HCWs to follow the recommendations introduced in the trainings?**

  This is unknown, but the team decided to investigate this further by engaging with participants who were in managerial or leadership roles. This is a good question that sparked a lot of discussion and curiosity.

- **Are there other services or programs within organizations, professional associations, and health care settings to promote practicing or continuing the content in this training?**

  There are minimal services providing mental health training for health workers to care for their own mental health as well as the health of others. This was talked about mostly during the discussion of Domain 7. Care for Staff (see below). It is hard to access psychologists or counselors in the country at this time, and there is a lot of stigma about mental disorders that affects the ability to do one's daily duties.

DOMAIN 4. CONSISTENT WITH THE EVIDENCE BASE

- **These trainings are developed and informed by local mental health professionals. How are they incorporating evidence-based interventions into the trainings?**

  This was not discussed in depth, but the team was reassured that the content and techniques were in accordance with local Ministry of Health and/or WHO guidelines. The team may investigate this further.

- We discussed some of the foundational resources that might be used to expand the key areas identified during this 8Cs Collaborative Consultation. The country team will refer to the following resources, with clear guidance on why a particular resource may be helpful in improving an aspect of their project.

Foundational resources in 8Cs Model for additional support for HCW trainings:

- More information about the IASC MHPSS pyramid layers and strategies that should be implemented, and components that should be avoided, can be found in the **IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings**.
- It is important to cover the MHPSS pyramid by reviewing mental health needs for each layer and considering changes in the existing health system one stage at a time to address the full spectrum of MHPSS needs. The **WHO Mental Health Policy, Plans and Programmes** is a module providing detailed information about the process of developing policy and implementing it through strategic plans and programs. Following a reading of this module, countries may wish to focus on specific aspects of mental health covered in other modules.

- Establishing MHPSS services at different tiers of the pyramid should be informed by landscaping activities, ensuring that existing MHPSS programs are not re-established but integrated.
- More information on services for mental health condition treatment can be found in the **MHPSS Minimum Service Package (MSP)**. The MSP consists of a list of core activities and a menu of additional actions. The core activities should, in principle, be available and accessible to people in all emergencies, be of high quality, and be provided in an acceptable manner to affected populations. If a core activity is not in place, it should be made available as soon as possible. Use of the MHPSS MSP is expected to lead to better coordinated and more predictable and equitable responses that make effective use of limited resources and thus improve the scale and quality of programming. This will ultimately result in substantially better mental health and psychosocial well-being for larger numbers of people.

DOMAIN 5. CULTURE, CONTEXT, AND LANGUAGE CONSIDERATIONS

Upon review, there are several very strong aspects of inclusivity and cultural appropriateness in these modules. Some questions that arose for specific modules included:

- **Are there any specific considerations needed for marginalized or minority cultural groups in your country?**

  There are some minority groups, but we have largely considered their cultural and linguistic needs. Perhaps this is an opportunity to engage with members of these groups to hear from them directly about their needs and whether these services might be improved for them.

- **Are telephone-based services appropriate for all? Who may be unintentionally excluded from accessing these services in this format?**

  Text, SMS, or WhatsApp messaging services may resonate more among younger generations and/or people in rural areas where phone service for conversations may be challenging. Perhaps we can consider a message-based option. Perhaps we can explore options to connect with very hard-to-reach groups (i.e., the elderly, the very rural).

- **Are there any mandatory reporting laws or other legal contexts for emergency/crisis situations?**

  There are guidelines for crisis situations, but information on mandatory reporting laws is unclear. This is an area we should look into to confirm that we are very clear about this in all of our training modules, especially for the telephone counseling services.

