World Health Organization

Psychological interventions implementation manual

Integrating evidence-based psychological interventions into existing services

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Psychological interventions implementation manual: integrating evidence-based psychological interventions into existing services
ISBN 978-92-4-008714-9 (electronic version)
ISBN 978-92-4-008715-6 (print version)

Graphic design and layout. Café.art.br

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Preface

In all countries, mental health conditions are highly prevalent and cause immense suffering. Most people who experience mental health conditions, including common conditions such as depression and anxiety, cannot access effective care and go untreated.

To reduce the vast care gap and progress towards universal health coverage, health and social care planners and practitioners increasingly deploy evidence-based psychological interventions to scale up options for care. The emphasis here is not conventional psychotherapy delivered by specialists but rather manualized psychological interventions that can be delivered by trained and supervised non-specialists and are more likely to be scalable.

The number of psychological intervention manuals that are proven to work in low-, middle- and high-income settings has grown rapidly in the last two decades. A next step is to increase their actual availability, reach and impact so that more people can benefit from them. Psychological intervention manuals give instructions on how to deliver the intervention but do not typically include guidance on how to design and deliver services that offer psychological interventions.

This implementation manual aims to fill that gap. It offers planners and service managers practical guidance on how to make available and implement psychological interventions by integrating them within existing health, social, protection or education services.

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Financial support

Bureau for Humanitarian Assistance (BHA), USAID; Deutsche Gesellschaft für Internationale Zusammenarbeit GmbH (GIZ).

Abbreviations

CBT	cognitive behavioural therapy
CETA	Common Elements Treatment Approach
CIDT	Community Informant Detection Tool
CST	Caregivers Skills Training
EASE	Early Adolescent Skills for Emotions
EQUIP	Ensuring Quality in Psychological Support
IASC	Inter-Agency Standing Committee
IPT	interpersonal therapy
LMICs	low- and middle-income countries
M&E	monitoring and evaluation
mhGAP	WHO's Mental Health Gap Action Programme
MHPSS	mental health and psychosocial support
PM+	Problem Management Plus
PTSD	post-traumatic stress disorder
SH+	Self-Help Plus
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WHO	World Health Organization

1

Introduction

KEY MESSAGES

- Evidence-based psychological interventions to treat mental health conditions can help address the mental health care gap that exists in all countries.
- Many manualized psychological interventions have good evidence for effectiveness in different settings and with different target populations, including in low- and middle-income countries (LMICs).
- This manual provides practical guidance on how to implement evidence-based, manualized psychological interventions and make them more widely available by integrating them within existing health, social, protection or education services.

1.1 Background

In all countries, mental health conditions[1] are highly prevalent. In 2019, around one in eight people in the world lived with a mental disorder (*1*). These conditions are the leading cause of years lived with disability (*2*). The economic consequences of mental health conditions are enormous, with productivity losses and other indirect costs to society often far outstripping health care costs (*2*).

Most people who experience mental health conditions, including common conditions such as depression and anxiety, do not receive treatment. This may be because mental health services are not available, lack capacity, are inaccessible or unaffordable; or because stigma stops people from seeking help (*2*).

The high prevalence and vast treatment gap for common mental health conditions mean that countries need to diversify and scale up options for care if they are to move towards universal health coverage. To this end an important strategy is to add evidence-based psychological interventions to existing services, such as health (including mental health) services, social care, protection services, and psychological services at schools and universities (see Box 2.1 Why implement psychological interventions?).

Evidence-based psychological intervention manuals for mental health conditions are informed by and make intentional use of techniques from established psychological treatments such as behavioural activation, stress management, problem-solving therapy, cognitive behavioural therapy (CBT) and interpersonal therapy (IPT).

Traditionally, psychological interventions are delivered in person, by trained specialists. But there is now significant evidence to show that briefer, manualized versions of psychological interventions can also be effectively delivered by trained and supervised non-specialists, either face-to-face or remotely, including in LMICs (*3*). People with a wide range of mental

[1] The term "mental health condition" includes mental disorders and psychosocial disabilities. It also covers other mental states associated with significant distress, impairment in functioning, or risk of self-harm.

health conditions – including those experiencing subclinical symptoms as well as those with diagnosed conditions – have been shown to benefit from these types of psychological interventions (*3*,*4*). Adding them to services has been shown to improve outcomes for people with depression and anxiety (*2*).

Experience further shows that psychological interventions can be added to a service in many innovative ways to greatly increase access. For example, they may be delivered within primary health care (e.g. through collaborative care, see section 2.7.1 Collaborative care), as stepped care (e.g. by providing different interventions depending on need, see section 2.7.2 Stepped care) or as remote care (e.g. by providing a psychological intervention over the telephone, see Annex 2 Points to consider for remote delivery).

The range of manualized psychological interventions tested in LMICs has expanded rapidly over the past 20 years. Universities, nongovernmental organizations and international agencies, including WHO, have developed, tested and disseminated numerous such psychological interventions – mostly for adults – around the world.

As the number of these interventions continues to grow, there is a need to consider how best to implement them on a wider scale and how to ensure that the services delivering these interventions remain sustainable. The question here is: **how can service planners and programmers increase the availability of existing evidence-based psychological interventions so that more people can benefit from them?**

Psychological intervention manuals describe the content of an intervention and provide specific instructions on how to deliver it consistently. But such manuals do not typically cover actions around service design and provision. It can be difficult for service planners and programmers to decide which psychological intervention to use in which context, and these decision-makers do not always have a clear overview of the likely steps and resources required to implement psychological interventions at significant scale.

1.2 Purpose and use

This implementation manual provides practical guidance on how to implement manualized psychological interventions by integrating them within existing services such as health, social, protection, rehabilitation or education services. This includes how to choose an intervention and delivery model that will support integration within a given context.

Written for managers and others responsible for planning and implementing services, this manual offers an overview of key activities and considerations required to provide and potentially scale manualized psychological interventions delivered by non-specialists for adults, adolescents and children. It does not include specific details of individual interventions but gives general guidance on how to plan, prepare and provide manualized psychological interventions within existing services.

While this guidance focuses on how to implement evidence-based psychological intervention manuals using a non-specialist workforce, different aspects of this guidance may also be useful for implementing psychological interventions in general.

All the activities covered in this manual require collaboration and coordination across

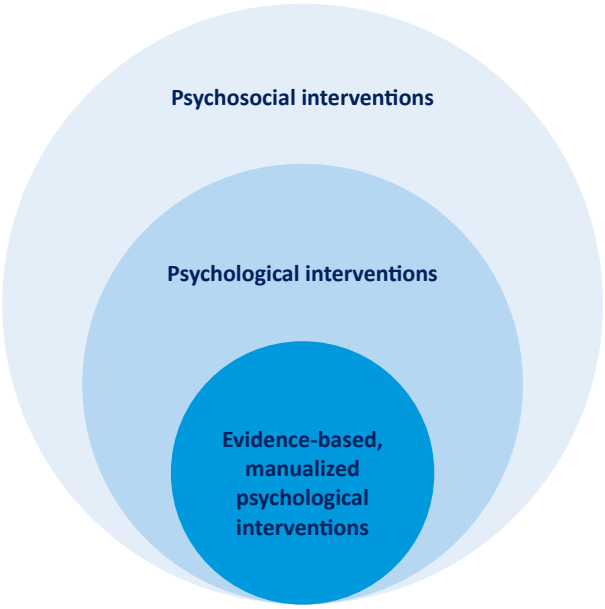
stakeholders and sectors to ensure that interventions are relevant and accessible to those who need them most. This includes engaging nongovernment organizations and governments as well as representatives of local communities, including people with lived experience. At every stage of service design and delivery, community engagement is important to identify and overcome barriers to help-seeking and secure the buy-in of potential service users.

1.2.1 Notes on terminology

1. In this implementation manual, the term psychological intervention refers to an evidence-based psychological intervention that is manualized. There are many other psychological interventions that are not evidence-based or that are not manualized, which are not covered in this document.
2. This implementation manual does not use the broader term psychosocial intervention, which refers to all interpersonal or informational activities, techniques, or strategies to improve health, functioning and well-being (see Fig. 1.1) (5). Psychosocial interventions may or may not be manualized and may or may not be evidence-based.

FIG. 1.1

This manual covers the implementation of evidence-based, manualized psychological interventions.



1.3 Structure and overview

The remaining chapters of this manual focus on five key steps for implementing psychological interventions within an existing service: make an implementation plan; adapt for context; prepare the workforce; identify, assess and support potential beneficiaries; and monitor and evaluate the service (see Fig. 1.2).

Each chapter describes the activities required, outlines why they are important and sets out the main points to consider when carrying them out. The need to meaningfully engage local communities and people with lived experiences of mental health conditions cannot be overstated. Throughout this manual you will find boxes that specifically focus on the priorities for engagement at that stage of implementation.

You will also find practical tips and tools to help plan, prepare and provide psychological interventions within an existing service as well as links to further resources that can support implementation. An overall checklist summarizing key activities to do at each stage of implementation is available in Annex 1.

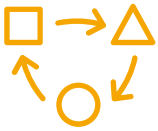
FIG. 1.2

Steps to implement psychological interventions.

Planning

Choose one or more psychological interventions for a specific setting and plan how to deliver them to a target population.

Adaptation



Adapt the psychological interventions for use in a specific context, including translating them into local languages.

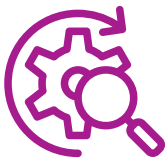
Workforce

Prepare and sustain a competent workforce to deliver the psychological interventions by selecting, training, assessing and supervising providers.

Identification, assessment and delivery

Identify potential beneficiaries of the psychological interventions and ensure they are directed to the right source of support.

Monitoring and evaluation



Monitor and evaluate the outcomes and impacts of the service with integrated psychological interventions.

COMMUNITY ENGAGEMENT

Engage local communities.

2

Planning

KEY MESSAGES

- Establish the purpose of introducing a psychological intervention that is informed by a local situation analysis to identify local mental health needs, capacities and priorities.
- Include multiple stakeholders, including community representatives (e.g. community leaders and people with mental health conditions) in the implementation team.
- Select evidence-based psychological interventions.
- Map out available services (e.g. health, rehabilitation, education, protection and social services) and build multisectoral links for referral.
- Consider models for delivery that maximize efficiency (e.g. task sharing, collaborative care or stepped care).
- Identify the groups of workers that will deliver psychological interventions and provide training and supervision.
- Decide on a format for delivery (individual, group or self-help).
- Specify where and how interventions will be delivered (e.g. in-person, remotely or a combination).
- Allocate sufficient human and financial resources to implement the psychological intervention within the service.

