Training of Trainers and Supervisors (ToTS) training programme

Welcome

Find an individual you have not met before and partner with them.

Find out the following and introduce your partner to the whole group:

- Name
- Profession
- Current posting
- Interest and experience in mental health.

Welcome

In this first section we will discuss:

- The training agenda
- Background and learning objectives of the workshop
- Pre-test.

	Day 1	Day 2	Day 3	Day 4	Day 5
Session 1 9:00–10:30	Welcome and introduction to Mental Health Gap Action Programme Importance of integrating mental health into non-specialized health settings	Introduction to mhGAP ToHP training methodology and competencies	Training skills: Using mhGAP ToHP person's story Video demonstrations	Participant facilitation exercise and feedback	Supervision: Theory and practice
Session 2 11:00– 12:30	Implementation of mhGAP-IG Familiarization with mhGAP-IG Version 2.0	Preparing and evaluating a training course (including training needs assessment – TNA)	Training skills: Role play	Participant facilitation exercise and feedback	Supervision: Theory and practice
Session 3 13:15– 15:00	Essential care and practice module	Training skills: Presentation skills	Competency-based assessments: structure and feedback	Participant facilitation exercise and feedback	Individual feedback and plan for running own course
Session 4 15:30– 17:00	Essential care and practice (continued)	Training skills: Facilitating group discussions Facilitator demonstrations	Participant facilitation exercise: Participants given time to prepare delivery of mhGAP ToHP training	Participant facilitation exercise and feedback	Individual feedback and plan for running own course (continued) Finish and wrap up

Aims of mhGAP ToTS

What can you expect?

As a **future facilitator** your role will be to learn about the structure of mhGAP-IG, how to teach the materials and utilize opportunities to prastice facilitation and supervision skills.

As a **supervisor** your role will be to serve as a point of reference for non-specialized health-care providers, supporting them in providing service for individuals with MNS disorders in non-specialized health settings.

REMEMBER: You are learning **how to conduct** a training on mhGAP-IG and/or provide supervision.

Overall ToTS learning objectives

1. Become familiar with mhGAP Intervention Guide (mhGAP-IG) and training manuals.

2. Develop and practise interactive facilitator and training skills using the mhGAP material.

3. Develop and practise supervision skills.

Pre-test

Pre and Post-test MCQs

Test the participants' knowledge of mhGAP-IG by doing the pre-post test MCQs

Mental Health Gap Action Programme (mhGAP)

mhGAP is a WHO programme, launched in 2008, to scale-up care for mental, neurological and substance use (MNS) disorders.

The programme asserts that with proper care, psychosocial assistance and medication, tens of millions of people could be treated for depression, psychoses and epilepsy, prevented from suicide and begin to lead normal lives – even where resources are scarce.

Its focus is to increase non-specialist care, including primary health care, to address the unmet needs of people with priority MNS conditions.

https://www.youtube.com/watch?v=TqlafjsOaoM&feature=youtu.be%29

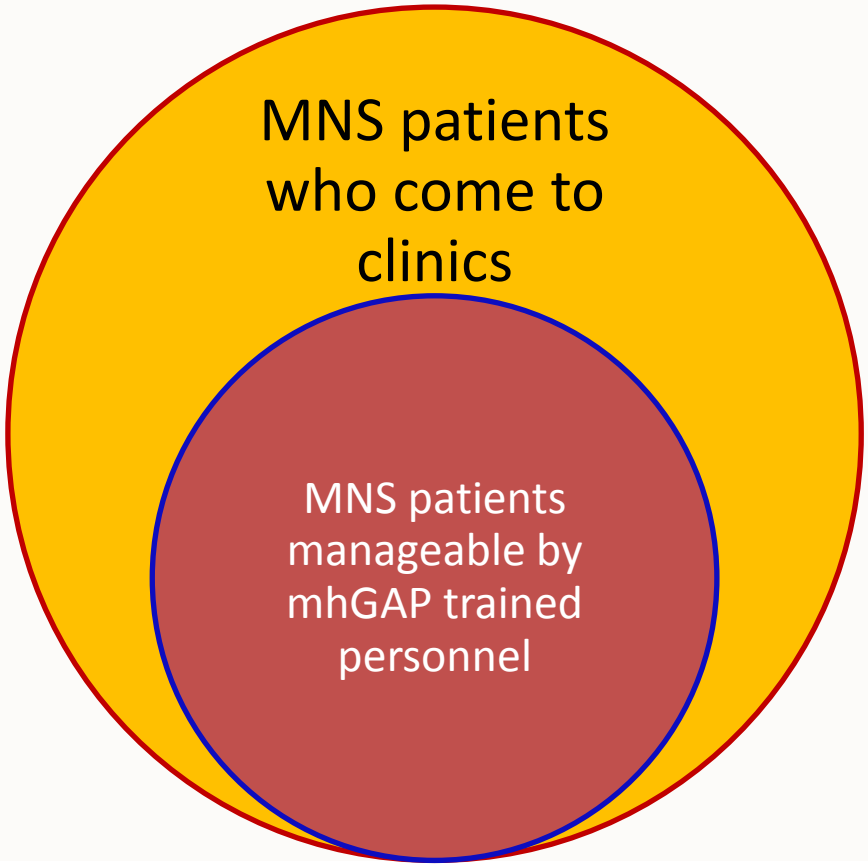
mhGAP-IG target audience

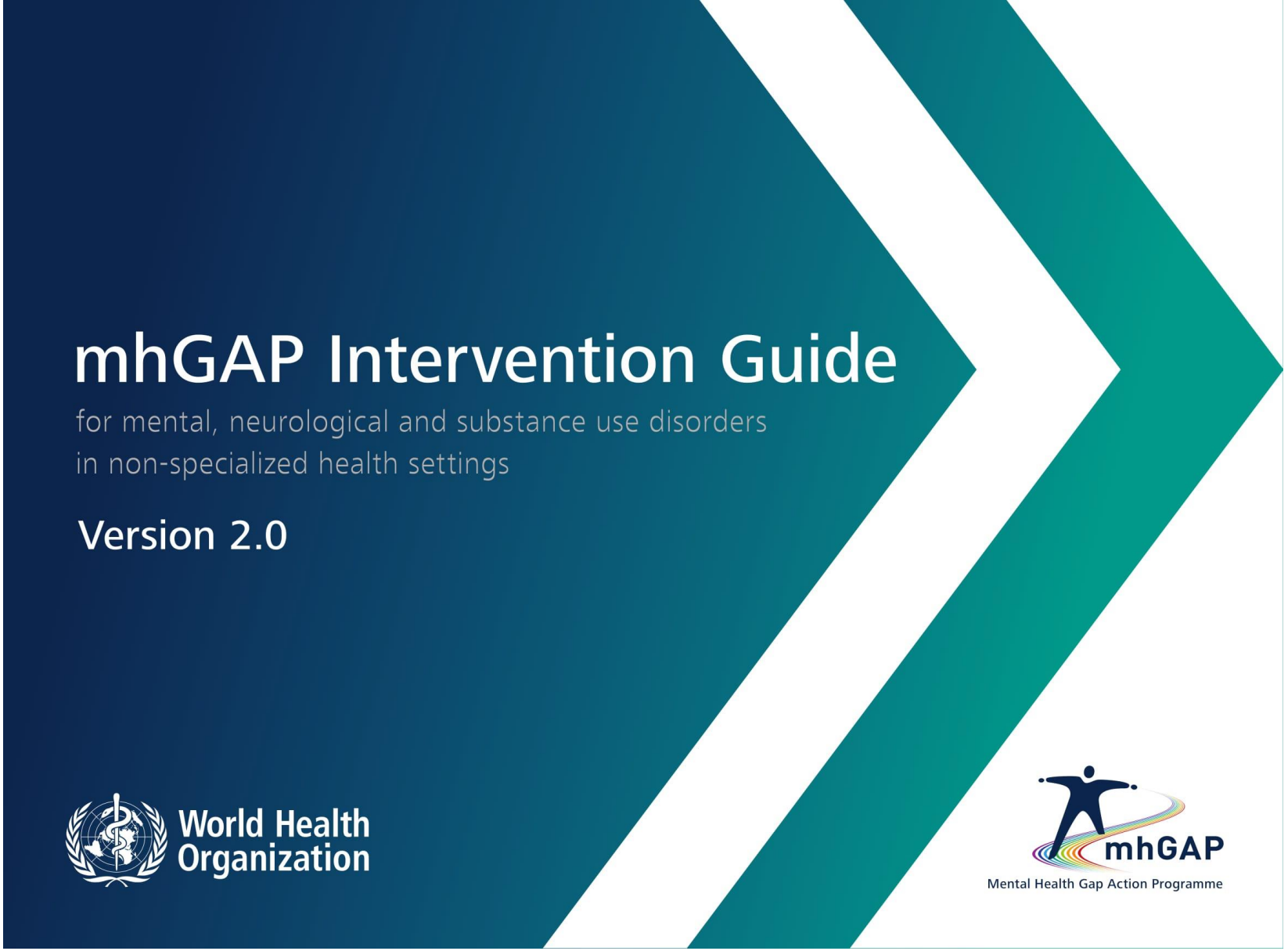
Health-care providers without specialized training in mental health or neurology:

- General physicians, family physicians, nurses
- First point of contact and outpatient care
- First level referral centres.

REMEMBER: You will be teaching health-care providers who are not specialized in mental health in how to utilize the mhGAP-IG

mhGAP concept





An evidence-based, clinical guide for the assessment and management of mental, neurological and substance use disorders in non-specialized health settings

mhGAP-IG modules

1. Essential care and practice
2. Depression
3. Psychoses
4. Epilepsy
5. Child & adolescent mental & behavioural disorders
6. Dementia
7. Disorders due to substance use
8. Self-harm/suicide
9. Other significant mental health complaints

Brainstorm

Think about the health care systems in your local setting.

Answer these questions:

1. Is mental health care integrated into primary health care/non-specialized health care?
2. If not, why not?

Seven good reasons for integrating mental health into non-specialized health settings

1. The burden of mental disorders is great
2. Mental and physical health problems are interwoven
3. The treatment gap for mental disorders is enormous
4. Enhance access to mental health care
5. Promote respect of human rights
6. It is affordable and cost-effective
7. Generates good health outcomes.

Implementation of mhGAP

Phases of implementation

Phase I: Plan

- Assemble an mhGAP operations team
- Conduct a situational analysis
- Develop an mhGAP operations plan and budget

Phase II: Prepare

- Adapt components of the mhGAP package
- Train health care providers and others in the health system
- Prepare for clinical and administrative supervision
- Strengthen care pathways
- Improve access to psychotropic & psychological interventions

Phase III: Provide

- Provide services at facility level
- Provide treatment and care in the community
- Support delivery of prevention and promotion programmes

Phase I: Plan

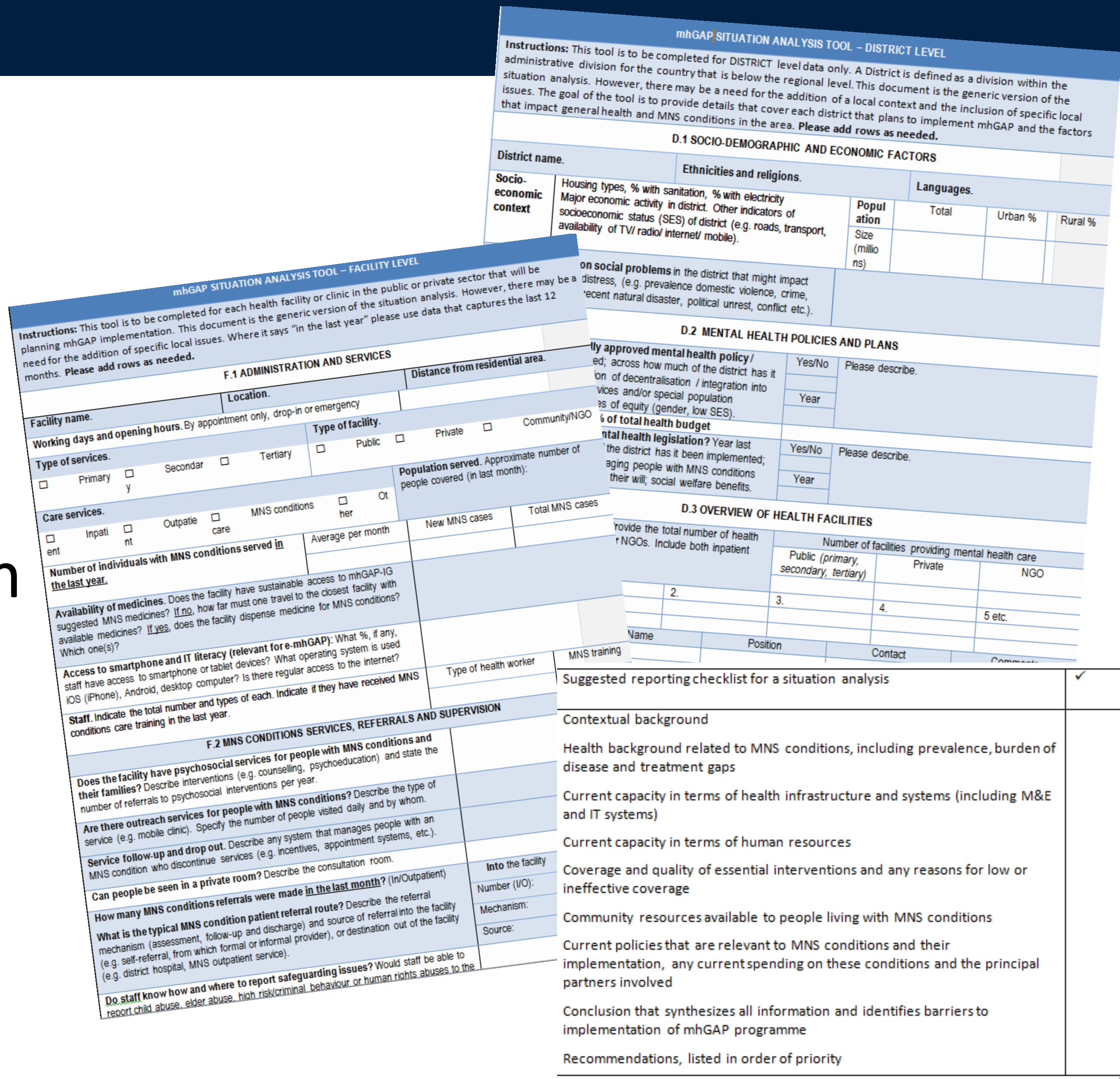
1.1 Assemble an mhGAP operations team

1.2 Conduct a situation analysis

1.3 Develop an mhGAP operations plan and budget

Phase I: Plan

- The manual includes adaptable implementation tools



Phase II: Prepare

2.1 Adapt components of the mhGAP package

2.2 Train health care providers and others in the health system

2.3 Prepare for clinical and administrative supervision

2.4 Strengthen care pathways

2.5 Improve access to psychotropic medicines

2.6 Improve access to psychological interventions

Phase II: Prepare

- Practical tips for preparing mhGAP operations
- Guidance on how-to implement mhGAP for district health managers

Practical tips for adaptation of mhGAP package components
A workshop is an effective method for adaptation, because it provides an opportunity for the working group to discuss issues face-to-face and reach a consensus efficiently. Alternatively, feedback and translation may be received by e-mail or videoconferencing, which may be more cost–effective.
Adaptation is continuous, and some may also be done during training and supervision. Detailed notes on adaptations and translations of mhGAP materials should be recorded.
Make only essential adaptations to the mhGAP-IG 2.0. Large changes that are contrary to the formal evidence-based mhGAP recommendations should be avoided.
Any local literature about MNS conditions and the services available in the country or district should be provided during the adaptation workshop, in addition to the results of the situation analysis.
Remember that the guide is not for specialists.
It is sometimes better to test particular interventions or modes of delivery. If necessary, changes can be made in a subsequent revision.
Ensure that adaptations are appropriate for the district of implementation, which may differ in a country. Invite the minister of health or other leaders to endorse the adapted materials.