DOMAIN 6. COMPETENCY-BASED TRAINING AND SUPERVISION

- **What is your plan to introduce competency-based training and supportive supervision, both as a concept in these trainings and in follow-up support as the participants continue in their work?**

This was not considered at first, but upon further discussion, the country team adapted the training materials to include:

- Introduction of competency-based training and supervision
- Conducting initial competency assessment during the training as an example
- Inviting identified supervisors to trainings to learn about this approach

The team also reviewed the EQUIP Platform during the collaborative consultation and will work internally to see how they might be able to develop a longer-term approach to competency-based training and continuous supportive supervision for all cadres, especially the telephone counselor program.

DOMAIN 7. CARE OF STAFF

- **What safety mechanisms are in place for ambulance teams? How can the team improve or promote a higher level of safety (physical and psychological)?**

  Content was included for ambulance teams on how to safely manage an agitated patient in the community setting, but with minimal information on maintaining personal safety for staff. This was expanded, including content on correct PPE (in the context of the ongoing COVID-19 pandemic), avoiding injury, working as a team, de-escalation techniques, and processing techniques for intense or traumatic incidents.

- **How might your approach to supportive supervision (discussed in Domain 4) be developed with the well-being of staff in mind?**

  The team wanted to discuss this internally as they review the current support structures and the resources available on the EQUIP Platform.

- **There are only very brief mentions of self-care, resilience, and mental health for the front-line workers participating in these trainings. Can this be expanded?**

  After a lengthy discussion about the importance of protecting and promoting the mental health of those who are caring for the mental health of others, the collaboration team realized that this essential domain was left out of all the training modules. After internal discussion and review of the evidence and examples from other settings, the country team and local mental health professionals added content to each module about self-care, signs of burnout, resilience, secondary or vicarious trauma, and pathways to mental health care for themselves and their families. They even produced short videos in the local language on breathing exercises and mini meditations to distribute to all participants!

  The team decided to center much of their content around the concept of compassion — for patients, colleagues, and the self — to improve mental health care for all stakeholders. This had great cultural significance in their country and was well received.

DOMAIN 8. CHANGE-BASED MEASUREMENT

- **What is the monitoring and evaluation strategy to monitor the reach of this TOT cascade?**

  The program will capture how many people attended the TOT training, and then how many people attended future trainings in cascade fashion.

The program may be able to partner with local governmental officials to track users of the telephone counseling services.

- **How might the program capture impact of these training modules? Is there a mechanism to track quality outcomes? Other health outcomes? Self-reported competency and confidence outcomes?**

  Impact frameworks have not been developed due to the current reporting indicator requirements that were built into the program, and this may be complicated with the current structure of the program.

- **The team reviewed the foundational resource (M&E) and discussed opportunities to capture impact with course evaluations or even a potential research partnership with a local university.**

Analysis of this collaborative consultation scenario

After presenting the 8Cs Model to the country team and discussing the planned TOT modules by applying the eight domains to the planned intervention and providing some additional references and foundational resources, the in-country EpiC team made several adjustments to the planned training. They did not request any additional support from EpiC HQ technical teams for the ongoing development of the training modules and reported feeling confident with the direction and resources shared in the collaborative consultation. There were several key action points that the country team decided to incorporate right away or investigate further, and they planned to consider adapting their approach based on the new information they found.

One of the most significant adaptations that was planned immediately because of the 8Cs Collaborative Consultation was a robust expansion of the content that focused on self-care, burnout, stress management, teamwork, and mental health care-seeking for the *health workers themselves*. Using a foundational concept of compassion (for others and self) was very well received.

The in-country team felt that the 8Cs Collaborative Consultation was so beneficial to the improvement of their program that they included a brief presentation about the model to kick off the TOT sessions, held in late November/early December 2022. The team felt it would be helpful to provide a high-level overview of the concept and share with the participants exactly how the 8Cs Model was applied to improve the trainings they were about to receive.

The in-country team also reported feeling prepared to consider additional MHPSS interventions in the future, building on the capacity developed in the primary series of trainings and incorporating some of the additional considerations recommended in the first round of 8Cs Collaborative Consultations.

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