Planning is the first step to implement psychological interventions. It involves deciding which interventions will be provided, why, where, how and when. Choosing relevant and effective psychological interventions for the given setting is critical. Ultimately, the decisions made during planning will determine the interventions' reach and usefulness. The implementation plan should be tailored to local needs and contexts and based on evidence of effectiveness in comparable situations.

To ensure the plan can be successfully carried out it should be:

- comprehensive in listing activities throughout implementation;
- specific in defining roles, responsibilities and timelines for action; and
- fully budgeted and appropriately resourced.

Ensuring that all activities in the plan are properly resourced may require additional fund-raising and advocacy work.

Key questions to address in an implementation plan are highlighted in Fig. 2.1. Importantly, there is no single order in which to answer these questions, but all should be answered as part of the plan.

Planning should be undertaken by a multistakeholder implementation team that contains a broad range of knowledge and skills. This could potentially include service managers, local mental health professionals, community representatives, as well as stakeholders from other non-health sectors (including relevant nongovernment organizations).

The implementation team uses situation analyses, evidence reviews and stakeholder engagement to address the seven questions above and develop an implementation plan (see sections 2.1–2.7 below). The team continues to work together throughout implementation, overseeing and facilitating activities.

FIG. 2.1

Seven key questions to address in an implementation plan.

COMMUNITY ENGAGEMENT

When implementing psychological interventions:

- **Involve** community members (e.g. community leaders and people with lived experience of mental health conditions) in decision-making processes to design services that include relevant, accessible and acceptable psychological interventions (including potentially as core members of the implementation team).
- **Inform** community members about mental health conditions and the psychological intervention (both before and while the intervention is available) to increase awareness, understanding and uptake of psychological interventions.
- **Collaborate** with community members to communicate about and deliver the psychological interventions in a way that meets community needs to maximize the interventions' reach and impact. This may include understanding whether people can access an intervention remotely.

2.1 Establish the purpose of psychological intervention

A first task in planning is to establish the rationale for implementing psychological interventions (see Box 2.1 Why implement psychological interventions?). This is about establishing the need for action in a specific setting. It is achieved through situation analyses of local mental health needs, capacities (e.g. services and resources available to treat mental health conditions) and demands (e.g. use of mental health services).

BOX 2.1

Why implement psychological interventions?

There are many reasons why psychological interventions need to be made available in communities around the world. The need for action on mental health is indisputable and urgent, and psychological interventions are part of the answer to the gap between the prevalence of mental health conditions, which is high, and access to adequate care, which is low.

Psychological interventions – which can be delivered and potentially scaled by non-specialists – can be highly effective for many mental health conditions, particularly depression and anxiety. They offer an evidence-based alternative to psychotropic medicines, especially in services that mainly offer medicines to manage mental health conditions (e.g many primary health care clinics around the world); or services that do not cover pharmacological interventions (e.g. social or community services) or that experience drug supply problems. Psychological interventions can also effectively complement psychotropic medicines in health services that mainly offer medicines to manage mental health conditions.

Implementing psychological interventions can help improve effectiveness of care. For example, psychological interventions and antidepressants are likely equally effective in treating depression in the short term. But psychological interventions have shown higher sustained response than antidepressants over the long term and antidepressants have more adverse effects. Also, psychological interventions are known to be more effective than pharmacological ones in treating certain conditions such as post-traumatic stress disorder (PTSD). Collaborative care for depression and anxiety – which typically includes a psychological intervention as part of the treatment plan – is similarly more effective than routine pharmacological treatment of depression in primary health care.

In some situations, psychological interventions can be used to overcome logistical barriers to access through remote delivery (see section 2.3 Decide setting for delivery). For example, when psychological interventions are made available digitally through guided self-help.

Making psychological interventions available is especially important in settings where the target population prefers psychological interventions over pharmacological ones.

Sources: WHO, 2022 *(2)*; Furukawa et al, 2021(*6*); Archer et al, 2012 (*7*); Xiao et al, 2021 *(8)*; Affengruber et al, 2023 (*9*), WHO, 2013 (*10*).

2.1.1 Points to consider

Local epidemiology. There are many psychological interventions available to help people with different mental health conditions. Before deciding which ones to implement, establish which mental health conditions are most prevalent or burdensome in the local context. Review:

- local or national epidemiological data; and
- international estimates of prevalence rates calculated by the Institute for Health Metrics and Evaluation (IHME) (*11*) and burden of disease calculated by WHO (*12*).

In all cases, depression and anxiety will likely be targets for psychological interventions as both conditions are very common in adolescents and adults across the world. But there may be situations where there is reason to focus on other mental health conditions. Often multiple mental health conditions can be targeted at once.

Local services and resources. Review existing mental health care – whether within health, social or educational settings. This includes assessing service providers' capacities for treating specific conditions, identifying if any interventions are already available and mapping out gaps and requirements in services and resources (both human and financial). Hold discussions with local and national stakeholders during the situation analysis to help you identify perceived needs and priorities, raise awareness of plans and lay the foundations for future engagement. Such a mapping may also help to inform referral routes and multisectoral cooperation (see section 2.5 Identify associated services).

Target population. Clearly specify the intended population to be served by the interventions, as well as expected outcomes.

Barriers to participation. Consider the local context in which services are delivered to ensure that psychological interventions will be useful to the target population. Review service use by the target population and identify barriers to demand or inclusion so that these may be effectively addressed within the implementation plan. People with physical impairments or chronic illnesses may face physical or practical barriers to receiving a psychological intervention. Other groups may be marginalized in different ways. Language can be a major barrier to accessing care. Stigma as well as distrust of treatment and medical personnel can also prevent help-seeking and impact treatment adherence. If delivering an intervention remotely, consider whether most people will have access to a smartphone, other internet connected device or telephone. Consult local community members to gain insight to local attitudes and beliefs of people with mental health conditions, their families and health care providers.

2.2 Choose psychological interventions

Once you have identified local needs and priorities and specified target mental health conditions and populations, you need to select the most appropriate psychological interventions. You may choose to start by implementing a single intervention, or you may decide to plan for multiple interventions, for example as part of a stepped care system to address varying levels of distress (see section 2.4 Organize the system for delivery).

The key here is to choose psychological interventions with an established evidence base that is relevant to local realities. There should be enough evidence to give confidence that the intervention will likely be effective if properly implemented and that it is unlikely to cause harm. WHO has recommended different types of psychological treatments for different mental health conditions (see Table 2.1).

TABLE 2.1

Summary of WHO recommendations for psychological treatments.

PSYCHOLOGICAL TREATMENT[a]	RECOMMENDED FOR
Behavioural activation	• Adults with depression • People with dementia with depression
Behavioural intervention	• Children and adolescents with behavioural disorders, including conduct disorder
Brief interventions for hazardous and harmful substance use[b]	• Adults using cannabis • Adults using psychostimulants • People with hazardous or harmful alcohol use
Brief psychodynamic therapy	• Adults with depression
Caregivers skills training	• Caregivers of children and adolescents with behavioural, emotional or developmental disorders
Cognitive behavioural therapy (CBT)	• Adults and children with epilepsy (adjunct to antiseizure medicine) • Adults, children and adolescents with PTSD • Adults with acute traumatic stress symptoms • Adults with bipolar disorder in remission (adjunct to pharmacological interventions) • Adults with bodily distress complaints[c] • Adults with depression • Adults with generalized anxiety disorder • Adults with panic disorder • Adults with psychotic disorders (including schizophrenia) in the acute and maintenance phase • Children and adolescents with ADHD • Children and adolescents with autism and anxiety • Children and adolescents with emotional symptoms/disorders • Children and adolescents with somatoform disorder • Children whose parents have mental health conditions • People with alcohol and drug use disorders • People with dementia • People with dementia with depression • People with suicidal thoughts
Cognitive stimulation therapy	• People with dementia
Cognitive training	• People with dementia
Contingency management therapy	• People with alcohol and drug use disorder
Eye movement desensitization and reprocessing (EMDR)	• Adults, children and adolescents with PTSD
Interpersonal therapy / interpersonal psychotherapy	• Adults with depression • People with dementia with depression • Children and adolescents with emotional disorders

PSYCHOLOGICAL TREATMENT[a]	RECOMMENDED FOR
Interpersonal skills training	• Adolescents with disruptive/oppositional behaviours
Motivational enhancement therapy	• People with alcohol and drug use disorder
Problem-solving therapy	• Adults with depression and subthreshold depressive symptoms • Adults with generalized anxiety disorder • Adults with panic disorder • People with suicidal thoughts or with acts of self-harm in the last year
Problem solving skills training	• Adolescents with disruptive/oppositional behaviours
Interventions using cognitive learning techniques to enhance communication and social competencies	• Children and adolescents with neurodevelopmental disabilities
Interventions focused on social skills training and developmental behavioural approaches	• Children and adolescents with autism
Interventions focused on social skills, cognitive and organizational skills training	• Adults with psychosis and bipolar disorder and their carers • Children and adolescents with ADHD
Stress management (including relaxation and mindfulness training)	• Adults with generalized anxiety disorder • Adults with panic disorder • Adults with PTSD or symptoms of anxiety • Adults with epilepsy (adjunct to antiseizure medicine) • People with suicidal thoughts
Third wave therapies[d]	• Adults with depression • Adults with generalized anxiety disorder • Adults with panic disorder • Carers of people with dementia
Psychological interventions for people with substance use disorders[e]	• People with alcohol and drug use disorders

[a] This table includes indicated prevention for people with signs or symptoms of a mental health conditions but do not meet diagnostic criteria for mental disorder. It excludes WHO recommendations on a) treatment format (e.g. group, family, couples, digital, self-help, mutual help), (b) psychoeducation, (c) preventive universal psychosocial interventions, (d) multi-component interventions and (e) unspecified interventions (e.g. structured counselling, psychotherapy or structured psychosocial interventions). This table does not specify when interventions are recommended only for a specific severity level of the condition (e.g. mild, moderate or severe). It does not cover recommendations for combined psychotropic and psychological treatments and does not cover other required supports such as social interventions. WHO recommends that for some of the substance use disorders (e.g. alcohol and opioid use disorders), psychological treatment combined with pharmacological interventions. For a full list of WHO recommendations please see: Mental Health Gap Action Programme (mhGAP) guideline for mental, neurological and substance use disorders. Geneva: World Health Organization; 2023. https://www.who.int/publications/i/item/9789240084278

[b] Despite their name, brief interventions for substance use are not generic; they involve specific therapeutic techniques, including, possibly, psychoeducation, simple advice, motivational interviewing and referral.