Phase III: Provide

3.1 Provide services at facility level

3.2 Provide treatment and care in the community

3.3 Support delivery of prevention and promotion programmes

Phase III: Provide

- Lessons learned from projects using mhGAP globally
- Case stories of providing treatment and care in districts

TREATMENT AND CARE IN THE COMMUNITY: PRIME IN NEPAL

Continuing activities

- Raise awareness
- Ensure coordination
- Monitor and evaluate

Section	Indicator	Means of verification
1. Phase I. Plan for mhGAP implementation in the district		
1.1 Assemble an mhGAP operations team	• Total number of mhGAP operations team meetings per year; and • Total number of participants of mhGAP operations team.	Terms of reference, meeting minutes, plan and budget for the team's activities. Tool: Stakeholder engagement tool (Annex 1).
1.2 Conduct a situation analysis	A completed situation analysis is available to determine needs and resources at district and facility levels. [Yes/ No/ In progress].	Plan and budget for completion of situation analysis, adapted tools. Tools: mhGAP tools for situation analysis in district and facilities (see below) and mhGAP situation analysis report checklist (Annex 2).
1.3 Develop an mhGAP operations plan and budget	• MNS care is integrated into the district health plan [Yes/No/Partial] and approved by the government [Yes/No]; • A budget is available, which specifies the financial, human and physical resources required to implement mhGAP in the district.	Review meeting agendas and minutes, and continually adjusted the plan and budget. Tool: mhGAP operations plan checklist (Annex 4).
2. Phase II. Prepare by building capacity and enhancing health system readiness		
2.1 Adapt components of the mhGAP package	mhGAP-IG 2.0 training and supervision materials and e-mhGAP are adapted and available for implementation in the district [Yes/No/ In progress].	Adaptation workshop minutes, adapted mhGAP-IG 2.0, training and supervision materials and e-mhGAP. Tool: mhGAP-IG adaptation template (Annex 5).

Activity: Provide

In small groups:

- Identify and discuss current levels of MNS service provision in your areas.
- Use the flip chart paper to draw/map future levels of service provision including:
  - Possible multidisciplinary teams
  - Which facilities can provide services and how
  - What community services can be offered
  - What can be done to prevent and promote mental health.

Familiarization with mhGAP-IG Version 2.0

mhGAP-IG Version 2.0

Familiarization activity

Essential care and practice module

Introduction to mhGAP ToHP training methodology

Aim of the mhGAP Training of health-care providers training manual

- Build participants' clinical skills to be able to assess, manage and follow up individuals with priority MNS conditions.
- Train participants to use the mhGAP-IG Version 2.0 in their daily clinical practice.
- Improve participants' knowledge and understanding of priority MNS conditions.
- Give participants the confidence to provide care to people with priority MNS conditions and receive support and clinical supervision in mhGAP-IG.

Introduction to mhGAP ToHP training methodology

Think back to training sessions you have attended in the past.

What are the skills of a good trainer?

What made a training successful?

What made a training session less effective?

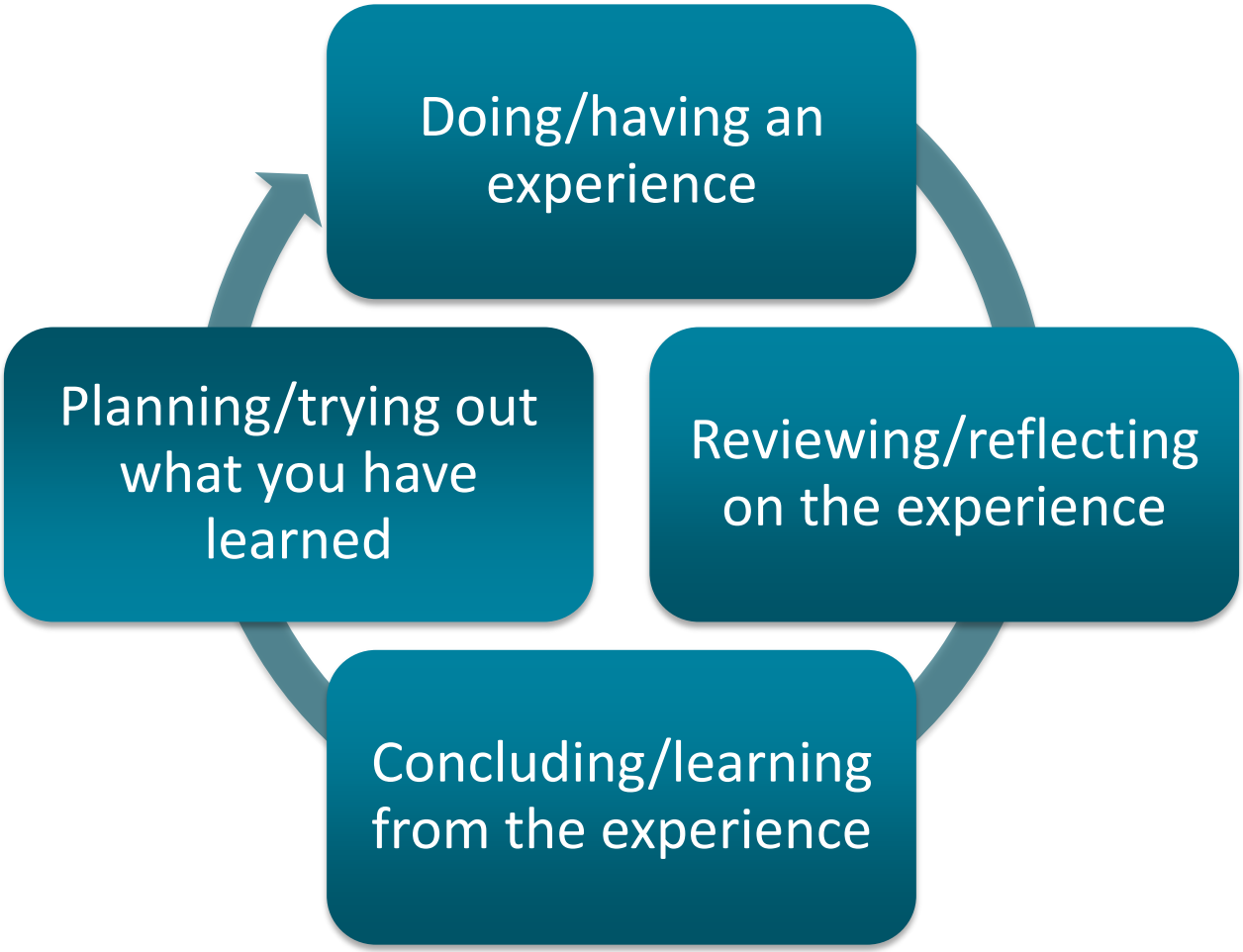
mhGAP ToHP approach to training

- The mhGAP ToHP training applies:
  - adult learning principles
  - an experiential learning cycle
  - competency-based learning
  - effective use of feedback.

Adult learning principles

- Adults learn best when they can use their own life experience.
- To learn, adults need to feel:
  - Valued and respected – they come with their own vast experience, ideas and perspectives, all of which must be brought into the training.
  - Adults learn better when they actively engage and experience the concepts being taught.
  - Adults learn best when the learning is reinforced, through various learning activities and when it relates to their everyday life.

Experiential learning cycle



Competency-based learning

- The mhGAP training manuals include a series of competency checklists to be used throughout the training and in supervision.
- Competency checklists describe essential steps needed to perform different clinical skills.
- The checklists represent a framework to evaluate the trainee's skills development.

Effective use of feedback

- Competency checklists and the constructive feedback they provide aim to build the skills and confidence of the health-care provider.

- To give effective feedback create a comfortable environment where participants are open to receiving feedback.

Activity 4: Feedback activity

Draw a house

Providing feedback

Do

- Provide feedback shortly after observation of the clinical interviews
- Allow health-care providers to reflect on their performance
- Give descriptive and specific feedback
- Acknowledge what was done well
- Focus feedback on actions
- Encourage health-care providers to identify areas of improvement.

Do not

- Focus on the person
- Use judgmental language
- Immediately list all the things that need improvement.

Preparing and evaluating an mhGAP ToHP training course

Preparing for an mhGAP ToHP training

Before the training starts:

- Conduct a brief training needs assessment (TNA).
- Adapt the material to fit the local context.
- Decide on the length and delivery method for the training.
- Prepare yourself.

Training needs assessment (TNA)

A TNA is a systematic process which identifies the gap between the participants' current skills and knowledge and the desired skills and knowledge.

The TNA should be brief and ensure that:

- The facilitator understands the participants' training needs.
- The facilitator understands expectations regarding how participants should apply the training.

Training needs assessment

Location of training:	Contact person:

Please identify which of the following sources were used to complete this form:

- ☐ WHO/UN sources of information
- ☐ National sources of information
- ☐ Other published literature
- ☐ Review of adverse events
- ☐ Audit reviews
- ☐ Review of hospital admissions data
- ☐ Discussion with management
- ☐ Discussion with staff
- ☐ Discussion with patients
- ☐ Other: . . . . . .

Target population

Which MNS conditions should be managed in non- specialized health settings? (as per national level protocols and guidelines or discussions with stake holders):

- ☐ Essential care and practice
- ☐ Depression
- ☐ Psychoses
- ☐ Epilepsy
- ☐ Child and adolescent mental and behavioural disorders
- ☐ Dementia
- ☐ Disorders due to substance use
- ☐ Self-harm/suicide
- ☐ Other significant mental health complaints

Local Resources

Which medications are available in this area?

- ☐ Acamprosate
- ☐ Amitriptyline*
- ☐ Benzhexol
- ☐ Biperiden*
- ☐ Buprenorphine
- ☐ Carbamazepine*
- ☐ Chlorpromazine*
- ☐ Cholinesterase inhibitors
- ☐ Clonidine
- ☐ Diazepam*
- ☐ Disulfram
- ☐ Fluoxetine*
- ☐ Fluphenazine*
- ☐ Haloperidol*
- ☐ Lithium*
- ☐ Lofexidine
- ☐ Methadone*
- ☐ Methylphenidate
- ☐ Midazolam*
- ☐ Morphine*
- ☐ Naloxone*
- ☐ Naltrexone
- ☐ Oxazepam
- ☐ Phenobarbitol*
- ☐ Phenytoin*
- ☐ Risperidone*
- ☐ Sodium Valproate*
- ☐ Thiamine*
- ☐ . . . . . .

*WHO Essential Medicines List 2017

What are local prescribing regulations?

What brief psychological treatments are available?

Are mental health specialists available locally (i.e. psychiatrists, neurologists, mental health nurses)? Provide names and contact details

Are other services available where people with MNS conditions can be referred? (i.e. gender-based violence support, financial support, aged-care)

Adapting the training material

- Adaptation is the process of deciding on and producing the changes needed in the mhGAP-IG training and supervision materials to fit a particular context.

- Although the structure of the training and supervision materials should stay the same, the content can be adapted to fit the local sociocultural context.

Purpose of mhGAP ToHP training manual adaptation

- To provide guidance on implementing mhGAP-IG components through the local health system.
- To clarify referral pathways.
- To align materials with relevant national treatment guidelines and policies where necessary.
- To ensure that the guidance is acceptable in the local sociocultural context.
- To improve communication with users and caregivers by incorporating local terms and concepts.
- To develop a consensus on technical issues across conditions.
- To provide a basis for the development of appropriate training programmes and tools.
- To ensure materials and services are informed by local cultural practices.

Method of mhGAP ToHP training manual adaptation

Use the situation analysis and operations plan conducted in regions where mhGAP-IG will be implemented to:

- Inform referral pathways
- Inform availability of medications, specialist services, community services
- Inform availability of supervision resources.

Use this ToTS training time to:

- Adapt the mhGAP ToHP training manual– make it culturally appropriate and relevant
- Adapt the supervision models to make them fit the local setting.

Decide the length of mhGAP ToHP training

- Complete mhGAP ToHP training consists of an introduction module and **nine** training modules (Essential care and practice and eight modules on different priority MNS conditions)

- Deliver training in all nine modules on consecutive days

or

- Deliver the training in three parts, e.g. over three weekends

or

- Choose not to deliver all nine modules but only chose ECP and the most relevant priority MNS condition.