[c] A synonym of bodily distress complaints is medically unexplained complaints.

[d] Third wave therapies include: Mindfulness based interventions, acceptance and commitment therapy, metacognitive therapy, and dialectical behavioural therapy.

[e] Psychological interventions with demonstrated effectiveness for substance use disorders include CBT, contingency management, community reinforcement approach, motivational interviewing, motivational enhancement therapy, and family orientated treatment approach.

Many evidence-based psychological intervention manuals cover one of these recommended psychological treatments. Ensuring that a selected psychological intervention manual makes use of a recommended treatment is an important part of the evidence review.

In addition to reviewing evidence of effectiveness for target mental health conditions, the implementation team should also look for any evidence that psychological interventions will be effective in the local context. This includes evidence of successful trials with populations affected by similar adversities, or with similarities in context in another setting. Such evidence greatly strengthens confidence that the interventions will work locally and means that less adaptation will be needed before the intervention can be used (see Chapter 3 Adaptation).

Many psychological interventions – including several developed by WHO – were developed for people with specific problems in low-resource settings. But they were also designed to suit many other contexts and types of adversity (see Table 2.2) (*3*). These interventions require some adaptation before they can be used in similar settings (see Chapter 3 Adaptation).

TABLE 2.2

Example WHO psychological interventions (including digital programmes) developed for different target groups with specific problems in low-resource settings.

WHO PSYCHOLOGICAL INTERVENTION[a,b]	FORMAT	TARGET POPULATION
Caregivers Skills Training (CST)	Group	Caregivers of children with developmental disabilities, including autism
Doing What Matters in Times of Stress	Self-help (digital, book)	Adults with psychological distress
Early Adolescent Skills for Emotions (EASE)	Group	Young adolescents with psychological distress
Group Interpersonal Therapy (IPT)	Group	Adults with depressive symptoms
iSupport	Self-help (digital, book)	Carers of people with dementia
Problem Management Plus (PM+)	Individual or group	Adults with depression or anxiety
Self-Help Plus (SH+)	Group/multi-media self-help	Adults with psychological distress
Step-by-Step (SbS)[c]	Digital self-help	Adults with depression
Thinking Healthy	Individual	Mothers with perinatal depression

[a] All these examples are (or will soon be) available to download from the WHO Institutional Repository for Information Sharing (https://apps.who.int/iris/).

[b] All the interventions developed by the WHO Department of Mental Health and Substance Use can be found on their page on scalable psychological interventions (https://www.who.int/teams/mental-health-and-substance-use/treatment-care/innovations-in-psychological-interventions).

[c] Carswell K, Harper-Shehadeh M, Watts S, van 't Hof E, Abi Ramia J, Heim E et al. Step-by-Step: a new WHO digital mental health intervention for depression. Mhealth. 2018;4:34. doi:10.21037/mhealth.2018.08.01.

2.2.1 Points to consider

Strength of evidence. Not all evidence deserves equal weight. Choose the psychological intervention that is supported by the strongest evidence, preferably multiple high-quality randomized controlled trials. These trials will preferably have been done in a similar context to the one where you are planning to implement psychological interventions. Ideally, they will have been replicated by independent researchers (which means that the scientists who developed the intervention manual are not co-investigators of the trial).

Search for and review other relevant information in the peer-reviewed and grey literature[2] to decide whether the intervention can be implemented locally. The literature review should include any information that:

- shows the intervention is feasible, affordable and cost–effective;
- suggests the intervention may be scalable; and
- identifies potential barriers to participation (for example, the number of sessions people are typically willing and able to attend), dropout rates and likely reasons for people dropping out.

Target population. Psychological interventions are sometimes only proven effective for a specific population group. Yet, the effectiveness of psychological interventions usually generalizes across genders, adult age groups, people with or without comorbid medical conditions, and people in or not in primary health care settings (*13*). After careful consideration and appropriate adaptation, it may be reasonable to implement an intervention outside its exact tested ranges (for example delivering an intervention tested with 18- to 60-year-old women with depression to anyone with depression aged 16 and over) (see Chapter 3 Adaptation). When choosing an intervention, also think about other factors such as any preferences within the target population for group, individual or remote models.

Transdiagnostic interventions. Transdiagnostic interventions tackle shared problems that frequently occur across a range of commonly occurring mental health conditions such as anxiety and depression. They are often preferable to psychological interventions that target a single mental health condition (e.g. depression).

A transdiagnostic psychological intervention takes shared, non-specific components of established psychological treatments for different mental health conditions and combines them into a single treatment model. One such example, the Common Elements Treatment Approach, has been tested for a wide range of outcomes (depression, anxiety, substance use and PTSD) in LMICs around the world (*14*). Examples of WHO transdiagnostic interventions are Problem Management Plus (PM+) and Self-Help Plus (SH+) (see Table 2.2).

Online availability of interventions. Intervention manuals may be (a) freely available online (open access), (b) available through online purchase, or (c) potentially available from the author or organization holding copyright (who can put limits on the manual's availability and use). How accessible a manual is should be a key consideration in deciding whether to use it. Although manual developers cannot control quality of care when their manual is available online, online availability of manuals is important to ensure equitable access.

[2] Grey literature refers to reports and publications that are not in peer-reviewed journals.

Available budget and resources. Make sure that all interventions you choose can be adequately delivered within the budget and resources available. This includes ensuring sufficient budget and resources to train and supervise the workforce. If it is not feasible to implement a multi-session, in-person intervention, implementing a group or guided self-help intervention is preferable to no intervention at all or an intervention that may prove unsustainable.

2.3 Decide setting for delivery

A key part of planning is to specify where the psychological intervention will be delivered, with a focus on integration to an existing community-based service. While there is no single model for organizing community-based mental health services, Fig. 2.2 shows WHO's model network of formal community-based mental health services. Within any network of services there are typically various opportunities to integrate one or more psychological interventions.

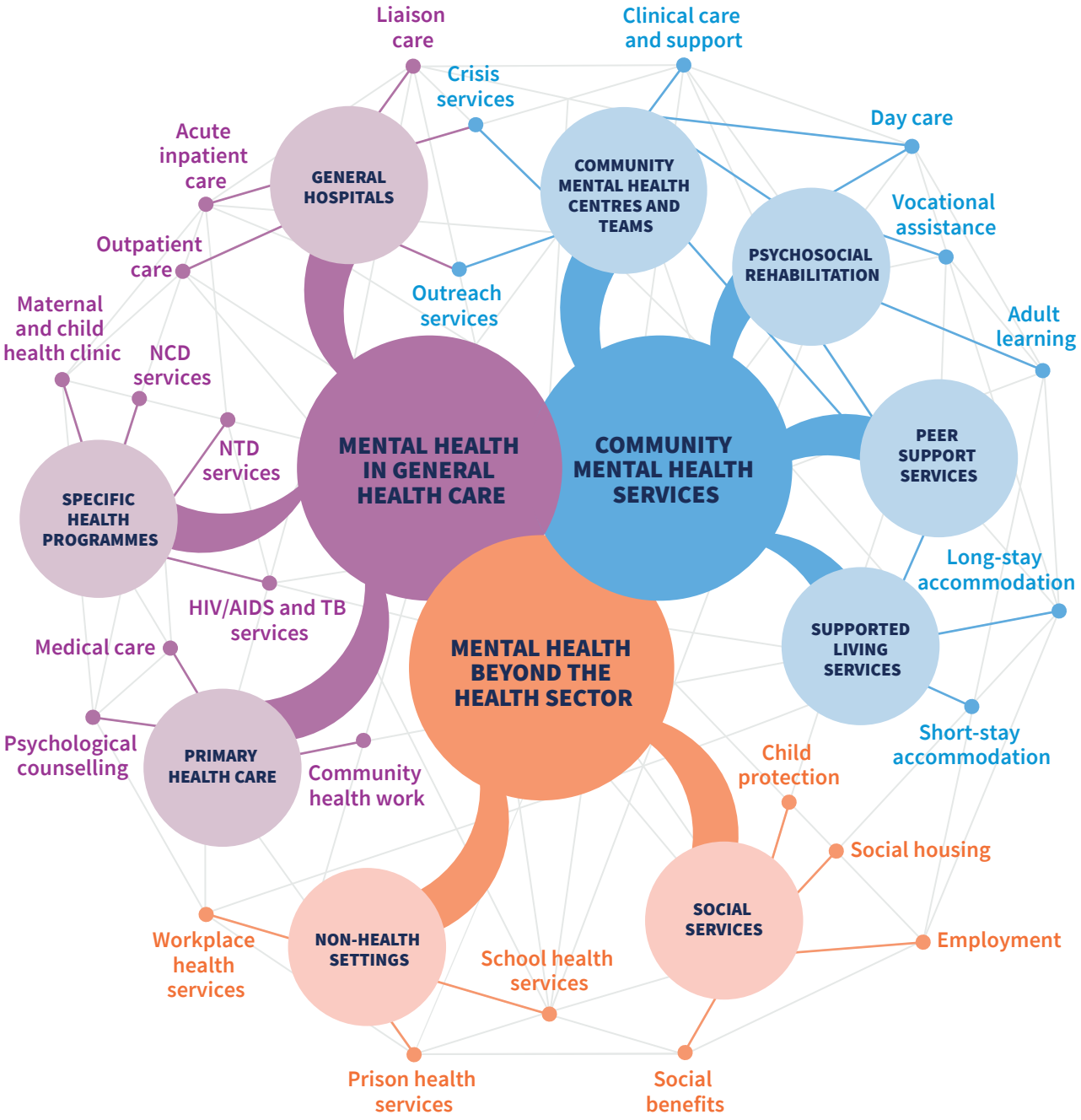
It is important to review the pros and cons of different services and settings for delivering psychological interventions. Table 2.3 reviews potential benefits and challenges for diverse settings that are commonly used for delivering psychological interventions. These also include settings outside the formal mental health system. Involving local communities can help identify spaces, services and organizations that are appropriate and acceptable to the target population.