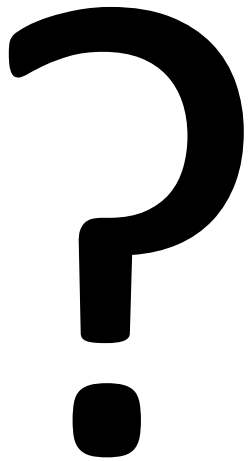
Discussion

Which MNS conditions would you prioritize?

Preparing yourself

- As the facilitator, you set the tone of the training.
- Know the material – practise, practise and practise some more.
- Create a comfortable training and learning environment.

Ways to create a comfortable learning environment



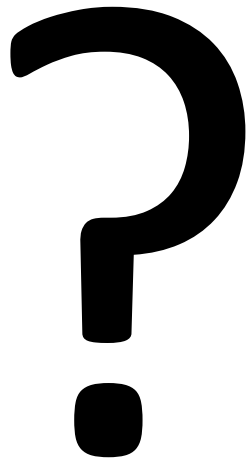
Ways to create a comfortable learning environment

- Show respect for the participants' individuality and experience – know the participants' names and make sure they know yours.
- Establish guidelines/ground rules for the training – e.g. one person speaking at a time, listening to each other, no telephones etc.
- Establish guidelines for giving feedback.
- Use non-judgmental language.

Ways to create a comfortable learning environment

- Promote an atmosphere that feels comfortable to share ideas and experience – acknowledge that it takes courage to act and share in front of strangers and peers but we are all in the same boat and this training is an opportunity to practise and learn new skills.
- Acknowledge the participants' existing skills and experience – encourage them to give their own experience as examples.
- Be encouraging and positive as participants practise new skills.
- Use charm and, where appropriate, humour, to put participants at ease.

Establishing Ground Rules



Evaluation

- Assess the strengths and weaknesses of the training. Did it achieve what it set out to achieve?
- E.g. Do the health-care providers have the skills and knowledge necessary to assess and manage people with priority MNS conditions
- Has it been worth the cost and efforts?

mhGAP-IG training methodologies and competencies

Brainstorm

- Think of as many training methods as you can

Training methods

- Lectures
- Real life stories/examples
- PowerPoint Presentations
- Small group discussions
- Large group discussions
- Role plays
- Facilitator Demonstrations
- Simulations
- Brainstorming
- Video demonstrations
- Quizzes
- Case studies
- Assignments
- Reading texts
- Storytelling
- Student demonstrations
- Reflection
- Games
- Group projects
- Written tasks
- Self study

Presentation skills

Practical session

- Everyone has three minutes each to deliver their presentation
- At the end of the presentation everyone will receive some brief feedback.

Training skills: Presentation skills

- Lecture-style format; telling someone about something
- Can be in printed or oral form.

How effective is a lecture alone?

Suggestions for an effective presentation

- Communicate in a language that is easy to understand (avoid jargon)
- Maintain eye contact with participants (if culturally appropriate)
- Project vocally so that those in the back of the room can hear clearly
- Be interactive; Use real life stories and examples
- Display enthusiasm for the topic and its importance
- Move around the room
- Use participants' names as often as possible
- Display a positive sense of humour
- Provide positive feedback
- Be an effective role model (if you are training in communication skills then use effective communication skills).

Components of a presentation

- Clear introduction
- Clear goals: Trainees and trainers know what the trainees will learn and why
- Training content is logical and facilitates learning
- Learner participation: Space for questions and discussions, debates and reflections
- Inclusion: Trainees' ideas, experiences and knowledge are included in the presentation
- Summarize: Review what was taught, why and how it fits into the overall learning goal.

Group discussions

Training skills: Facilitating group discussions

Some discussions during mhGAP ToHP training will be conducted in small groups under the supervision of facilitators (e.g. discuss psychosocial interventions for depression).

Some discussions will be conducted with the entire group under the supervision of the facilitator (e.g. how is mental health perceived and understood in your community?).

Small group work

- Small group work provides an opportunity to fully engage participants in the training
- It can save time – a large task can be divided into subtasks addressed by different small groups
- It can generate more ideas
- It can facilitate the expression and considerations of a greater number of view points

Tips on working with groups

- When a group of individuals comes together for a training it is the responsibility of the facilitator to manage the interaction between group members
- Characteristics of an effective group:
  - The group understand its goal (overall and immediate)
  - There is good communication between group members
  - The members share leadership responsibilities
  - The group can make decisions considering everyone's view point.

Tips on creating small groups

- Keep the composition of the groups varied:
  - Assign participants to a group
  - Ask participants to count off “one, two, three” etc. with all the ones working together, all the twos together and all the threes together
  - Ask participants to form their own small groups
  - Ask participants to draw a group number from a basket.

Practicality of facilitating a large group discussion

When facilitating a group discussion think about:

- The physical environment
- Guidelines on how to treat each other
- Clear instructions
- Encouraging quiet people to engage and share
- Correcting any incorrect information without embarrassing or minimizing the contribution
- Deal with disagreements
- Keeping to time
- Coping with tangents
- How to summarize, reflect, repeat and accentuate.

Practical session

- Group discussion facilitation activity

Facilitator demonstration

Training skills: Facilitator demonstration

Demonstration is a interaction between trainers to illustrate possible scenarios.

Demonstration by the master trainer and co-facilitator.

Participant discussion after the demonstration:

- How did the second role play differ from the first?
- What was it like to experience those two interactions as an observer?
- How might it be to experience those types of interaction as a patient/client?
- How can this demonstration be helpful to you as a provider/facilitator?

mhGAP-IG person’s story

Training skills: Person's story

Using a person's story is an effective way to communicate an important idea to another person. The stories of the people will stay with participants much longer than facts or statistics.

The technique involves a mixture of story and reflection to stimulate discussions on people's understandings of priority MNS conditions.

Person's story

- In each module there are different story options for each priority MNS condition – either a script that is read out or a video. You can also use a taped narration. Choose the option that is most relevant to the cultural context you are in and/or adapt the story when necessary.

- Try to stay true to the experience of the person in the story but adapt the language and/or be creative with the style of delivery to ensure that the story speaks to the common understanding of the people in your training group. Ensure the story includes a description of the condition, their feelings about it and how it has affected them.

How to use persons' stories

- Introduction
- The story
- Immediate first thoughts
- Local descriptions
- In each module after the person's story, move on to the common presentations of the particular MNS condition.

Practical session

- Familiarize yourself and practise using the person’s story technique

Video demonstrations

Training skills: Video demonstrations

Video demonstrations are used as an example of a clinical interaction (either assessment, management intervention and/or follow-up session) between a health-care provider and an individual (with or without their family member/carer).

Participants are advised during the video demonstration to look at the different clinical decision-making steps in the mhGAP-IG so that they can reflect on and discuss the interaction and how the health-care provider behaved.

Video demonstration tips

Video demonstrations:

- State clearly the objective of the demonstration.
- Follow instructions in the facilitator's guide, especially when facilitating the discussion and eliciting opinions from participants.
- If a video is not available for a module that should have one (such as not available for the training language or a power outage), act out the ***entire*** correct script with a co-facilitator.

Practical session

- Practise using a video demonstration from mhGAP ToHP training manual material

Role plays

Training skills: Role plays

- Effective for practising and building assessment, management and communication skills.
- Effective for addressing stigma.
- Small groups of three people: two play active roles while one person observes and provides feedback.
- Large role plays facilitated as a demonstration for the entire group by the facilitator and a volunteer.
- Emphasis of role plays should not be placed on acting skills, but rather on the content and the lessons of the activity.

Role play tips

- State clearly the objective of the role play.
- Explain the situation and the roles to be played.
- Guide a discussion asking questions of both actors and observers.
- Explain to the observers the evaluations and how they should conduct the peer evaluations.
- Summarize what happened and what lessons should be gained from the exercise.

Practical session

- Choose a role play from any of the priority MNS conditions.

Competency-based learning assessments: Structure and Feedback

Competency-based education and assessment

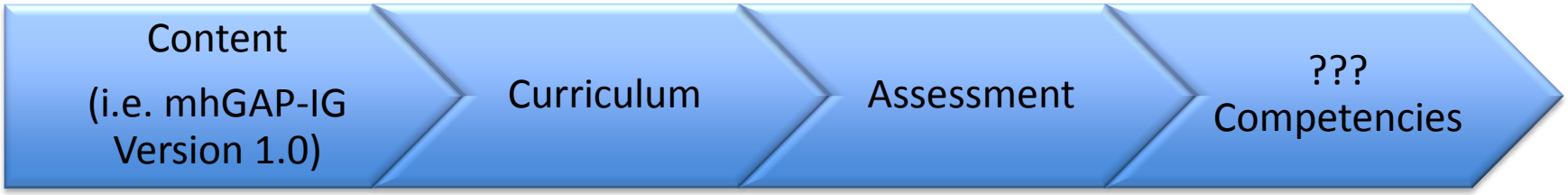
- Introduction to competency-based education and assessment:
  - Why have competencies?
  - Key features of competencies
  - What are the competencies for the mhGAP ToHP training ?
  - How will we assess competencies?
- Activity
- Reflection

Introduction to competency-based education and assessment

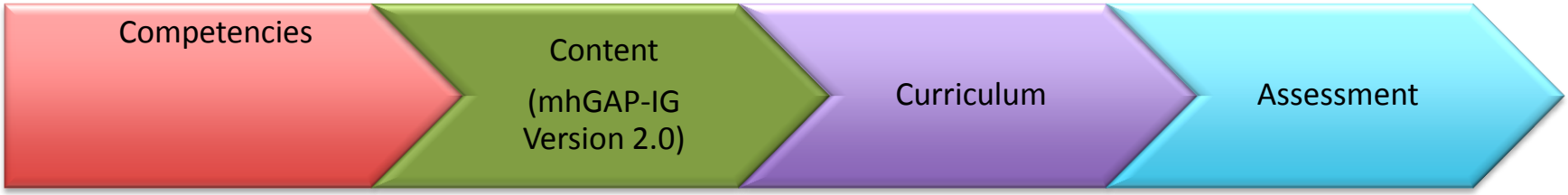
Introduction

- Competency-based health education has been around for 20 years.
- Uses outcomes to inform curricula and assessment processes.
- Each competency tells us what a person should
- New to the training of mhGAP-IG Version 2.0.

Without competencies



Competency-based education



Key features of competencies in the mhGAP ToHP training

1. Competencies are considered in terms of **knowledge, skills and attitudes**

2. Competencies are the **building blocks** of teaching and practice.

3. Competencies are **dynamic** and dependent on **context.**

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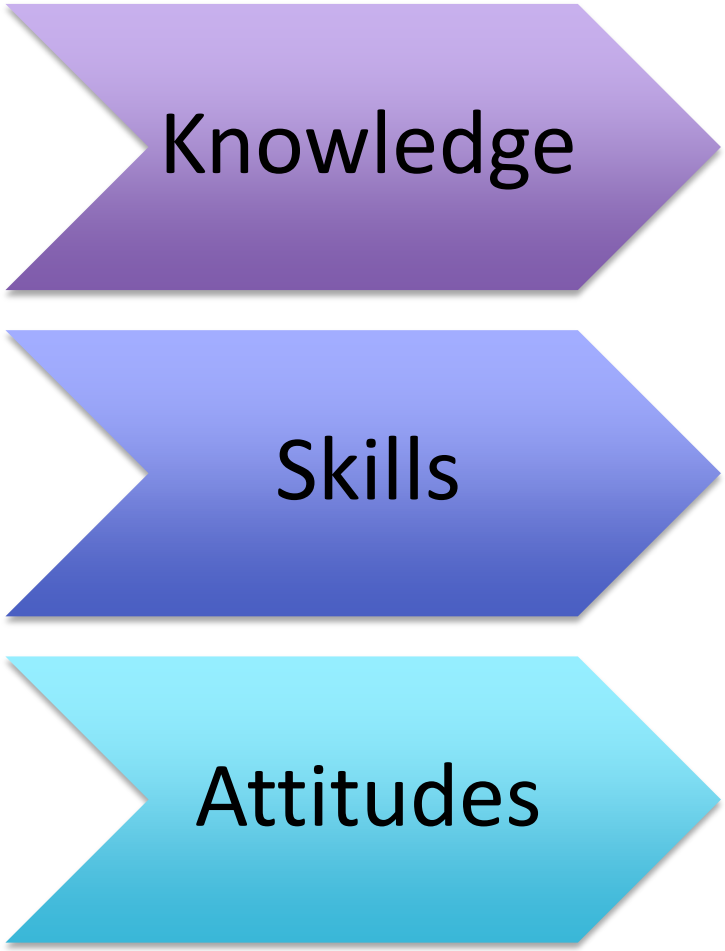
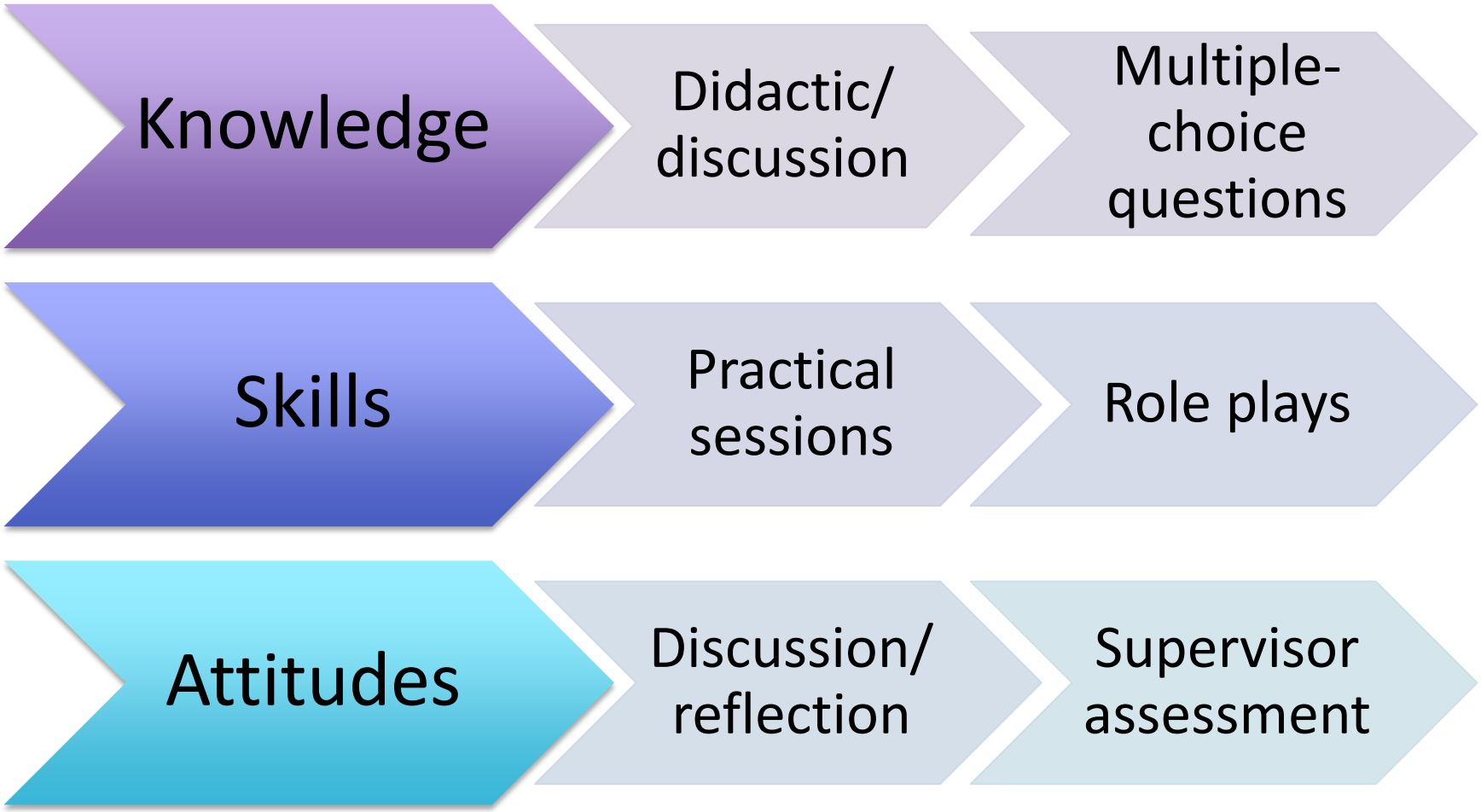


How competencies inform teaching and assessment



Key features of competencies in the mhGAP ToHP training

1. Competencies are considered in terms of knowledge, skills and attitudes.

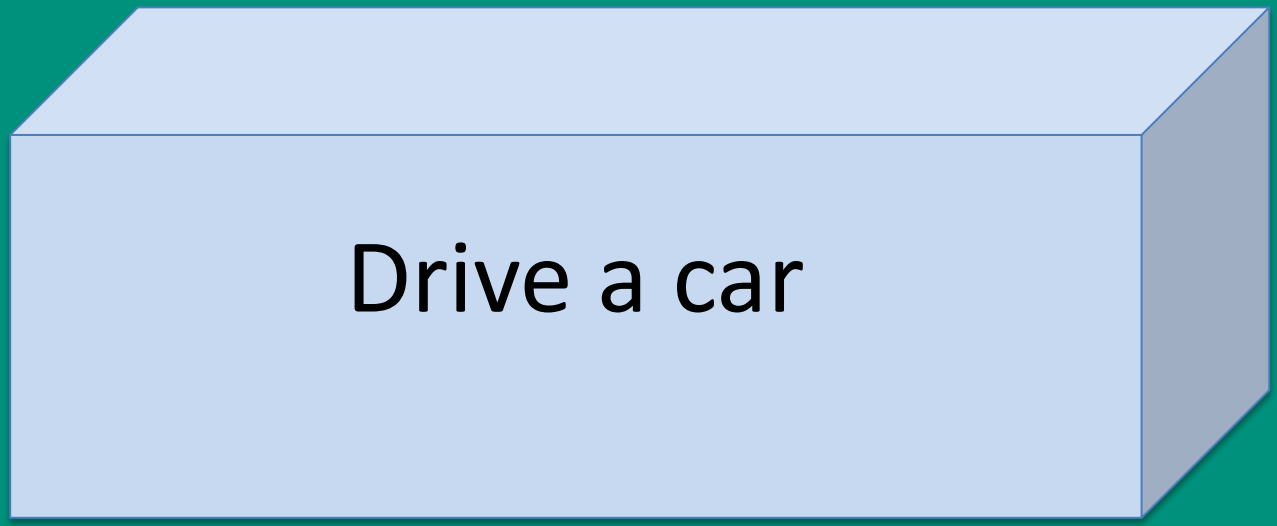
2. Competencies are the **building blocks** of teaching and practice.

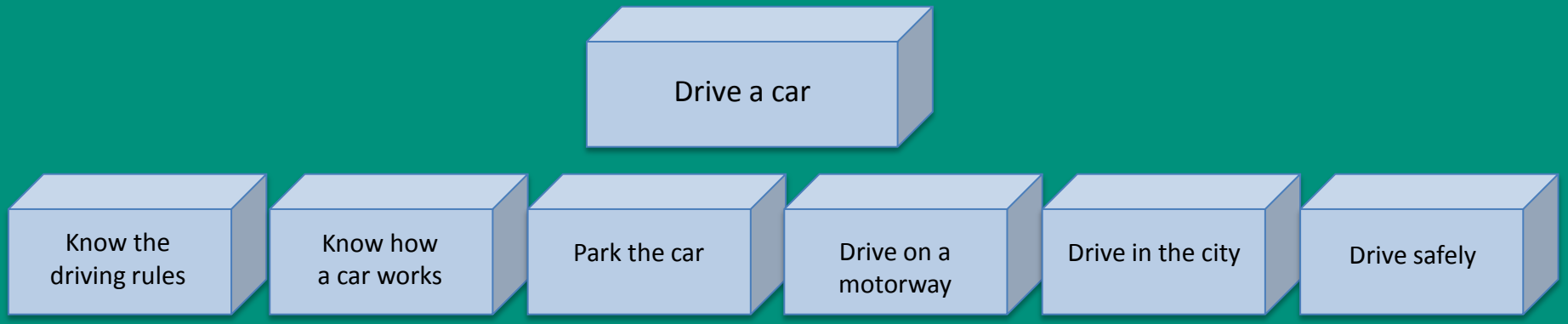
3. Competencies are dynamic and dependent on context.

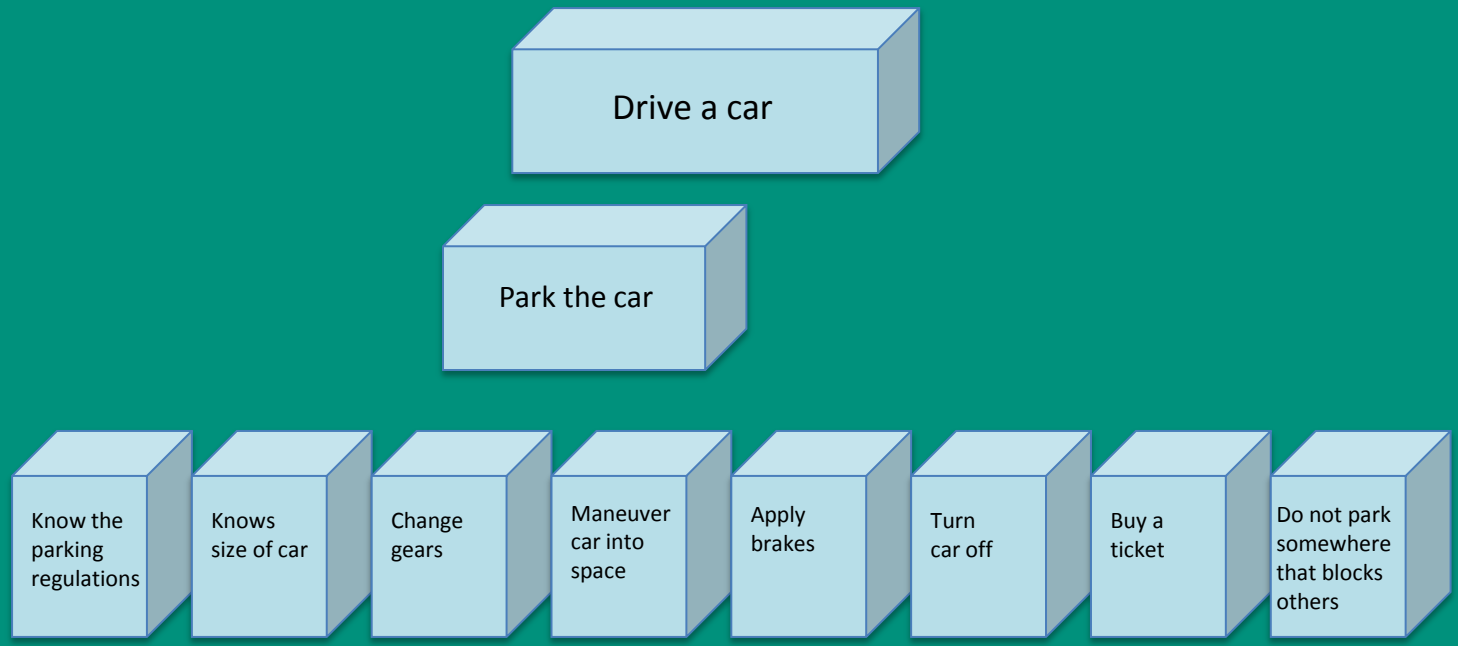
Competencies are the building blocks of teaching and practice

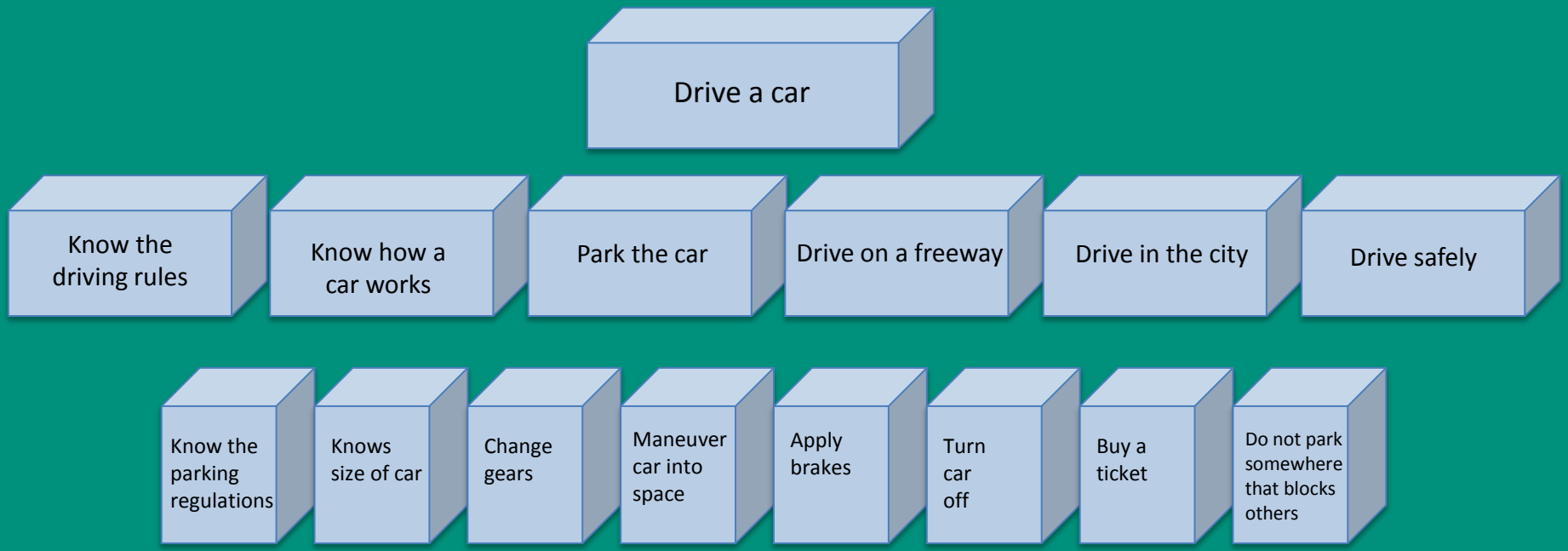
- Competencies can both be and
- Competencies should build on each other to ensure the person is

- They can also be broken down into the specific needed for each competency.