Where face-to-face support is difficult to provide, or where support is needed across a large area, remote delivery (by videoconference, online messaging or telephone) may be a good option. For example, in conflict-affected areas where providers cannot safely gain access to populations, or in spread-out regions, where providers have difficulties reaching individuals in need. During the COVID-19 pandemic, there was a global upsurge in remote delivery. Evidence shows that psychological interventions delivered remotely are likely as effective as face-to-face interventions. (*15*) Interventions designed for face-to-face delivery can typically also be adapted for remote delivery.

Remote delivery should not be seen as a replacement for in-person support. Relying on digital technologies to deliver interventions risks excluding poor or marginalized people without access to the internet or a private phone (*2*). A key objective in organizing services is to offer different delivery options to support a broad range of needs and preferences (*2*).

FIG. 2.2.

WHO's model network of community-based mental health services includes many options for integrating psychological interventions.



Source: WHO 2022 (*2*).

TABLE 2.3

Common settings for delivering psychological interventions and their potential benefits and challenges.

EXAMPLE SETTING	POTENTIAL BENEFITS	POTENTIAL CHALLENGES
Community spaces or homes	• Convenient location for the service user. • Private and confidential space (if the space is not shared).	• Not a necessarily convenient location for the provider. • Lack of privacy (if the space is shared). • Lack of confidentiality and associated risk of stigma. • Risk of interruptions and noise. • Weak links to referral pathways to health and social services if the providers are not part of these services.
Women's centres, youth clubs or similar spaces	• Low stigma setting to help survivors of gender-based violence (if the intervention is just one of many different supports provided at a women's centre). • Accessible to those not enrolled in school (if the intervention is for young people).	• Not accessible to all. • May have weak links to health and social services.
Schools	• Convenient location (for those attending school). • Accessible to many young people.	• Risk of stigma from peers. • Not accessible to those not enrolled in school. • Weak links to referral pathways to health and social services.
Primary health care	• Convenient location. • Can use existing links to other health care services. • Low stigma compared with mental health services. • Intervention can be combined with psychotropic medicine if indicated.	• Private space might not be available. • Typically requires adding human resources to deliver the psychological intervention. • Risk of unnecessary prescription of psychotropic medicine.
Mental health unit in general hospital or community mental health centre	• Convenient location (for those already attending these services). • Private and confidential space. • Well-known and accepted location to receive care. • Access to specialized care. • Intervention can be combined with psychotropic medicine if indicated.	• Usually far away from where people live. • Risk of unnecessary prescription of psychotropic medicine.

EXAMPLE SETTING	POTENTIAL BENEFITS	POTENTIAL CHALLENGES
Remote delivery	• Private and confidential space (if the space or device is not shared). • Continuity of care during crises. • Overcomes transport barriers (such as distance, cost or travelling time). • Accessible to people with physical disabilities or other difficulties that make it hard to travel. • Accessible to people in remote communities or other hard-to-reach areas (if they have a phone or internet).	• Fewer non-verbal cues make communication harder. • Harder to manage high-risk situations (such as imminent risk of suicide). • Reliance on technology and telecommunications that may be unreliable. • Not accessible to people without a phone or internet (equity issue). • Potential for major interruptions (e.g. software freezes or crashes), background noise and distractions. • Costs may be incurred through mobile or data plans. • Data privacy concerns and reluctance to share private information online.

2.3.1 Points to consider

Accessibility. The target population should be able to access the intervention easily and affordably. For each potential delivery setting, consider:

- how far the proposed location is from the target population;
- whether or not people already go to that location;
- the extent to which there is stigma attached to the location; and
- what other barriers may prevent people from wanting or being able to get there.

Talk to local communities to gain insight to people's likely attitudes and behaviour; people are less likely to attend a setting that they believe stigmatizes them.

Existing services. Before choosing a setting for delivery consider the quality and sustainability of existing services. This includes the potential capacity of staff (in terms of skills and workloads) to deliver or supervise psychological interventions. Potential settings can also be assessed on the strength of their links to associated services and on the extent to which other relevant benefits or supports (such as health care, economic support, nutrition programmes or social activities) are provided there.

Safety and security. Consider whether the setting for delivery is safe and secure for both service users and providers. The setting for delivery should have:

- a private space for confidential conversations;
- appropriate on-site physical security measures for staff and service users; and
- adequate data security for any private information, including service user files.

If you are implementing a digital intervention, consider any additional requirements such as data protection and operating procedures to ensure safety *(16)*.

Remote delivery. See Annex 2 for additional points to consider for remote delivery.

2.4 Organize the system for delivery

With a range of psychological interventions shown to be effective in LMICs, service planners can consider using more comprehensive and integrated systems for delivery. These provide one or more psychological interventions, coordinated with other services and supports (see section 2.5 Identify associated services).

There are various models available for organizing the delivery of psychological interventions. Here we briefly describe two: collaborative care and stepped care. These can be used separately or together.

2.4.1 Collaborative care

Collaborative care is a multi-component system for delivery with a large body of evidence that strongly supports its use in managing depression and other common mental health conditions (*17*). In collaborative care systems, a health team shares tasks, with a care manager playing a central role and coordinating the care (*2*). For example, in collaborative care for depression, individuals are typically:

- identified through screening;[3]
- linked with community resources to address any social needs;
- given evidence-based psychological interventions;
- prescribed psychotropic medicine if indicated; and
- monitored over time using the same measure.

A care manager is central to the delivery or coordination of collaborative care. They work alongside general medical practitioner, and can, when trained, deliver psychological interventions. A mental health specialist supports the team through regular meetings to review cases where people are not improving and recommend adjustments to their care. Changes potentially include stepping up the intensity of care and specialist referral.

Collaborative care has been applied in primary care settings as well as disease-specific programmes (e.g. for diabetes or HIV) (see Box 2.2 Collaborative care in India). Research shows it is much more effective and cost–effective than routine integration of mental health in general health care (*18*). But collaborative care requires the resources for employing a care manager, which can pose a barrier to use of this model.[4]

2.4.2 Stepped care

Stepped care offers a pragmatic approach to ensuring that more resource intensive interventions are reserved for people for whom less costly interventions are not sufficient. In practice, it typically includes two components for organizing delivery:

1. a choice of different interventions that can be matched to people's needs and suitability; and
2. a process for directing individuals to care, both after their initial assessment and after each step of intervention.

Exactly how these components come together to implement stepped care varies, depending on local contexts, including what mental health conditions are addressed, the availability of local services and resources, and sociocultural considerations (see Box 2.3 Stepped care in the United Kingdom). For example, people may initially be offered a lower-intensity intervention, such

[3] Screening may be opportunistic or systematic, depending on the capacity of the service to support people who screen positive (see section 5.1 Identify and reach potential beneficiaries).

[4] For more information on implementing collaborative care, see WHO's forthcoming collaborative care manual.

as unguided or guided self-help delivered by supervised non-specialists. Those who do not respond adequately to this are subsequently stepped up to a higher-intensity intervention, for example an individual or group psychological intervention, also delivered by a supervised non-specialist, and possibly combined with psychotropic medicine if indicated. A final step for people who still do not respond adequately might then be support from a specialist.

BOX 2.2

Collaborative care in India

In India, the Integrating Depression and Diabetes Treatment (INDEPENDENT) model of collaborative care was designed to improve access to mental health care by using multi-disciplinary health teams to integrate treatments for depression and diabetes within a single setting (an urban diabetes clinic).

Over two years (2016–2018), care managers were trained and supervised to deliver psychological interventions (mainly based on behavioural activation) to people with diabetes and comorbid depressive symptoms. Care managers also received peer support as well as coaching and emotional support from specialist supervisors to help them cope with the stress and emotional burden of their new role.

A randomized controlled trial of the INDEPENDENT model of collaborative care found it led to much better clinical outcomes than usual care.

Source: Ali et al, 2020 *(19)*.

BOX 2.3

Stepped care in the United Kingdom

Improving Access to Psychological Therapies (IAPT) is a national programme of psychological interventions for anxiety and depression in the United Kingdom. This is delivered to individuals or groups, by supervised non-specialists called Psychological Well-being Practitioners. Receiving around 1.25 million referrals per year, IAPT is the world's largest systematic implementation of evidence-based psychological treatment.

IAPT uses a stepped care approach to offer progressively intensive treatments, based on clinical need. People may first receive a lower-intensity, guided self-help based on CBT principles. Practitioners monitor service users' progress during the guided self-help and those who do not improve by the end of it are stepped up to receive high-intensity psychological treatments from qualified therapists. In IAPT, people initially presenting with more complex needs may be immediately offered a higher-intensity intervention.

A review of 60 studies found large improvements in depression and anxiety among people attending IAPT services.

Sources: adapted from WHO, 2022 (*2*) (original source: Wakefield et al, 2021 (*20*).

2.5 Identify associated services

No single psychological intervention can address the full range of needs that people living with mental health conditions may have. Any service offering psychological interventions needs to be linked to a range of other services and supports.

Identifying and connecting to associated services involves building on the findings of the situation analysis (see section 2.1 Identify local mental health needs and capacities) and connecting with any stakeholders that coordinate responses or services in the local setting (e.g. district health and social care bodies).

In mapping services, it is important to think about the needs of people who will not receive the psychological intervention for any reason or who need extra support. People at imminent risk of suicide or people severely impaired by psychosis, dementia, intellectual disability or substance dependence also need to be referred to relevant mental health and social care services.

All referral options for care should be mapped. This includes services that address child, gender-based violence and livelihood supports which can be engaged before or during the psychological intervention as required (see section 5.3 Refer people to the right source of support).

Overall, associated services likely include mental health and social services, mental health professionals in private practice, protection and legal services and supports as well as services in schools and possibly universities.

2.5.1 Points to consider

Multisectoral coordination. Identify and coordinate referral services across sectors before implementation begins and engage them during the planning phase. Community workers and gatekeepers (e.g. traditional and religious leaders, community leaders and village elders) can be very valuable partners to help address social needs and to identify people for psychological interventions.

Minimum requirements for referral. Referral options for people at imminent risk of suicide and for people with severe mental, neurological or substance use conditions must be in place when implementing psychological interventions for people with depression or anxiety. Referral options may be created by training and supervising staff in the local health system to assess and manage mental, neurological and substance use conditions, for example through the mhGAP programme (*21*) or through referral to a local hospital. Relevant referral options must also be in place for gender-based violence and violence against children (*22*).