Drive a car


Drive a car
Know the driving rules
Know how a car works
Park the car
Drive on a motorway
Drive in the city
Drive safely


Drive a car
Park the car
Know the parking regulations
Knows size of car
Change gears
Maneuver car into space
Apply brakes
Turn car off
Buy a ticket
Do not park somewhere that blocks others


Drive a car
Know the driving rules
Know how a car works
Park the car
Drive on a freeway
Drive in the city
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Change gears
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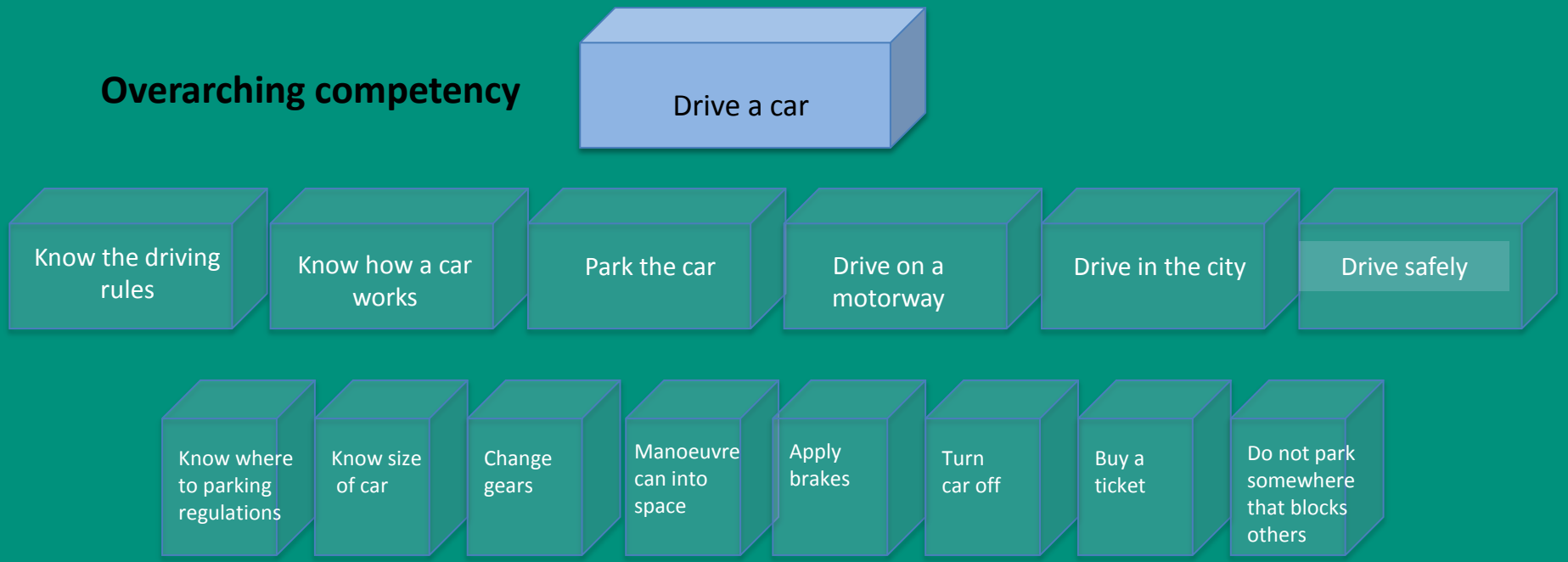
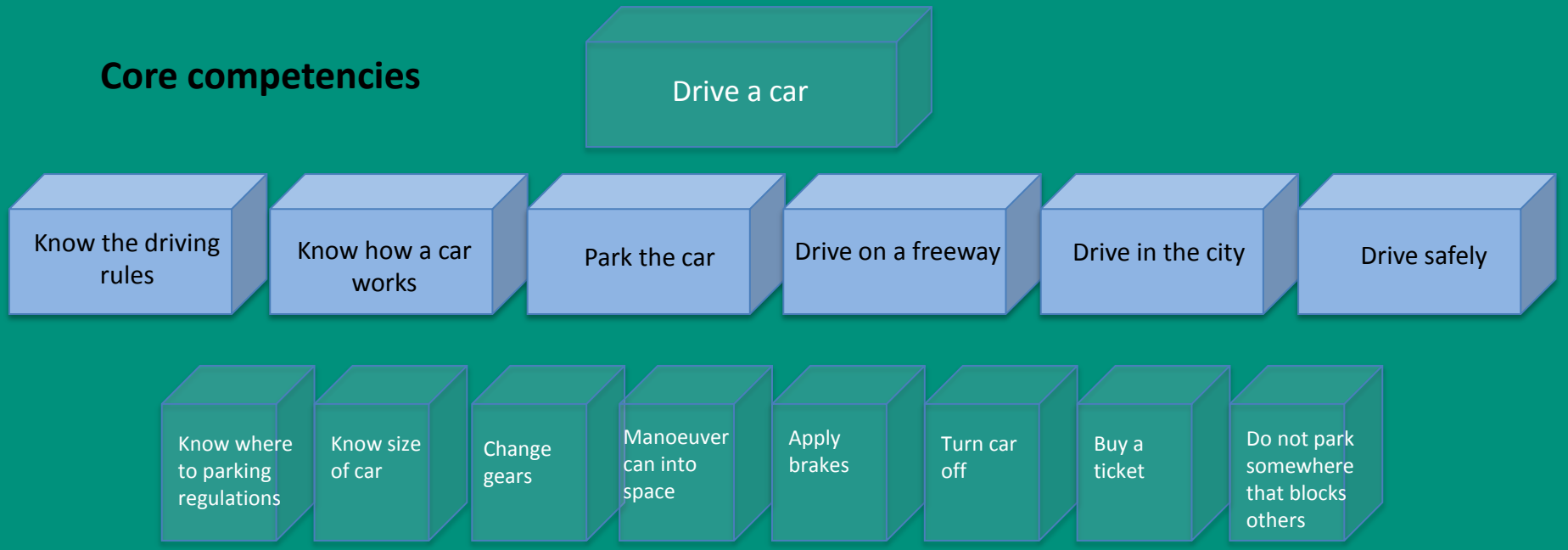
Apply brakes
Turn car off
Buy a ticket
Do not park somewhere that blocks others

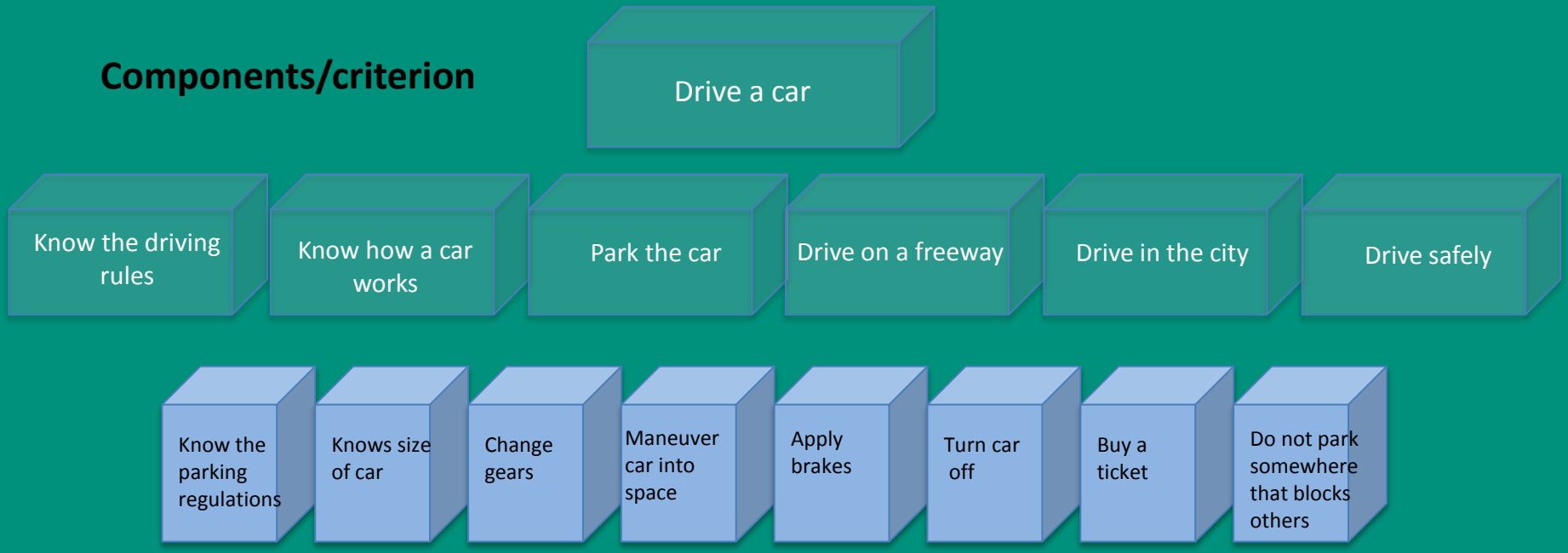
Overarching competency



Core competencies



Components/criterion



Key features of competencies in the mhGAP ToHP training

1. Competencies are considered in terms of knowledge, skills and attitudes.

2. Competencies are the building blocks of teaching and practice.

3. Competencies are **dynamic** and dependent on **context.**

Competencies are dynamic and dependent on context

- People move through stages of competency.
- Competencies can change over time.
- Competencies are dependent on the situation (i.e. role play vs real life).

→ This needs to be considered when developing assessment.

What are the competencies for the mhGAP ToHP training?

	Domain	Competency
1	Attitude	**Promote respect and dignity** for people with MNS conditions
2	Knowledge	**Know common presentations** of priority MNS conditions
3	Knowledge	**Know assessment principles** of MNS conditions
4	Knowledge	**Know management principles** of MNS conditions
5	Skill	**Use effective communication skills** in all interactions with people with MNS condition
6	Skill	**Perform an assessment** for priority MNS conditions
7	Skill	Assess and manage **physical conditions** of people with MNS conditions
8	Skill	Assess and manage **emergency presentations** of priority MNS conditions
9	Skill	Provide **psychosocial interventions** to a person with a priority MNS condition and their carer
10	Skill	Deliver **pharmacological interventions** as needed and appropriate in priority MNS conditions, considering special populations
11	Skill	Plan and perform **follow-ups** for priority MNS conditions
12	Skill	**Refer to specialists and link with outside agencies** for priority MNS conditions, as appropriate and available

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12	Skill	**Refer to specialists and link with outside agencies** for priority MNS conditions, as appropriate and available

	Domain	Competency
1	Attitude	**Promote respect and dignity** for people with depression
2	Knowledge	**Know common presentations** of depression
3	Knowledge	**Know assessment principles** of depression
4	Knowledge	**Know management principles** of depression
5	Skill	**Use effective communication skills** in all interactions with people with depression
6	Skill	**Perform an assessment** for depression
7	Skill	Assess and manage **physical conditions** of people with depression
8	Skill	Assess and manage **emergency presentations** of depression
9	Skill	Provide **psychosocial interventions** to a person with depression and their carer
10	Skill	Deliver **pharmacological interventions** as needed and appropriate in depression, considering special populations
11	Skill	Plan and perform **follow-ups** for depression
12	Skill	**Refer to specialists and link with outside agencies** for depression, as appropriate and available

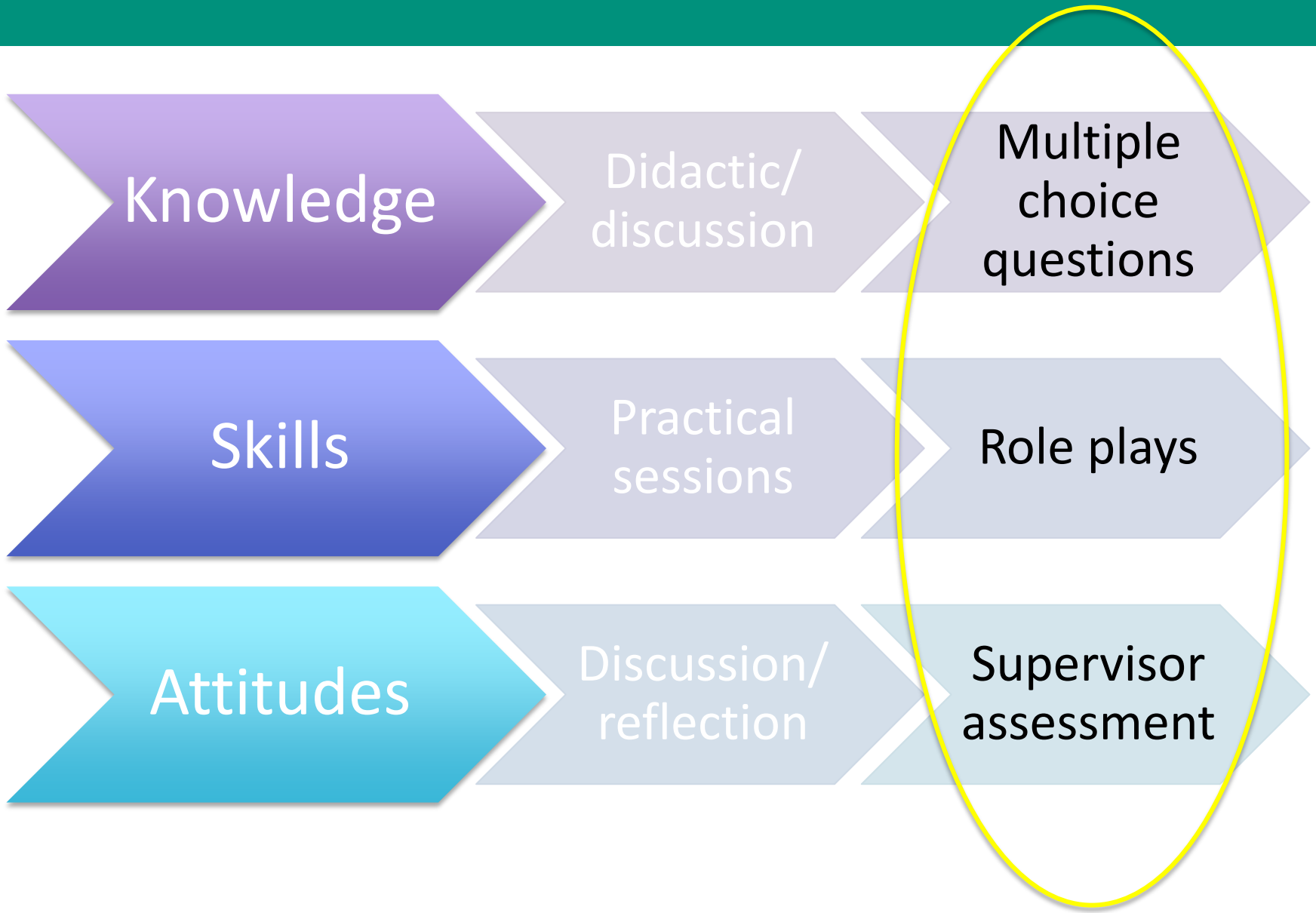
How will we assess the competencies?

Assessment in the mhGAP ToHP training

Specific considerations:

- Pass/fail not appropriate
- Developmental levels not appropriate
- Limited time and other resources
- Focus on feedback and ongoing improvement

Types of assessment



Multiple-choice questions

- Written examinations are a good way to test knowledge
- Well-written MCQs can differentiate between stronger and weaker learners
- Standardized, easy, cost and time-effective

DEP multiple choice questions

1. Which of the following is a core symptom of depression? Choose the best answer:
   - ☐ A Lack of realization that one is having mental health problems.
   - ☐ B Loss of enjoyment in activities that are normally pleasurable.
   - ☐ C Fatigue, sleepiness and abnormal behaviour after having a seizure.
   - ☐ D Using alcohol or other substances.

2. Which of the following is a core symptom of depression? Choose the best answer:
   - ☐ A An attempt to harm oneself
   - ☐ B Delusions or hallucinations.
   - ☐ C Persistent low mood.
   - ☐ D An episode of mania.

3. Which of the following statements concerning depression is correct? Choose the best answer:
   - ☐ A a. It is a common mental health condition.
   - ☐ B It is commonly the sufferer's fault for being weak or lazy.
   - ☐ C It is commonly expected after a bereavement.
   - ☐ D It is commonly caused by drug and alcohol use.

4. Which of the following statements concerning depression is correct? Choose the best answer:
   - ☐ A Depression often presents with multiple persistent physical symptoms with no clear cause.
   - ☐ B Depression often presents with delusions and hallucinations.
   - ☐ C Depression often presents with confusion and disorientation.
   - ☐ D Depression often presents with reduced need for sleep and increased activity

5. Which of the following cluster of symptoms best describes what can occur in depression? Choose only one answer:
   - ☐ A Elevated mood, decreased need for sleep, increased activity, loss of normal social inhibitions.
   - ☐ B Delusions, hearing voices, disorganized thinking, showing signs of neglect.
   - ☐ C Poor appetite, feeling worthless and guilty, having suicidal thoughts.
   - ☐ D Severe forgetfulness and disorientation to place and time, behavioural problems.

6. Which of the following cluster of symptoms best fits with an episode of depression? Choose only one answer:
   - ☐ A Marked behavioural change, agitated or aggressive behaviour, fixed false beliefs.
   - ☐ B Decline in memory, poor orientation, loss of emotional control.
   - ☐ C Inattentive, over-active, aggressive behaviour.
   - ☐ D Low energy, sleep problems, and loss of interest in usual activities.

Role plays

- Can be used for both practising and assessing skills.
- Properties similar to an observed structured clinical examination (OSCE), which can be a reliable method of examination.
- Uses criteria-based assessment to provide feedback on skills.

PSY role plays

Note: Role plays 3 and 4 are additional to those supplied for the activities – for those wanting to extend training.

Role play 1: Assessment

Purpose: To assess a person for possible psychosis.

Duration: 30 minutes or less.

Situation: PERSON SEEKING HELP
- You are Mr Fadel, a man who is homeless and normally stays in a park outside the clinic.
- You already know the health-care provider and you accept to talk to them.
- You are poorly groomed and keep scratching your head.
- You drink excessive amounts of alcohol.
- You are struggling to concentrate on what the person is saying to you and you find it very difficult to answer their questions.
- You start to get quite annoyed and frustrated by their questions.
- When they ask you about hallucinations you don't understand the question and do not give a clear answer but you are hearing a voice. You are hearing a voice that is telling you not to talk to the health-care provider because he wants to harm you.
- You do not believe the voice but the voice is very insistent and you feel the need to tell the voice to "shut up" or "be quiet" at several points during the interview.

Instructions:
You ask for food and money as soon as you enter the room.

Extended version (only read this if instructed by facilitator)

Option 1: After 10 minutes, you start to get very angry with the questions being asked and with this voice that keeps talking to you. You start to yell at the health-care provider, you stand up and start kicking and throwing things. You only settle down when the health-care provider speaks to you calmly and listens to your worries.

Option 2: After about eight minutes of the interview, you clutch your chest and start complaining of chest pain. You remain calm, but it feels as though you are being crushed. **Only if the health-care provider asks**, you let them know that your father died of a heart attack at 47 years old, you have smoked all your life, and you have never been checked for any other health problems before so you do not know about any other conditions. You get this pain occasionally when you are walking up hills.

PSY

Role play 1: Assessment

Purpose: To assess a person for possible psychosis.

Duration: 30 minutes or less.

Situation: HEALTH-CARE PROVIDER

- You are a health-care worker in a clinic.
- Mr Fadel, a person known to you, is homeless and lives under the tree opposite your practice. He has been drinking excessive amounts of alcohol, been seen talking and laughing to himself, and is unkempt and ungroomed.
- You suspect psychosis.
- Assess Mr Fadel according to the psychoses module.

Instructions:

- Mr Fadel will start the conversation.
- At the end, you are to explain to Mr Fadel his diagnosis.

Extended version (only read this if instructed by facilitator)

If there is an extended version, you will get new information from the person seeking help towards the end of the interview.

You may need to revise your assessment based on the new information or focus on additional aspects.

Role play 1: Assessment

Purpose: To assess a person for possible psychosis.

Duration: 30 minutes or less.

Situation: OBSERVER/SUPERVISOR
- You will observe a health-care provider in a clinic
- Mr Fadel, a person known to the health-care provider, is homeless and lives under the tree opposite the practice. He has been drinking excessive amounts of alcohol, been seen talking and laughing to himself, and is unkempt and ungroomed.
- The health-care provider suspects psychosis.
- The health-care provider will assess Mr Fadel according to the psychoses module.

Instructions:
Please keep to time:
- 3 minutes reading
- 15–20 minutes' consultation
- 5–10 minutes for feedback and small group discussion.

Please assess the following competencies:

4. Uses effective communication skills
5. Performs assessment
6. Assesses and manages physical condition **(extended version option 2 only)**
7. Assesses and manages emergency presentation **(extended version option 1 only)**

And grade the level of competency the health-care provider achieves.

Extended version (only read this if instructed by facilitator)

Option 1: After 10 minutes, Mr Fadel will start to get very angry with the questions being asked and with the voice that keeps talking to him. He will start to yell at the health-care provider, stand up and start kicking and throwing things. He will only settle down when the health-care provider speaks calmly and listens to his worries.

Option 2: After about eight minutes of the interview, Mr Fadel will clutch his chest and start complaining of crushing chest pain. **Only if the health-care provider asks,** he will let them know that his father died of a heart attack at 47 years old, that he has smoked all his life, and has never been checked for any other health problems. He gets this pain occasionally when walking up hills.

Competency assessment (Only use competencies which apply to task)	Needs work	Achieved	N/A
1. Promote respect and dignity			
Treat all persons with MNS conditions with respect and dignity in a culturally appropriate manner			
Promote inclusion and collaborative care of people with MNS conditions and their carers			
Protect the confidentiality and consent of people with MNS conditions			
2. Know common presentations			
Know common presentations of priority MNS conditions			
Know other symptoms that may present as part of priority MNS conditions			
3. Know assessment principles			
Name steps of history-taking for an MNS assessment and key features of each: presenting complaint, past MNS history, general health history, family history of MNS conditions, psychosocial history			
Name assessment principles for MNS conditions: physical examination, mental status examination, differential diagnosis, basic laboratory tests, identify the MNS condition			
Name two or three key points under each of the assessment principles for MNS conditions			
4. Know management principles			
Understand importance of integrating care for priority MNS conditions into primary practice			
Name management principles of priority MNS conditions, i.e. develop treatment plan in collaboration, psychosocial interventions, pharmacological interventions when indicated, refer to specialist, appropriate plan for follow-up, work together with carer and families, foster strong links with other services, modify treatment plans for special populations			
Name one or two key points under each of the management principles of priority MNS conditions			
5. Use effective communication skills			
Create an environment that facilitates open communication in priority MNS conditions			
Involve the person, and their carer when appropriate, in all aspects of assessment and management of priority MNS conditions			
Actively listen to the person with an MNS condition			
Is friendly, respectful and non-judgemental at all times in interactions with a per-son with an MNS condition			
Use good verbal communication skills in interactions with a person with an MNS condition			
Respond with sensitivity when people with MNS condition disclose difficult expe-riences			
6. Perform assessment			
Perform an MNS assessment using history-taking, including: presenting complaint, past MNS history, general health history, family history of MNS conditions and psychosocial history			
Consider and exclude other conditions to priority MNS conditions			
Perform collateral assessment (i.e. carer, school), as appropriate, in priority MNS conditions			
Consider other concurrent conditions, both MNS and physical conditions			
7. Assess and manage physical conditions			
Understand importance of assessing physical health in assessment for priority MNS conditions			
Take a detailed history of physical health, including asking about physical risk factors, in priority MNS conditions			
Perform a physical examination and investigations for priority MNS conditions, as appropriate and available			
Manage physical health conditions and risk factors or refer to specialist if needed in people with MNS conditions			

Competency assessment (Only use competencies which apply to task)	Needs work	Achieved	N/A
8. Assess and manage emergency presentations			
Recognize emergency presentations of priority MNS conditions			
Perform emergency assessment of priority MNS conditions, including risk-assessment			
Manage emergency presentation of priority MNS conditions using non-pharmacological interventions			
Manage emergency presentation of priority MNS conditions using pharmacological interventions, as appropriate and available			
9. Provide psychosocial interventions			
Perform psychoeducation, including about the priority MNS condition and treatment available			
Address current psychosocial stressors to reduce stress and strength social supports, as appropriate for the priority MNS condition			
Promote functioning in daily activities, as appropriate to the priority MNS conditions			
Involve carer and others in psychosocial intervention for priority MNS conditions, as appropriate			
Recognize role of other psychological treatments in priority MNS conditions, and either provide or refer on, as appropriate, (i.e. brief psychological treatments for depression; specific advice regarding child and adolescent mental and behavioural disorders; interventions to improve cognitive functioning in dementia; motivational interviewing in disorders of substance use; relaxation training in other significant mental health complaints)			
10. Deliver pharmacological interventions as needed and appropriate			
Identify if there is a need for medication in priority MNS conditions			
Work collaboratively with person with priority MNS condition to educate them about risks and benefits of treatment, potential side-effects, duration of treatment, and importance of adherence			
Select and prescribes medication for priority MNS conditions (if has prescribing rights), as appropriate and available			
Consider needs of special populations when prescribing for priority MNS conditions			
Follow-up medications for priority MNS conditions, including monitoring for side-effects and adherence, considering special populations, and knowing when medications can be safely reduced and/or stopped			
11. Plan and perform follow-up			
Understand importance of follow-up for priority MNS conditions			
Know when and how to plan for follow-up for priority MNS conditions			
Perform a follow-up assessment for priority MNS conditions, determining management dependent on progress of priority MNS condition			
Manage crisis presentations and deviations from treatment plan in priority MNS conditions			
12. Refer to specialist and link with outside agencies			
Know when to refer to a specialist at any stage of assessment or management of a priority MNS condition, as appropriate and available			
Link with other services and outside agencies for priority MNS conditions, as appropriate and available			

OVERALL
Areas of strength:
Areas for improvement:

Supervisor assessment

- Uses a longer period of observation to assess attitude.
- Whilst providing feedback on attitude, can also give feedback on knowledge and skills.
- The same assessment form can be used for role plays, final feedback and workplace-based assessment.
- Be honest with feedback and give as much detail as possible.

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Work collaboratively with person with priority MNS condition to educate them about risks and benefits of treatment, potential side-effects, duration of treatment, and importance of adherence			
Select and prescribes medication for priority MNS conditions (if has prescribing rights), as appropriate and available			
Consider needs of special populations when prescribing for priority MNS conditions			
Follow-up medications for priority MNS conditions, including monitoring for side-effects and adherence, considering special populations, and knowing when medications can be safely reduced and/or stopped			
11. Plan and perform follow-up			
Understand importance of follow-up for priority MNS conditions			
Know when and how to plan for follow-up for priority MNS conditions			
Perform a follow-up assessment for priority MNS conditions, determining management dependent on progress of priority MNS condition			
Manage crisis presentations and deviations from treatment plan in priority MNS conditions			
12. Refer to specialist and link with outside agencies			
Know when to refer to a specialist at any stage of assessment or management of a priority MNS condition, as appropriate and available			
Link with other services and outside agencies for priority MNS conditions, as appropriate and available			

OVERALL

Areas of strength:

Areas for improvement:

Competency assessment (Only use competencies which apply to task)	Needs work	Achieved	N/A
1. Promote respect and dignity			
Treat all persons with MNS conditions with respect and dignity in a culturally appropriate manner			
Promote inclusion and collaborative care of people with MNS conditions and their carers			
Protect the confidentiality and consent of people with MNS conditions			
2. Know common presentations			
Know common presentations of priority MNS conditions			
Know other symptoms that may present as part of priority MNS conditions			
3. Know assessment principles			
Name steps of history-taking for an MNS assessment and key features of each: presenting complaint, past MNS history, general health history, family history of MNS conditions, psychosocial history			
Name assessment principles for MNS conditions: physical examination, mental status examination, differential diagnosis, basic laboratory tests, identify the MNS condition			
Name two or three key points under each of the assessment principles for MNS conditions			
4. Know management principles			
Understand importance of integrating care for priority MNS conditions into primary practice			
Name management principles of priority MNS conditions, i.e. develop treatment plan in collaboration, psychosocial interventions, pharmacological interventions when indicated, refer to specialist, appropriate plan for follow-up, work together with carer and families, foster strong links with other services, modify treatment plans for special populations			
Name one or two key points under each of the management principles of priority MNS conditions			
5. Use effective communication skills			
Create an environment that facilitates open communication in priority MNS conditions			
Involve the person, and their carer when appropriate, in all aspects of assessment and management of priority MNS conditions			
Actively listen to the person with an MNS condition			
Is friendly, respectful and non-judgemental at all times in interactions with a per-son with an MNS condition			
Use good verbal communication skills in interactions with a person with an MNS condition			
Respond with sensitivity when people with MNS condition disclose difficult expe-riences			
6. Perform assessment			
Perform an MNS assessment using history-taking, including: presenting complaint, past MNS history, general health history, family history of MNS conditions and psychosocial history			
Consider and exclude other conditions to priority MNS conditions			
Perform collateral assessment (i.e. carer, school), as appropriate, in priority MNS conditions			
Consider other concurrent conditions, both MNS and physical conditions			
7. Assess and manage physical conditions			
Understand importance of assessing physical health in assessment for priority MNS conditions			
Take a detailed history of physical health, including asking about physical risk factors, in priority MNS conditions			
Perform a physical examination and investigations for priority MNS conditions, as appropriate and available			
Manage physical health conditions and risk factors or refer to specialist if needed in people with MNS conditions			

Competency assessment (Only use competencies which apply to task)	Needs work	Achieved	N/A
8. Assess and manage emergency presentations			
Recognize emergency presentations of priority MNS conditions			
Perform emergency assessment of priority MNS conditions, including risk-assessment			
Manage emergency presentation of priority MNS conditions using non-pharmacological interventions			
Manage emergency presentation of priority MNS conditions using pharmacological interventions, as appropriate and available			
9. Provide psychosocial interventions			
Perform psychoeducation, including about the priority MNS condition and treatment available			
Address current psychosocial stressors to reduce stress and strength social supports, as appropriate for the priority MNS condition			
Promote functioning in daily activities, as appropriate to the priority MNS conditions			
Involve carer and others in psychosocial intervention for priority MNS conditions, as appropriate			
Recognize role of other psychological treatments in priority MNS conditions, and either provide or refer on, as appropriate, (i.e. brief psychological treatments for depression; specific advice regarding child and adolescent mental and behavioural disorders; interventions to improve cognitive functioning in dementia; motivational interviewing in disorders of substance use; relaxation training in other significant mental health complaints)			
10. Deliver pharmacological interventions as needed and appropriate			
Identify if there is a need for medication in priority MNS conditions			
Work collaboratively with person with priority MNS condition to educate them about risks and benefits of treatment, potential side-effects, duration of treatment, and importance of adherence			
Select and prescribes medication for priority MNS conditions (if has prescribing rights), as appropriate and available			
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OVERALL
Areas of strength:
Areas for improvement:

Activity

Role plays…with a twist

- Divide into groups of four.
- Each group will be given a role play that assesses a different skill competency.
- One person will play the person seeking help.
- One person will play the “health-care provider”, who will be given a special instruction on how to act their part.
- There will be two people, each separately playing the observer:
  - Two people will use competencies to mark the role play

- At the end, the two observers should practise providing feedback to the health-care provider, and the group should discuss the use of the competencies in assessment.