2.6 Identify human resource needs

A large part of ensuring quality and effective psychological interventions is about securing adequate human resources for implementation. Any implementation plan should include a consideration of likely staffing needs and identify groups of workers that can deliver, train and supervise psychological interventions in practice.

Psychological interventions can be delivered effectively by mental health specialists (such as clinical psychologists, professional counsellors, psychiatrists, mental health nurses, and social workers) when they have received appropriate training and completed relevant supervised practice. But these interventions can also be effectively delivered by trained and supervised non-specialist providers. This includes a wide range of community providers, such as community health workers, volunteers, and people with lived experience of mental health conditions.

In practice, the choice of provider largely depends on their availability to take on this role. General health care providers for example are certainly capable of delivering psychological interventions with the right training and support but they are often already too busy with existing workloads and as such rarely implement psychological interventions that involve multiple sessions. See section 4.1 Choose the workforce for more details on selecting trainers, supervisors and providers.

2.6.1 Points to consider

Suitability of providers When specifying groups of non-specialist providers, consider their ability to provide multiple sessions of psychological interventions. Providers can be trained, supervised and supported to develop the necessary skills but they, like their trainers and supervisors, also need the appropriate attitudes to undertake the work (see section 4.1 Choose the workforce).

Sustainability. To ensure that psychological interventions can be provided over the long term, think about how providers and supervisors will remain incentivized and supported over time. The use of volunteers or project-funded staff is usually difficult to sustain.

2.7 Choose format for delivery

Psychological interventions are typically delivered to individuals or groups (see Table 2.4), in person or remotely (see section 2.3 Decide setting for delivery). They can also be provided as self-help interventions that may be delivered through multiple media including books, audio or video materials and online or app-based platforms.

Self-help may or may not be guided (facilitated). Self-help psychological interventions are likely more effective and have lower dropout when guidance is provided to help people work through the content of the intervention (*23*). Guided self-help interventions, especially when delivered remotely, can also be delivered more easily to large numbers of people than conventional face-to-face psychological interventions. They can be used alongside more conventional face-to-face interventions or as a first step in stepped care (see section 2.4.2 Stepped care).[5]

[5] For more information, see WHO's forthcoming manual on guided self-help.

TABLE 2.4

Potential advantages and drawbacks of example delivery formats available for psychological interventions.

INTERVENTION TYPE	ADVANTAGES	DRAWBACKS
1. Individual interventions A single service provider delivers the intervention to a single service user.	• More opportunity to build a supportive therapeutic relationship. • Easier to respond to the person's individual situation or needs. • Easier to ensure confidentiality. • Likely more acceptable to people who find it difficult to share their problems with community members.	• Reaches fewer people at a time. • Relatively resource intensive. • Less opportunity to build relationships with or learn from peers with similar lived experiences. • Individual interventions may not be consistent with cultural coping norms.
2. Group interventions One or two facilitators deliver the intervention to multiple service users at once.	• Reaches multiple people at a time. • Group members can support and learn from each other and feel validated in their feelings and experiences. • People can build supportive peer relationships that may endure even after the intervention is completed.	• Can take longer to set up and difficult to organize outside local communities (because multiple people must get to the same place at the same time). • Confidentiality is harder to ensure. • Some people can find it hard to listen to other people's problems. • Not necessarily acceptable or suitable to all service users. • Dropouts can cause disruption to the group.
3. Self-help interventions Individual service users complete the intervention themselves, alone or in groups, with or without guidance from a service provider.	• Requires fewer human resources. • Can be feasibly used as a first intervention in a stepped care system. • Potentially reaches people that cannot access in-person interventions (e.g. those living in hard to reach areas). • Reduces waiting lists and barriers associated with travel. • Except for group self-help, people participate in their own time, at their own pace, and wherever they prefer. • Potentially less stigmatizing.	• Some people may feel they are being offered an inferior service. • Monitoring can be difficult. • People may not use the intervention as intended. • Dropout may be higher and harder to identify. • Written self-help materials may be inaccessible to people who cannot read or write. • Access to digital self-help interventions can be uneven across populations.

2.7.1 Points to consider

Changes to the intervention. When choosing an intervention consider the degree to which it can be delivered in a similar way as done in the research trial. Do not change the core components of the intervention and monitor any adaptations in case of problems (see Chapter 3 Adaptation). You may need to make changes to the timing (frequency of sessions) and dose (overall number and length of sessions) of the intervention because of your setting, yet these may impact the intervention's effectiveness. In general, research suggests that two sessions per week is more effective than once a week (*24*).

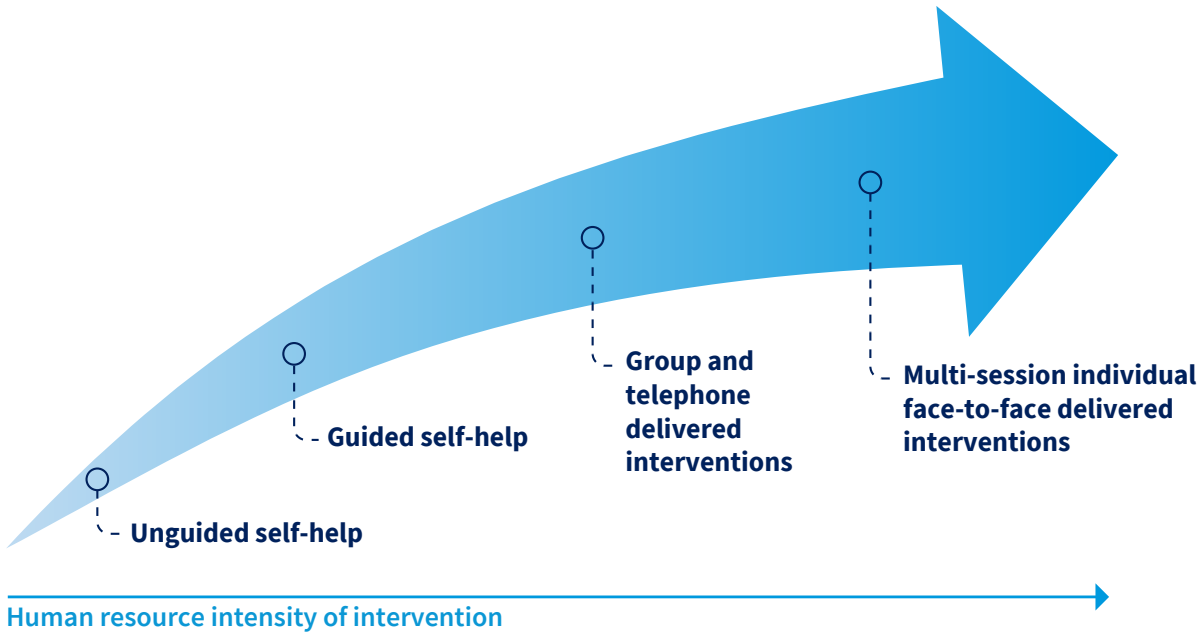
Resources. Different delivery formats have different resource requirements (see Fig. 2.3). Consider the financial and human resources required before choosing a format. If one format is too costly for the setting, consider using a lower resource intensity format.

Scale up and impact. Some formats are easier to scale than others and there can be a trade off with effectiveness. For example, unguided self-help likely has a smaller benefit. But it can have far greater reach and is easier to implement compared with guided self-help, which is more resource intensive.

Still, the potential reach and effectiveness of an intervention are not always related. For example, CBT as guided self-help delivered online has the potential to reach many people (see Box 2.4 Step-by-Step in Lebanon). It has consistently been shown to be as effective as face-to-face CBT (*25*).

FIG. 2.3

Human resource intensity of different psychological interventions.



BOX 2.4

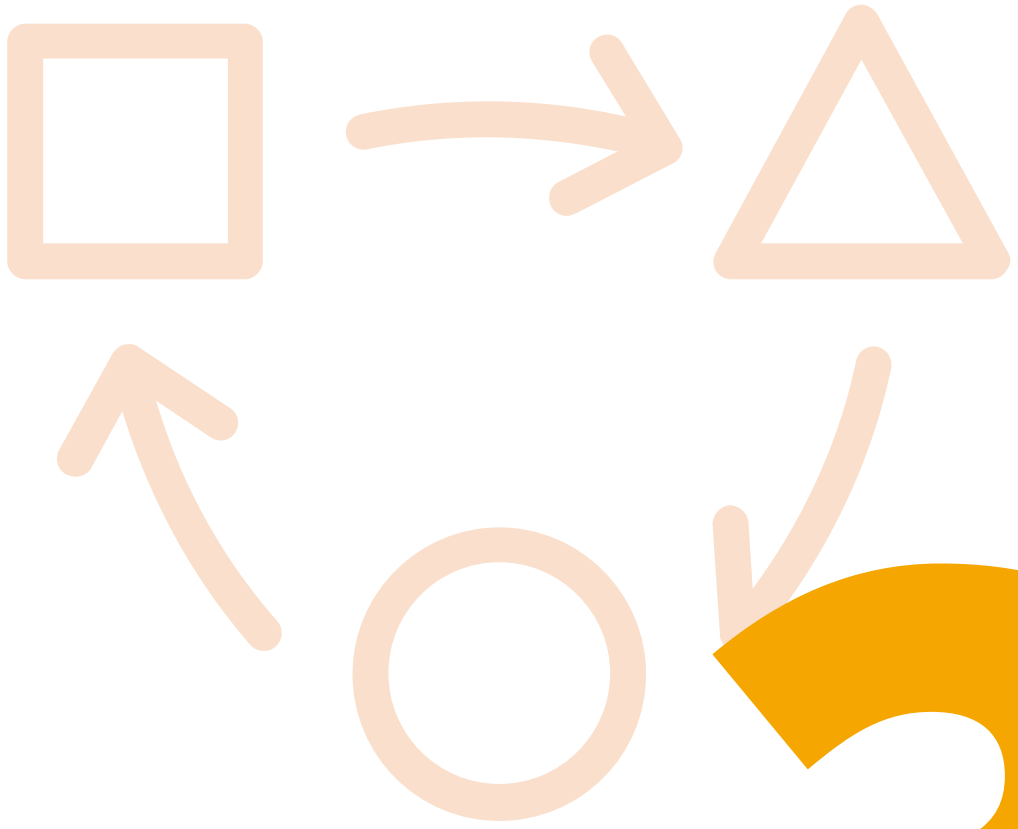
Step-by-Step in Lebanon

Step-by-Step is a WHO psychological intervention for depression. It uses a digital guided self-help format to train people in behavioural activation and other therapeutic techniques such as stress management and positive self-talk.

In 2020, amid concurring economic, humanitarian and political crises and the COVID-19 pandemic in Lebanon, a culturally adapted version of Step-by-Step using a guided self-help format was tested with Lebanese citizens and displaced Syrians through two large randomized controlled trials.

The trials showed that the intervention was effective in reducing symptoms of depression and improving functioning and well-being, including at three-month follow-up. The trials also showed it could be delivered safely, with procedures developed to ensure support to people in high-risk situations (e.g. imminent risk of suicide). Step-by-Step has subsequently been scaled up as a national service in Lebanon and is available to anyone in the country. People who completed the programme said it was relevant, acceptable and beneficial.

Sources: Cuijpers et al, 2022 *(26)*, Cuijpers et al, 2022 *(27)*.



3

Adaptation

KEY MESSAGES

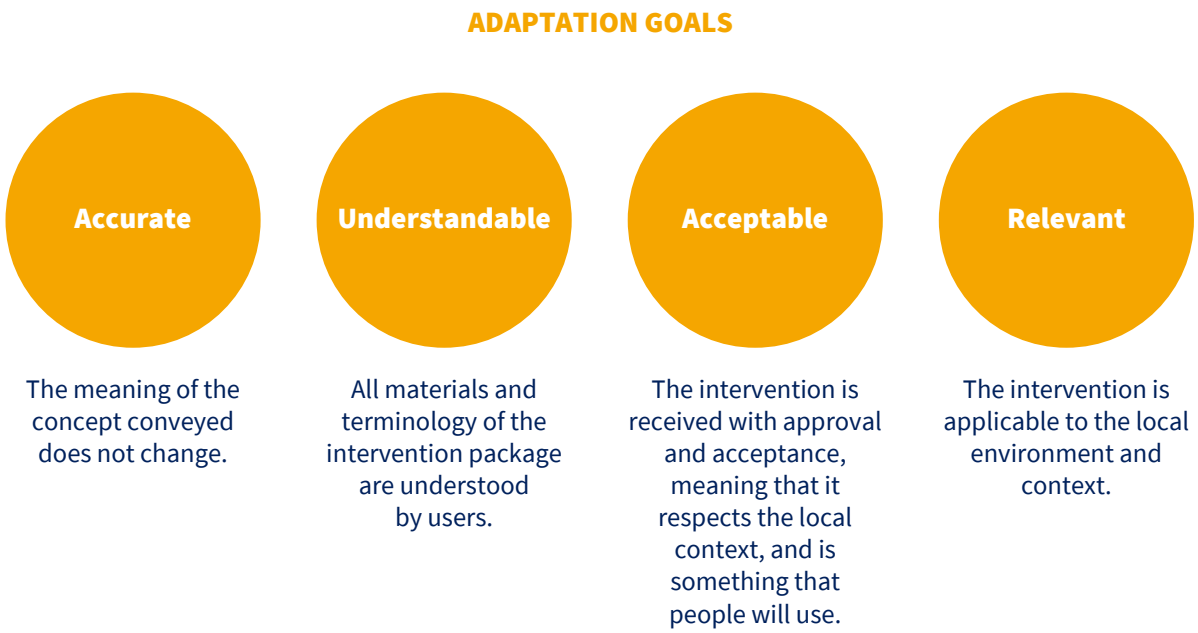
- Adapt intervention materials for use in the local context by ensuring they are accurately translated and locally understandable, acceptable and relevant.
- Ensure there is sufficient time and resources for adaptation.
- Maintain the core therapeutic components of the intervention during the adaptation process.
- Document all adaptations in a systematic way.

All chosen psychological intervention materials will need to be adapted to the local language, context (e.g. health system, human resources, infrastructure), and culture (e.g. attitudes, beliefs and social norms).

Adaptation not only involves translation but also changing other aspects of the materials related to the psychological intervention package. These materials include the intervention manual detailing the treatment protocol, training and supervision materials, handouts, and audio-visual materials.

All materials in the adapted intervention package need to be accurate as well as understandable, acceptable and relevant to the people using them (see Fig. 3.1).

FIG. 3.1
The goals of adaptation.



COMMUNITY ENGAGEMENT

Local community members provide essential insight into whether materials are understandable, acceptable and relevant. Involving local community members in the adaptation process will also increase their engagement with the service.

Adaptations will be most helpful when diverse members of communities are engaged, including not only people with lived experience but also potentially community workers, mental health professionals, traditional healers and future providers of the adapted intervention.

It is important to include representatives from marginalized groups and minority groups for whom equitable access to effective mental health supports is vital.

3.1 Prepare for adaptation

Successfully adapting the intervention package will increase an intervention's impact and uptake among the target population and reduce the risk of doing harm to local communities. It also allows planners to account for variable programme capacities and constraints.

The degree to which an intervention package needs adapting depends on how similar the target population is in terms of age and gender of the population in which the intervention was previously tested. It also depends on how similar the local context is to that where the intervention was previously tested. There may be different:

- social, individual and cultural issues, for example related to gender, disability, language, religion, idioms of distress, attitudes toward mental health and mental health care;
- resources available, for example for health care, social care, as well as informal supports; and
- other contextual issues, for example conflict, forced displacement, disease outbreaks, and climate challenges such as flooding.

There are different degrees to which materials may be adapted. Adaptation can simply mean re-drawing illustrations or changing people's names in case studies so that they are more familiar to target populations. Or it can involve more complex changes, for example to reflect local concepts of distress or healing (see Fig. 3.2).

The degree of adaptation may also depend on the intervention itself. Interventions that are broadly developed for low-resource settings tend to be designed for populations affected by different forms of adversity and may be easier to adapt for a specific LMIC context than interventions developed for high-income settings. Similarly, materials illustrated with people from different cultures may require fewer adaptations than those illustrated for a specific cultural or ethnic group. Often adapting an intervention for specific populations can be simply achieved by adding new examples relevant to that group, rather than re-writing the whole manual.

Importantly, adaptations should not cause the purported active ingredients of the intervention to be lost, as that may make the intervention's effectiveness highly uncertain. For example, if an intervention involves discussing risks of suicide, removing this aspect to be more culturally acceptable may ultimately undermine the intervention's benefits.

Adaptations may involve changes to both the content and format of the intervention package. For example, if the intervention uses text-based handouts but the target population is largely illiterate, the handouts may be adapted to be illustrations, audio materials or videos.

FIG. 3.2

Examples of cultural adaptation to PM+.

3.1.1 Secure financial and human resources

Before starting the adaptation process it is important to secure time and resources, and to set clear parameters, for adaptation.

An adaptation team is typically needed and should include people with a mix of expertise and experience. Adaptation teams should include at the very least:

- local mental health professionals with relevant language skills (i.e. the language of the original manual and the language spoken by local people); and
- future providers of the intervention with relevant language skills.

Depending on resources available, adaptation teams may also include:

- people with lived experience, including those from minority or marginalized groups;
- community gatekeepers from diverse backgrounds (for example village elders, religious leaders, traditional healers);
- local government representatives working in the areas of health and social care; and
- other experts in the local context, such as medical anthropologists.

Professional translators are rarely suited to translating intervention manuals as they tend to use language that is too difficult for lay providers.

The adaptation team should preferably be led by someone who is bilingual with experience in the intervention and/or adaptation. The team also needs a timeline and a budget. These will depend on the volume of the materials and the extent to which adaptation is necessary, as well as the thoroughness of the adaptation process. The process should include an evaluation of the adapted materials by stakeholders, including service users. Interventions that use audio or video materials or extensive illustrations may require more time and greater community review because such materials are hard to change once put to use (see Box 3.1 Adapting self-help materials in section 3.2 Adapt psychological interventions).

3.1.2 Set parameters for adaptation

Setting parameters for adaptation is about identifying which parts of the intervention package will be adapted. Key questions follow.

Who is going to use the materials? Different materials in the intervention package are designed for use by different groups of people, such as trainers, supervisors or service users. A nuanced approach based on likely user groups is important in multilingual settings.

How will the materials be used? Different parts of the intervention package will be used in different ways, which impacts whether and how they should be adapted. Written text and audio recordings are likely to require translating into local languages.

How will the materials be delivered? If the intervention will be delivered in a different format to the original, then the materials in the intervention package likely need adapting. For example, a change from in-person to remote delivery will mean the intervention manual and handouts for service users may need to change.

What are the intervention's active ingredients? All psychological interventions will include specific therapeutic components, or active ingredients, (for example behavioural activation) as well as non-specific components (such as showing empathy). Removing or changing active ingredients during adaptation risks undermining the intervention's effectiveness (see section 3.2.5 Agree on adaptations for examples of correct and incorrect adaptations).

In most cases, deciding which materials to adapt involves finding the right balance between preserving the therapeutic components of an intervention while making it understandable, acceptable and relevant to the target population.

BOX 3.1.

Adapting self-help interventions

Self-help interventions that use substantial media such as illustrations, audio materials or videos may present unique challenges. The components of adaptation still apply, but they may be implemented using a more iterative approach to adaptation and review. For example, rather than re-drawing all illustrations or re-recording an entire audio or video intervention, it may be better to take a small section, adapt that and then test it with community members before moving on to the next section and so on, until the whole intervention is adapted. An iterative approach will help reduce errors that may be costly to fix later.

The quality of audio and video production for self-help materials matters, including in adaptations. It is also important to get the language and tone correct, as this is hard to undo after recording. Reviewing examples of popular media (e.g. television adverts, national radio shows) can help with understanding the warmth or tone needed in self-help materials, especially if there are complexities, such as formal and informal types of expression, or multiple dialects.

3.2 Adapt psychological interventions

Adaptation comprises eight components that can be categorized as essential or optional, depending on context and resource availability (see Fig. 3.3 and sections 3.2.1 to 3.2.6) (*28*).

These components are not set in stone: both the components themselves and the order in which they are carried out can be modified. In some cases, there may be reason to exclude a component altogether. For example, if stakeholders already understand the language that the intervention package comes in, you do not need to translate materials. Similarly, you can substitute a literature review or rapid qualitative assessment with a wide variety of stakeholder interviews, particularly in areas where the context is already well understood. In some cases, you may choose to repeat components, for example doing multiple rounds of adaptation and re-evaluation with stakeholders for complex media (see Box 3.1. Adapting self-help interventions) or when indicated after pilot testing.