Reflection

- How was it to assess without the competencies?
- How was it to assess with the competencies?
- How was it to provide direct feedback?
- Other reflections?

Close

- Competencies comprise of **knowledge, skills and attitude**
- They are **building blocks** of teaching and practice
- They are **dynamic** and dependent on **context**
- **Assessment** of competencies involves discussing strengths and areas for improvement

Participant Training Exercise

Supervision:
Theory and technique

What is supervision?

In pairs, discuss:

- The definition and purpose of supervision
- Your own experiences with supervision, both good and bad.

(five minutes)

Share your thoughts with the group.

(10 minutes)

What is supervision?

- Supervision is a source of guidance for developing an individual's skills and abilities and helping them perform better in their clinical practice.

- A place to discuss challenging clinical cases as well as administrative and programmatic issues, problem solve, find solutions and set realistic goals.

What is supervision?

- Multiple definitions/types/models, but essential components are:
  - Two or more people
  - Case assessed/treated/followed-up and/or presented by a supervisee
  - Observation and/or review, discussion, feedback +/-training by supervisor

Why is supervision important?

- One-off training without supervision is unlikely to change practice.

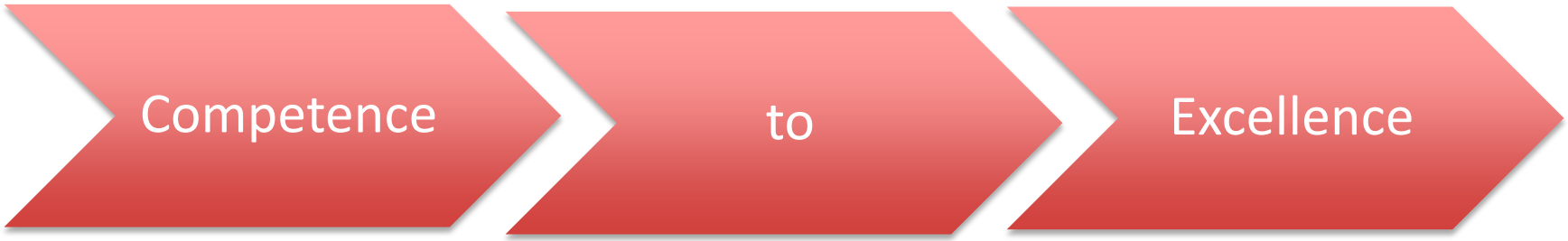
- Supervision should be seen as an essential, non-negotiable and ongoing component of mhGAP-IG implementation.

Goals of supervision

Post-training supervision has the following goals:

- **Clinical:** Ensures fidelity with mhGAP-IG and upskills supervisees.
- **Administrative:** Ensures documentation, record-keeping and processes are all adequate. Starts to identify future trainers to ensure sustainability.
- **Personal growth and support:** Ensures self-care and motivation are maintained, reduces stress and burnout.

Aim of support and supervision



How do we achieve these goals?

- **Direct observation:** Supervisee is observed in vivo as they perform assessment/treatment/follow-up.
- **Indirect observation:** Supervisee is observed at a later time via audio or video-recording as they perform assessment/treatment/follow-up.
- **Case presentation/discussions:** Supervisee brings key aspects of cases/workload for presentation and discussion.

Supervision styles

- Every supervisor will have their own style, but they will need to adapt to their supervisee's needs:
  - **Authoritative:** A more directive style. Useful for explicit advice or direction, challenging inappropriate behaviour or repeatedly poor clinical management.
  - **Facilitative:** More supportive and cathartic. Useful for self-reflection, validation and support.

Supervision techniques

Coaching	Guidance	Problem-solving
Collaboration	Handouts	Prompts
Confidence-building	Instruction	Reflection
Discussion	Listening	Rehearsal of skills/role plays
Encouragement	Modeling	Reinforcement
Explanation	Monitoring + evaluation	Self-disclosure (limited)
Feedback	Observation	Specific skills training
Formulating	Question + answer sessions	Summarizing
Goal-setting	Praise	Support

Features of poor supervision

Arrogant or self-interested	Focuses on administrative issues	Too busy, cancels sessions or unavailable
Avoids difficult or challenging issues	Inadequate attitude, knowledge or skills	Too directive, does not explore or allow self-reflection
Becomes a therapist to supervisee	Inadequate structure to each supervision session	Too hierarchical
Competitive	Insists supervisee work exactly like them	Unethical supervisory behaviour, does not maintain boundaries
Does not permit autonomy	Overly critical	Vague, distracted or disinterested
Does not provide feedback	Sets unrealistic or unclear goals	Vague or unclear guidance or feedback

Activity: Demonstration

Master trainer demonstration

Features of good supervision

Accessible and punctual	Directive when needed	Negotiates clear contract and structure at the start and maintains this
Addresses any problems in supervision	Emphasis on comprehension rather than recall	Opportunities for direct observation
Available to deal with crisis	Encourages greater autonomy as supervision progresses	Opportunities for practise and problem-solving
Clear questions and answers	Enthusiastic, dynamic, interested	Provides constructive feedback
Clear methods of governance	Flexible and adaptive	Provides specific skills training
Competent clinician	Focuses on specific examples	Respectful empathic, validating
Creates a nurturing, supportive climate that facilitates open disclosure	Identifies supervisee's strengths and weaknesses and develops goals	Seeks opportunities for feedback and evaluation on supervision
Develops trust and a good alliance	Maintains boundaries	

Activity: Role plays

In pairs:

- One person plays the role of supervisor
- One person plays the role of supervisee.

Activity: Role plays

As a group:

- Ask supervisors which techniques, styles and features of good supervision they tried to use.
- Ask supervisees which aspects of the supervision worked well for addressing the challenges they faced.

(10 minutes)

Supervisor skill set

- Supervisors should be any of the following:
  - A specialist in MNS disorders (psychiatrist, neurologist, psychiatric nurse)
  - A general health-care provider trained and practised in mhGAP-IG
  - A locally recognized/employed supervisor with skills in mhGAP-IG.
- When choosing supervisors, consider that the best supervisors are normally enthusiastic, dynamic, interested and competent clinicians.

Supporting supervisors

- Supervisors can face a number of challenges in performing good supervision. Consider things you can do to support them:
  - Incentives or remuneration
  - Reducing other tasks or clinical time
  - Supervisor training or refresher course, or access to their own supervision
  - Ensure supervisees are punctual, prepared, and ready to participate
  - ???

Take-home messages

- Supervision is an essential component of the mhGAP ToHP training and implementation.
- Supervision can address clinical, administrative and personal growth and support issues.
- Good supervisors are usually interested, enthusiastic, competent clinicians, who use multiple techniques and adjust their style to suit the supervisee.
- Good supervisors need support.

Supervision – practical

Activity: Barriers to supervision

As a group, discuss the different barriers that will exist when performing supervision in your area.

Document these on a white/blackboard or large piece of paper.

(10 minutes)

Barriers to supervision

Supervisee

- Lack of time
- Unmotivated
- Unprepared
- Unfamiliar with supervision principles
- Difficulties in supervision relationship

Supervisor

- Lack of time
- Unmotivated, no incentives
- Lacks clinical competence
- Does not match style to supervisee
- Difficulties in supervision relationship

System

- Lack of time allocated to supervision
- Lack of space available for supervision
- Lack of recognition of importance of supervision
- Clinical and academic matters take priority

Overcoming barriers to supervision

- For the mhGAP ToHP training, four different models of supervision have been suggested, although multiple modalities can be used if needed.
- Each supervision modality can be done as a pair or a group.
- Planning and preparing for a supervision, particularly putting aside regular time, allows for the best chance of success.
- Consider what training, incentives and support can be offered to supervisees and supervisors to help facilitate regular supervision.

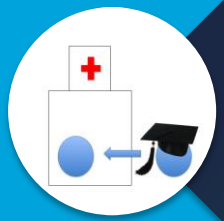
Models of supervision for mhGAP-IG Version 2.0

Apprenticeship Model

Supervisee does a 'placement' with supervisor for a set period of time (normally weeks to months).

Supervisee initially observes supervisor consultations, and is encouraged to interpret clinical information and ask questions.

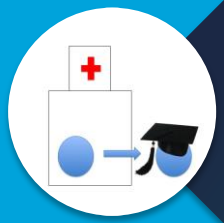
Supervisor then performs direct clinical observation of supervisee performing clinical review, and also provides discussion and de-brief, and feedback.



On-site Supervision

Supervisor performs regular, scheduled, on-site visits to the supervisee/s.

Supervisor performs clinical observations of supervisee, reviews patient documentation, holds de-briefing sessions, evaluates clinic implementation of mhGAP-IG, addresses clinical challenges.

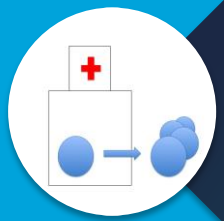


Case conference Supervision

Supervisor meets regularly with supervisee/s.

Supervisor usually does not perform direct clinical observation, but uses other supervision interventions, including indirect observation (listening to recordings), case discussion, instruction or teaching, feedback, goal-setting, reflection etc.

Can be performed as face-to-face (preferred) or remote.



Peer Supervision

A possible solution when no supervisor is available.

Supervisees form small groups (ideally >3 people), determine structure and function, and appoint or rotate a 'leader' who will ensure the group stays on task.

Can be performed as face-to-face (preferred) or remote.

Greater resources, likely to be more effective

Fewer resources required, less evidence about efficacy

Apprenticeship model

- Supervisee/s does a placement with supervisor for set period of time (weeks to months).
- Supervisee/s initially observe/s supervisor consultations, whilst interpreting clinical information and asking questions.
- Supervisee/s later start/s performing clinical reviews under direct observation, followed by discussion, debrief and feedback.

Apprenticeship model

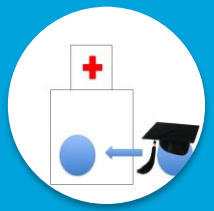
Advantages	Disadvantages	Formats available			
		One-on-one	Small group	Large group	Distance
• Effective • Opportunity for role modeling • "Real-life" experience before autonomous practice • Direct observation • Immediate feedback • Early detection of non-normative practice	• Most resource intensive method • Considerable supervisor time and effort • Supervisee/s will need to be released from usual duties for a set period of time • Requires patient consent	✔	✔		

Apprenticeship model

Case study

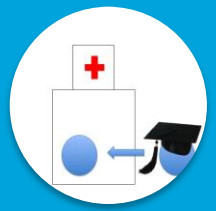
Training was provided on mental health and psychosocial support to community mental health-care providers and leaders, some non-medical, in rural Haiti, over three days. Following the training, three highly motivated participants undertook an “apprenticeship approach”, which included one week of observing a licensed counsellor conduct one to two counselling sessions/day, then another week where the supervisee could practise counselling skills in supervised sessions, followed by debriefing and problem-solving.

Two years after the training, all three “apprentices” were still involved in providing mental health support and referrals. Those who received the training without the “apprenticeship” or any other supervision had not provided any treatment or referrals for an individual with a mental health need.



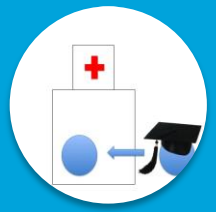
On-site supervision

- Supervisor performs regular, scheduled, visits to the supervisee/s' workplace.
- Supervisor performs direct observation of supervisee, reviews documentation, holds debriefing sessions, evaluates service implementation of mhGAP-IG.
- Supervisor addresses clinical and administrative challenges and provides general support.



On-site supervision

Advantages	Disadvantages	Formats available			
		One-on-one	Small group	Large group	Distance
• Effective • Direct observation • Immediate feedback • Early detection of non-normative practice • Ability to assess service implementation of mhGAP-IG	• More resource-intensive then other methods • Supervisor will need to be released from usual duties to attend workplace • Supervisee/s will need to be released from usual duties for several hours • Requires patient consent	✔	✔		

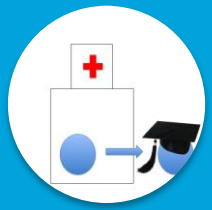


On-site supervision

Case study

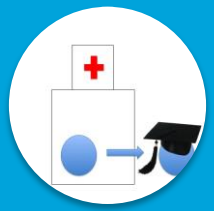
In Osun state in Nigeria, mhGAP-IG training was provided on depression, psychosis, epilepsy and alcohol use disorder, to 198 primary care workers. Following training, supervision consisted of regular clinic visits to perform direct clinical observation, review patients' clinical notes, and hold debriefing sessions with clinical staff. These sessions helped share experiences and address emerging clinical challenges. Supervision was performed by the course facilitators, but with support from mental health specialists who attended less frequently but also contributed to addressing any challenges.