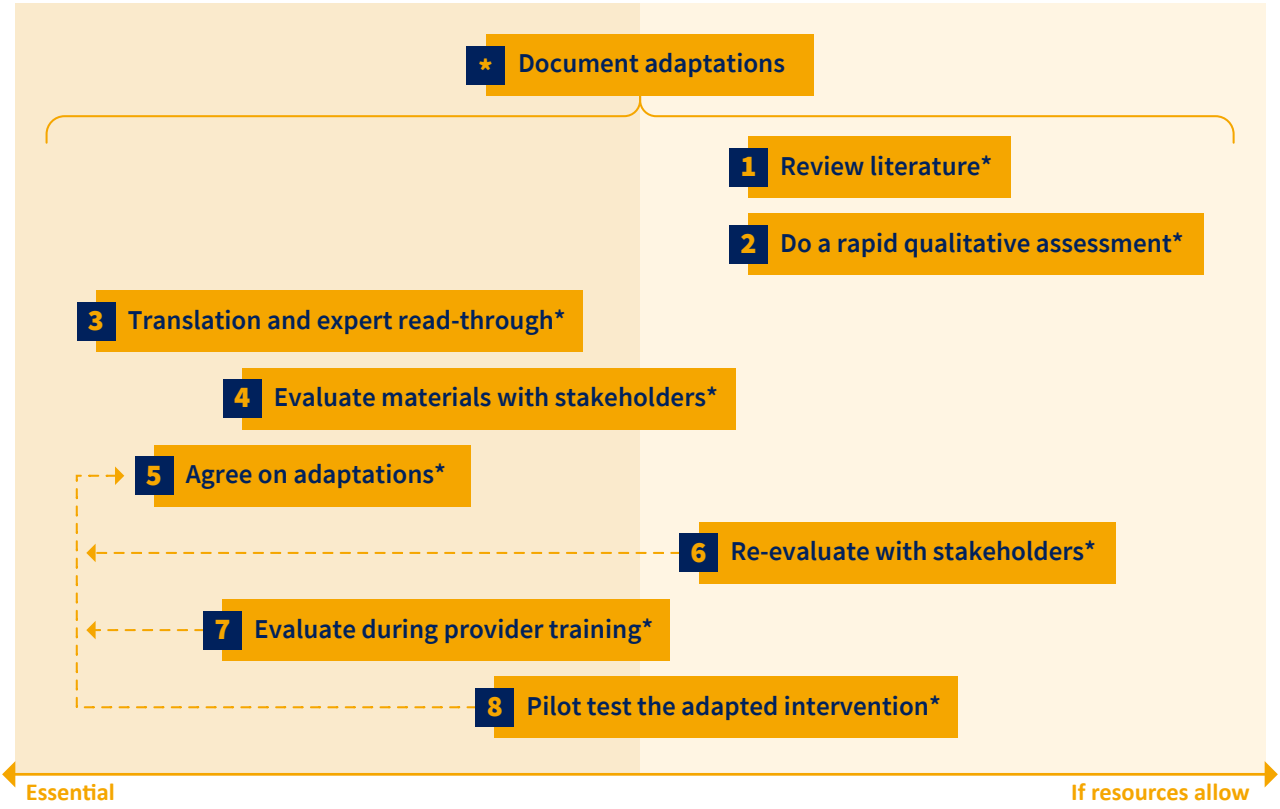
Ultimately, the time and effort given to adaptation will affect the impact and uptake of the intervention so even in low-resource settings, you should aim to do all components.

Documenting changes is a cross-cutting component that should be done continuously, throughout the adaptation process. You can use an existing adaptation monitoring form to document changes (see Annex 3 for an example) or you can create a new one. Either way, as a minimum, the form should, for each adaptation, record information on:

- which part of the intervention is being adapted (e.g. an exercise, illustration, text of storybook or training materials);

- what the problem with the source content is (e.g. an example is not understood) and how this problem was identified (e.g. user-testing);
- what the recommended adaptation is (e.g. change an example or term to something that is locally familiar); and
- what supports the decision to make an adaptation (e.g. it is not accurate, understandable, acceptable or relevant).

FIG. 3.3
Multiple components of adaptation.



3.2.1 Review literature

Activities. Review the literature – both peer-reviewed and grey – to:

- summarize information on the prevailing norms, attitudes, beliefs and behaviours around mental health (e.g. idioms of distress, explanatory models, help-seeking) for the setting and target population; and
- identify other relevant background information on mental health conditions and services.

Methods. Desk-based search for, and analysis of, locally relevant quantitative or qualitative information on mental health and mental health care.

Notes. These data may already have been collected as part of a situation analysis (see section 2.1 Identify local mental health needs and capacities). Do a regional review if you plan to implement the intervention for a specific region of a country; if you plan to implement it nationally, do a national review.

3.2.2 Do a rapid qualitative assessment

Activities. Gather information about local mental health conditions and concerns, specifically from local stakeholders, to better understand how communities perceive constructs relevant to the intervention being adapted.

Methods. Focus group discussions, free listing interviews, key informant interviews *(29)*.

Notes. These data may already have been collected as part of a literature review (see section 3.2.1 Review literature). Rapid qualitative assessment can have the added benefit of creating awareness of the intervention among the target population and building the trust and buy-in of local communities. Engage diverse local stakeholders to cover the full range of perspectives, including mental health service users, local mental health professionals, local health care workers and community leaders and representatives. You can also get information for adaptation by consulting local mental health professionals and medical anthropologists familiar with the context.

3.2.3 Translation and expert read-through

Activities. Translate the original intervention package into the target language. Document any items that were not literally translated and any resulting changes made to the content. Conduct an expert read-through of the materials to identify initial adaptations (e.g. suggesting changes in language and content to fit into the local context, without changing the active ingredients).

Methods. Full translation of all materials, followed by a one-day read-through workshop for experts (including a bilingual mental health professional).

Notes. One objective of the read through is to gain perspectives from people experienced in delivering similar psychological interventions. It is especially important to find the best translation possible of mental health terms (e.g. “suicidal thoughts” or “feeling sad”). Language describing emotions can be particularly difficult to translate, especially metaphors (e.g. “feeling empty”, “feeling blue”, “feeling down”). The translation should not only be accurate and understandable but also be acceptable. You want to avoid stigmatizing terminology that might keep potential beneficiaries away. Slang and derogatory terminology for mental health concerns can be a major deterrent to participation in care.

Maintain tone in translated materials and use informal language that is warm, friendly and easy to understand in materials designed directly for service users, such as handouts and audio-recorded relaxation exercises.

Pay special attention to sample dialogues and scripts: their translation should reflect simple, culturally appropriate spoken language. In some cases, this may mean translating the dialogues or scripts into a local language or dialect that does not exist in written form. Always check the accuracy of translated dialogues through blind back translation.

Doing translation iteratively – e.g. translating key terms or small sections of content, checking these with stakeholders and then translating further sections – can help save resources by reducing the need for re-translations later on (see also Box 3.1. Adapting self-help interventions).

Some psychological intervention manuals include copyrighted questionnaires, such as the Patient Health Questionnaire (PHQ-9) or the WHO Disability Assessment Schedule (WHODAS). Always get permission of the copyright owner before translating and reproducing these materials; it is

also worth checking whether the questionnaires have already been translated and validated. Procedures for translating and validating questionnaires are beyond the scope of this manual.

3.2.4 Review materials with stakeholders

Activities. Evaluate the materials with local stakeholders (including community members, service users and providers) to gather feedback on meaning, understanding, relevance, and acceptability of content. Test parts of the translated intervention with future trainers and providers. Use the information gathered to identify any further changes required to adapt the intervention to the local context.

Methods. Cognitive interviews and short practice training sessions with future providers.

Notes. Cognitive interviewing is a technique used to evaluate survey questions (*30*). But it has also proved useful for developing and adapting psychological interventions (*31*, *32*). During a cognitive interview, people listen to, read or look at specific materials and are asked questions such as "How do you understand this content?", "What relevance does it have to you and your community?", or "Is it offensive in any way?". Cognitive interviews can be conducted in a group or individually.

Including practice training and sessions for providers is important because it is easier for providers to comment on materials if they have had experience using them. Use the adapted materials during the practice training and include mock sessions (using pretend service users). Practice trainings can cover all adapted materials or just some of them. Evaluate the materials afterwards with both trainees and mock service users, either through individual interviews or group sessions.

3.2.5 Agree on adaptations

Activities. Review all potential adaptations, decide which ones will be made, and finalize a draft adapted intervention package. Document all adaptations in a systematic way.

Methods. One-day workshop for members of the adaptation team to review adaptations, followed by editorial changes to the translated materials. Where needed, do a blind back translation (where a different translator re-translates the content from the target language back to the source language).

Notes. In deciding and implementing adaptations it is not enough to just state what will be adapted. You should also specify exactly why and how it should be adapted. Table 3.1 gives examples of correct and incorrect adaptations.

3.2.6 Re-evaluate, test in training and pilot the adapted intervention

Activities. Once an adapted manual is available for use, you can choose to do another round of evaluation by stakeholders (and a subsequent round of agreeing adaptations) if resources allow (see sections 3.2.4 and 3.2.5). Otherwise, start testing the adapted intervention package. Train providers in how to use the adapted intervention, then pilot test it with a small number of service users before refining the adaptation based on feedback received.

Methods. Full training for providers (including practice cases under close supervision) and interviews with providers, supervisors and service users after practice cases. This can be followed by further revisions then a pilot or small-scale implementation and even further revisions if required.

Notes. Use evaluations and feedback forms to gather qualitative data from providers, supervisors and service users on the clarity, relevance and acceptability of the intervention throughout re-evaluation, testing and pilot implementation. All these insights help inform further suggestions for adaptations and refinements of the intervention package.

TABLE 3.1

Examples of correct and incorrect adaptations to psychological interventions.