These sessions were clearly structured to ensure quality of supervision was high and effective. All activities sought to reinforce skills acquired during training and ensure fidelity with mhGAP guidelines. Evaluation scores at the end of nine months showed that whilst there was a drop from immediate post-baseline knowledge and skills, they still remained higher than baseline.



Case conference supervision

- Supervisor meets regularly with supervisee/s.
- Does not involve direct observation, but instead utilizes indirect observation (audio or video-recordings) or case discussion.
- Also involves debrief, feedback and other supervision techniques.



Case conference supervision

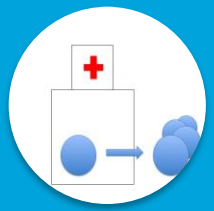
Advantages	Disadvantages	Formats available			
		One-on-one	Small group	Large group	Distance
• Likely to be effective • Less resource-intensive • Flexible, efficient, can be done out of hours and workplace • Can be done distance and by larger groups • Can be used in emergency situations	• No opportunities for direct supervision • Personal reporting of cases can be inaccurate • Less opportunity to detect non-normative practice	✔	✔	✔	✔

Case conference supervision

Case study

One month after the Nepal earthquake of 2015, mental health and psychosocial support clusters began to coordinate the activity of multiple partners involved in the response. Around 500 primary care doctors and paramedics were trained in mhGAP-HIG (mhHAP-Humanitarian Intervention Guide).

Following the training, the health-care providers received monthly case conference supervision. The primary care doctors reported increased competence in diagnosing and managing common mental disorders, and in identifying and managing risk of suicide. Overall, the intervention in Nepal was felt to be a success.

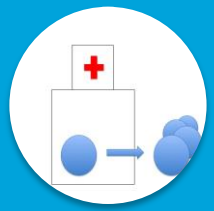


Peer supervision

- Supervisees form groups (ideally three to six) and provide support and advice to each other on practice, using indirect observation or case discussion. Also provides administrative and personal support.

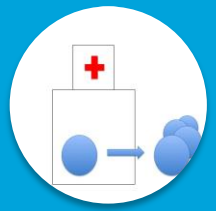
- Usually involves appointing or rotating a leader, determining structure and function, and ensuring the group stays on task.

- Ideally, an outside supervisor visits every three to six months, or as frequently as is possible, to ensure fidelity to mhGAP-IG.



Peer supervision

Advantages	Disadvantages	Formats available			
		One-on-one	Small group	Large group	Distance
• Low resource • Acceptable to supervisees • Likely to offer good personal support, motivation and encouragement • Suitable for distance and larger groups	• Less evidence for effectiveness • No opportunity for direct supervision • Personal reporting of cases can be inaccurate • Less opportunity to detect non-normative practice, and risk of spread within group		✔	✔	✔



Peer supervision

Case study

In Goa, India, in 2013, lay therapists were taught psychological treatments for alcohol use and depression in a three-week workshop, followed by weekly expert-led supervision for four months. Following this, the groups transitioned to peer supervision, where one peer (chosen in rotation), performed the tasks of moderating the group. Individual audio-recorded sessions were listened to in full, then rated by each peer. Ratings were then discussed and feedback provided by all group members.

The lay therapists expressed more positive perspectives towards peer-led supervision as compared with expert-led supervision, including that it bolstered self-esteem and created a positive learning environment, as well as putting an emphasis on equality and participation. The lay therapists felt that moderating the sessions helped them to empathize with the challenges of being a supervisor. This study confirmed previous studies' support for peer-led supervision.

Preparing for supervision

Regardless of which model you choose, consider the following areas when preparing for supervision in your area:

- Who?
- What?
- When?
- Where?
- How?

Preparing for supervision – who?

Who will be the supervisor?

- Ideally a mental health specialist or trainer.
- Can also use peers or non-specialist health-care providers with experience using mhGAP-IG.
- The best supervisors are enthusiastic, interested, accessible and competent clinicians.

Who will be the supervisees?

- The smaller the group the better supervision is likely to be.
- Consider practicalities such as availability and location when choosing people in your group.

Preparing for supervision – what?

What type of supervision group will you have?

- Choose from:
  - Apprenticeship model
  - On-site supervision
  - Case conference supervision
  - Peer supervision
- Determining what type of group you will have is dependent on resources and settings.
- Where resources permit, supervision that allows for direct observation should be encouraged. However, in low-resource settings, providing supervision through case conference or peer supervision is still better than no supervision at all.
- You can utilize multiple supervision models, or progress from a more intensive to a less intensive model.

Preparing for supervision – when?

When will supervision occur?

- Consider issues of frequency and duration.
- Supervision should be at least monthly at the start. Aim for as much supervision as resources will allow.
- Supervision sessions generally last one to three hours, but may be longer if there is direct observation or a site visit.

Preparing for supervision – where?

Where will supervision occur? Consider issues around location:

- What is the most practical location for the most people?
- Will location remain constant or rotate?
- Is space available for direct observation or large groups?
- Will supervision need to occur by distance?

Preparing for supervision – how?

How will supervision take place?

- Supervision session structure and agenda should be predetermined and adhered to.
- Use multiple interventions in supervision, including direct observation, instruction, demonstration, role play, discussion and reflection. If there is no capacity to perform direct observation, consider indirect observation through videoed or taped sessions.

How will the group function?

- Develop contracts and agreements for how each group's supervision will run. This includes considering criteria for membership, how feedback will be given, and the session structure.
- For peer supervision groups, a leader should be determined to ensure that the structure is maintained.
- Consider how fidelity to mhGAP-IG will be maintained, and how progress and success will be monitored.
- Proformas have been designed to help perform supervision

Difficult case report

Facility:	Supervisee name:
Date:	Supervisor name:

Case details

History

Current situation/problem

Your assessment and management plan (consider psychosocial and pharmacological interventions)

Points you want to discuss

Suggestions from supervisor or peers (consider psychosocial and pharmacological interventions)

Next steps

Supervision report and feedback

Facility:

Supervisee name:

Date:

Supervisor name:

Clinical feedback

Strengths (e.g. attitude, knowledge, communication, assessment, interventions, referrals, follow-up)

Areas for improvement

Administrative/programmatic feedback

Strengths (e.g. processes, supplies, staffing)

Areas for improvement

Personal reflection

Facility:	Supervisee name:
Date:	Supervisor name:

Please complete the following every three to six months, then discuss with supervisor

Personal strengths

Areas for development

Administrative or other challenges

Future plans (to be filled in with supervisor)

Competency assessment (Only use competencies which apply to task)	Needs work	Achieved	N/A
1. Promote respect and dignity			
Treat all persons with MNS conditions with respect and dignity in a culturally appropriate manner			
Promote inclusion and collaborative care of people with MNS conditions and their carers			
Protect the confidentiality and consent of people with MNS conditions			
2. Know common presentations			
Know common presentations of priority MNS conditions			
Know other symptoms that may present as part of priority MNS conditions			
3. Know assessment principles			
Name steps of history-taking for an MNS assessment and key features of each: presenting complaint, past MNS history, general health history, family history of MNS conditions, psychosocial history			
Name assessment principles for MNS conditions: physical examination, mental status examination, differential diagnosis, basic laboratory tests, identify the MNS condition			
Name two or three key points under each of the assessment principles for MNS conditions			
4. Know management principles			
Understand importance of integrating care for priority MNS conditions into primary practice			
Name management principles of priority MNS conditions, i.e. develop treatment plan in collaboration, psychosocial interventions, pharmacological interventions when indicated, refer to specialist, appropriate plan for follow-up, work together with carer and families, foster strong links with other services, modify treatment plans for special populations			
Name one or two key points under each of the management principles of priority MNS conditions			
5. Use effective communication skills			
Create an environment that facilitates open communication in priority MNS conditions			
Involve the person, and their carer when appropriate, in all aspects of assessment and management of priority MNS conditions			
Actively listen to the person with an MNS condition			
Is friendly, respectful and non-judgemental at all times in interactions with a per-son with an MNS condition			
Use good verbal communication skills in interactions with a person with an MNS condition			
Respond with sensitivity when people with MNS condition disclose difficult expe-riences			
6. Perform assessment			
Perform an MNS assessment using history-taking, including: presenting complaint, past MNS history, general health history, family history of MNS conditions and psychosocial history			
Consider and exclude other conditions to priority MNS conditions			
Perform collateral assessment (i.e. carer, school), as appropriate, in priority MNS conditions			
Consider other concurrent conditions, both MNS and physical conditions			
7. Assess and manage physical conditions			
Understand importance of assessing physical health in assessment for priority MNS conditions			
Take a detailed history of physical health, including asking about physical risk factors, in priority MNS conditions			
Perform a physical examination and investigations for priority MNS conditions, as appropriate and available			
Manage physical health conditions and risk factors or refer to specialist if needed in people with MNS conditions			

Competency assessment (Only use competencies which apply to task)	Needs work	Achieved	N/A
8. Assess and manage emergency presentations			
Recognize emergency presentations of priority MNS conditions			
Perform emergency assessment of priority MNS conditions, including risk-assessment			
Manage emergency presentation of priority MNS conditions using non-pharmacological interventions			
Manage emergency presentation of priority MNS conditions using pharmacological interventions, as appropriate and available			
9. Provide psychosocial interventions			
Perform psychoeducation, including about the priority MNS condition and treatment available			
Address current psychosocial stressors to reduce stress and strength social supports, as appropriate for the priority MNS condition			
Promote functioning in daily activities, as appropriate to the priority MNS conditions			
Involve carer and others in psychosocial intervention for priority MNS conditions, as appropriate			
Recognize role of other psychological treatments in priority MNS conditions, and either provide or refer on, as appropriate, (i.e. brief psychological treatments for depression; specific advice regarding child and adolescent mental and behavioural disorders; interventions to improve cognitive functioning in dementia; motivational interviewing in disorders of substance use; relaxation training in other significant mental health complaints)			
10. Deliver pharmacological interventions as needed and appropriate			
Identify if there is a need for medication in priority MNS conditions			
Work collaboratively with person with priority MNS condition to educate them about risks and benefits of treatment, potential side-effects, duration of treatment, and importance of adherence			
Select and prescribes medication for priority MNS conditions (if has prescribing rights), as appropriate and available			
Consider needs of special populations when prescribing for priority MNS conditions			
Follow-up medications for priority MNS conditions, including monitoring for side-effects and adherence, considering special populations, and knowing when medications can be safely reduced and/or stopped			
11. Plan and perform follow-up			
Understand importance of follow-up for priority MNS conditions			
Know when and how to plan for follow-up for priority MNS conditions			
Perform a follow-up assessment for priority MNS conditions, determining management dependent on progress of priority MNS condition			
Manage crisis presentations and deviations from treatment plan in priority MNS conditions			
12. Refer to specialist and link with outside agencies			
Know when to refer to a specialist at any stage of assessment or management of a priority MNS condition, as appropriate and available			
Link with other services and outside agencies for priority MNS conditions, as appropriate and available			

OVERALL

Areas of strength:

Areas for improvement:

Which forms when?

	Apprenticeship model	On-site supervision	Case conference supervision	Peer supervision
Difficult case report form		✔	✔	✔
Supervision report and feedback form	✔	✔	✔ (supervisors may wish to use this form to give feedback)	
Personal reflection form	✔ (every three to six months)	✔ (every three to six months)	✔ (every three to six months)	✔ (every three to six months, can be done for own reflection)
Competency assessment form	✔	✔		

Evaluation of supervision

- The supervisor or allocated group leader will take brief notes on each session, including attendance and de-identified case summaries. Each supervisee should also keep their own de-identified case notes and any assessment sheets completed during direct observation. These can be audited by local trainers and implementation coordinators to:
  - Ensure supervision is occurring and functioning appropriately.
  - Ensure assessment and management of priority MNS conditions remains adherent to mhGAP-IG guidelines.
  - Provide feedback when planning future training programmes on which modules/presentations seem to present the greatest challenges.

- Individual supervision groups are encouraged to periodically invite an outside supervisor to observe their group and provide feedback.

Activity: Supervision in your area

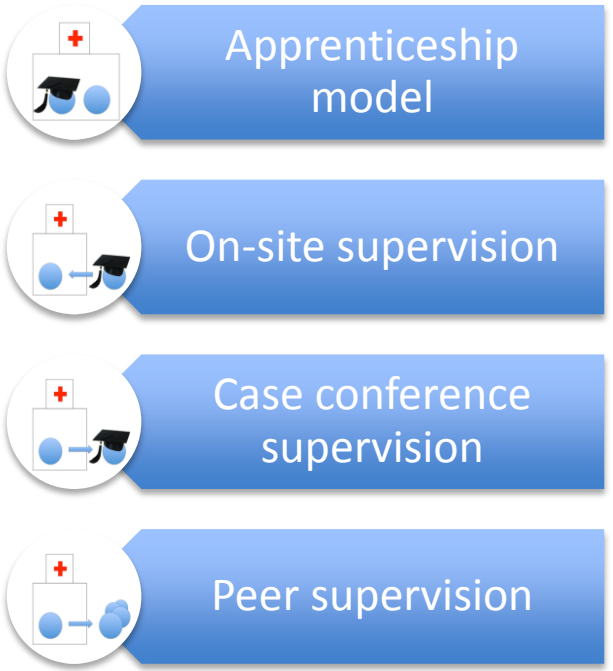
With other participants from your service or area, start preparing for supervision in your area considering:

- Who?
- What?
- When?
- Where?
- How?

(15 minutes)

Present your findings to the group and provide your rationale.

(30 minutes for everyone; three to five minutes/group)



Take-home messages

- Supervision is an essential component of mhGAP ToHP training and implementation.
- There are models of supervision to suit every service and context.
- As a trainer, consider how you can support local supervision.
- You now have a plan for supervision in your area – use it!