COMPONENT TO BE ADAPTED	CORRECT ADAPTATION	INCORRECT ADAPTATION
Slow breathing (for stress management)	Replace the breathing exercise with another effective relaxation exercise such as progressive muscle relaxation or mindfulness meditation.	Replace the breathing exercise with an exercise that has not proven to have an equivalent relaxing effect such as watching television, listening to music, drinking alcohol, smoking etc.
Behavioural activation	Change any metaphors used to explain behavioural activation to be more relevant.	Delete explanation of why behavioural activation works. Change the protocol to only include pleasant or task-oriented activities (protocols should include both).
Problem solving	Change how problem-solving is explained or break problem-solving steps down to make them easier to understand.	Delete or skip problem-solving steps from the protocol. Change the strategy to be used for unsolvable problems.
Seeking social support	Choose locally relevant examples of seeking social support. Add an illustration to show different types of social support.	Leave out guidance about seeking different types of social support.
Case examples	Change the names and activities in case examples to be more relevant in the local context.	Change the case examples in such a way that it is no longer clear how the intervention had an impact. Limit case examples to members of the majority social group.
Illustrations	Show local people in local clothing, homes and community settings.	Delete all illustrations.
Suicide risk management	List locally available referral options for people at imminent risk of suicide.	Remove any suicide risk assessment because it is considered culturally insensitive.

4

Workforce

KEY MESSAGES

- Select providers based on attitudes, personal characteristics (e.g. compassion), knowledge, skills and experience (e.g. in helping roles) in the community.
- Equip providers with the right skills through competency-based training.
- Ensure ongoing supportive supervision from appropriately experienced people to build providers' confidence and competence, promote safe and ethical practice, provide support for challenging cases and encourage providers' self-care.
- Use regular assessments of fidelity, competency and attendance throughout training and in supervision to assure quality of care.

The main resource required to deliver psychological interventions is people, so developing a competent and confident workforce is key. The groups of workers that will provide the intervention should have been identified during planning (see section 2.6 Identify human resource needs).

In many cases, especially in LMICs, these providers will likely be non-specialists. It is important to ensure they are properly trained, regularly assessed for competency when they start delivering interventions, and continually supervised and supported throughout the time they provide interventions. The need for quality training, supervision and support of non-specialist providers is often underestimated.

4.1 Choose the workforce

Providers, trainers and supervisors require different levels of knowledge, skills and experience. In many cases, the planned psychological interventions will be delivered by a limited group of existing staff in a service, and it will be clear exactly who will do what. In other cases, the workforce for psychological interventions will need to be developed by carefully choosing specific people from existing personnel to serve as providers, trainers or supervisors; or by recruiting new workers.

4.1.1 Choosing providers

Providers need to be motivated, compassionate and have various other attitudes, skills and experience to help them excel in their role (see Table 4.1). Some attitudes are harder to change through training than others so it can be useful to evaluate these during the selection process. One way of doing that is to present candidates with case studies and role plays during their interview and observe their reactions and suggested responses.

Providers need a range of foundational) helping skills (also known as basic helping skills) as well as technique-specific skills to deliver the psychological intervention. It is not essential for people to have prior experience as a provider, as helping skills are teachable (see section 4.2.1 Competency-based training). Nonetheless, it is preferable to choose people with demonstrated foundational helping skills.

COMMUNITY ENGAGEMENT

A broad range of community providers (e.g. community workers, volunteers, people with lived experience of mental health conditions, and university graduates in psychology without clinical training) can be trained and supervised to effectively provide psychological interventions (2). These providers may vary substantially by setting. They are often more acceptable and approachable to service users because they tend to share or have deeper knowledge of local attitudes, customs and languages.

Community providers are well-placed to reach out and discuss mental health and psychological interventions with fellow community members. They can help inform and involve community members in planning the psychological interventions (see Chapter 2). Community providers can help identify people with mental health conditions, provide them with care, and connect them to relevant services and resources in the community.

TABLE 4.1

Examples of preferred attitudes, skills and experience to look for when choosing providers of psychological interventions.

AREA OF EXPERTISE	EXAMPLES
Attitudes and personal characteristics	• Motivation to help others. • Sense of compassion. • Being non-judgemental, especially towards vulnerable individuals.[a] • Being trustworthy and reliable. • Being mature, insightful, and self-motivated. • Being currently emotionally stable (note that a history of lived experience of a mental health condition can be an asset).
Knowledge and skills	• Education requirements (e.g. completion of a specified number of years of schooling). • Foundational helping skills. • Organizational skills. • Knowledge of the local context. • Relevant language skills for training and service provision. • Group leadership and facilitation skills (only for group interventions).
Experience	• No history of perpetrating violence, exploitation or abuse. • Previous experience in providing psychological interventions or other psychosocial support. • Previous experience with, current links to, and standing in, the local community. • Previous experience in working with adolescents and children (for interventions with adolescents and children).

[a] Including anyone who may be vulnerable or marginalized because of their: ethnicity or nationality, gender, mental health conditions, substance use, exposure to sexual violence or intimate partner violence, child abuse, poverty, disability, sexual orientation or gender identity, legal status (e.g. refugee status), political affiliation, or history of having perpetrated violence or crime, among other things.

It is also important to consider a potential provider's experience with the community and whether this will have any impact on the target population's readiness to receive help from them. For example, in some contexts it might not be seen as appropriate for male providers to see female participants.

4.1.2 Choosing trainers and supervisors

Trainers and supervisors are often the same individuals. Both need substantially more mental health knowledge and skills than providers. But the level of expertise required will vary depending on the intervention and the model of training and supervision used (see section 4.2.2. Training model and structure).

Trainers and supervisors should have the same inherent attitudes and personal characteristics as those identified for providers (see Table 4.1). They should also have:

- mental health care provision skills and experience;
- relevant administrative skills, including record-keeping, follow-up and referral;
- good facilitation and problem-solving skills;
- enthusiasm for, interest in and commitment to training and supervision; and
- availability to provide support and supervision (*33*).

The best trainers and supervisors are enthusiastic, empathetic, interested, accessible and skilled. They are also competent providers. They are eager to mentor and support less experienced workers. They understand and value different training and supervisory techniques. They have a good understanding of mental health and experience in providing care. Ideally, they have experience with the chosen psychological intervention manual, or at least the type of psychological treatment (e.g. CBT, IPT) on which the intervention is based. In settings where no mental health specialists are available, non-specialists that are trained and experienced in assessing and caring for mental health conditions (for example through long-term work delivering psychological interventions) may fill the role of supervisor or trainer, although these providers will then also need some level of supervision *(33).*

4.1.3 Other points to consider

Intervention-specific criteria. Check whether the psychological intervention comes with specific criteria for providers, trainers and supervisors. For example, the WHO Group IPT intervention manual states that trainers and supervisors must have received Group IPT training and completed at least three groups under supervision (*34*).

Selection process. In addition to specifying criteria for selection, think about how the selection process for providers, trainers and supervisors will work in practice. For example: who will be involved? How and where will the position be advertised? Will there be an interview involving case examples and role plays?

Existing workloads and availability. The existing workloads of potential trainers and supervisors is usually very high. In all cases, before appointing providers, supervisors or trainers, consider the other demands on their time and whether these will interfere with their prospective role. It is also important to make sure that providers are clear on the time expectations and commitment involved in their role. Check that providers plan to be available for training and for ongoing service delivery (to minimize staff turnover). Identify any reasons they may not be able to carry out this work over the expected timeframe for implementation.

Primary health care settings. In primary health care settings, beware selecting general health workers with physical health care responsibilities (e.g. general physicians) as providers of time-consuming interventions. These workers typically do not have time to deliver psychological interventions if these involve multiple sessions that may last up to an hour or more. Instead, consider selecting workers who can dedicate their time to offering the intervention. Depending on the context, these may be mental health specialists, care managers, or community providers.

Managing expectations. Before they commit to the role of provider, people must understand what will be expected of them before, during, and after the training. Clearly communicate the required time commitments and any financial compensation to all prospective providers and make sure they are well understood.

4.2 Train the workforce

Training is used to equip the workforce with the competencies they need to deliver psychological interventions safely and effectively. Competency has been defined as the observable ability of a person, integrating knowledge, skills and attitudes in their performance of tasks. Competencies are durable, trainable and, through the expression of behaviours, measurable (*35*). Supervisors and trainers also need training, especially if they are non-specialists themselves.

Many psychological intervention packages come with training materials.

4.2.1 Competency-based training

WHO promotes a competency-based training and education of health care providers *(36).* Providers of psychological interventions need two types of competencies to do their job. Foundational helping skills are generally applicable to all interventions and typically include building a warm and trustworthy relationship with the person receiving the intervention. They also include, for example, building rapport, using verbal and non-verbal communication skills, demonstrating genuineness, protecting confidentiality, and ensuring non-discrimination and inclusion.

As well as foundational helping skills, providers will typically also need technique-specific skills, which may include problem solving, cognitive or motivational enhancement techniques among others, depending on which psychological intervention is being implemented. They may require additional competencies if they are delivering the intervention to individual adults, children or families, or to a group.

For supervisors, other areas for training may include how to deliver constructive feedback, how to manage challenging situations when treating people, and how to manage any context-specific issues.

Ensuring Quality in Psychological Support (EQUIP) is a WHO initiative that supports competency-based training and assessment (*37*). It includes a range of competency assessment tools that cover both:

- foundational helping skills for working with adults (ENACT) or children and adolescents (WeACT) or for facilitating groups (GroupACT); and

- technique-specific skills, including in behavioural activation, cognitive behavioural therapy, interpersonal techniques, motivational enhancement, problem solving, and stress management.

Competencies for providing psychological interventions can be assessed by measuring providers' attitudes and knowledge as well as, importantly, their ability to perform required skills in controlled or real-world settings as measured using competency assessment tools. This can be achieved in different ways, including:

- structured role plays that allow for providers' skills and behaviours to be measured in a pretend session; and
- direct observation during live or recorded sessions with real people receiving the intervention to measure how well providers perform skills after training.

A key feature of EQUIP and other competency-based training is to assess and provide feedback on skills and competencies before, during and after training. Doing a baseline competency assessment at the start of training can help ensure that the training is pitched at the right level to meet trainees' needs. Regular assessments throughout training (and beyond) enable trainers and supervisors to chart progress in skill development over time, identify strengths and weaknesses in performance and customize training and supervision to fill gaps in skills and knowledge.

EQUIP assessments have been developed specifically for use with non-specialists. They are a critical ingredient of quality assurance (see section 4.3.3. Assure quality of service provision). They can also be complemented by additional tests for measuring knowledge and attitudes.

EQUIP-based training has been proven to reduce harmful behaviours and increase competencies of trainees compared with conventional training methods (*38*).

4.2.2 Training model and structure

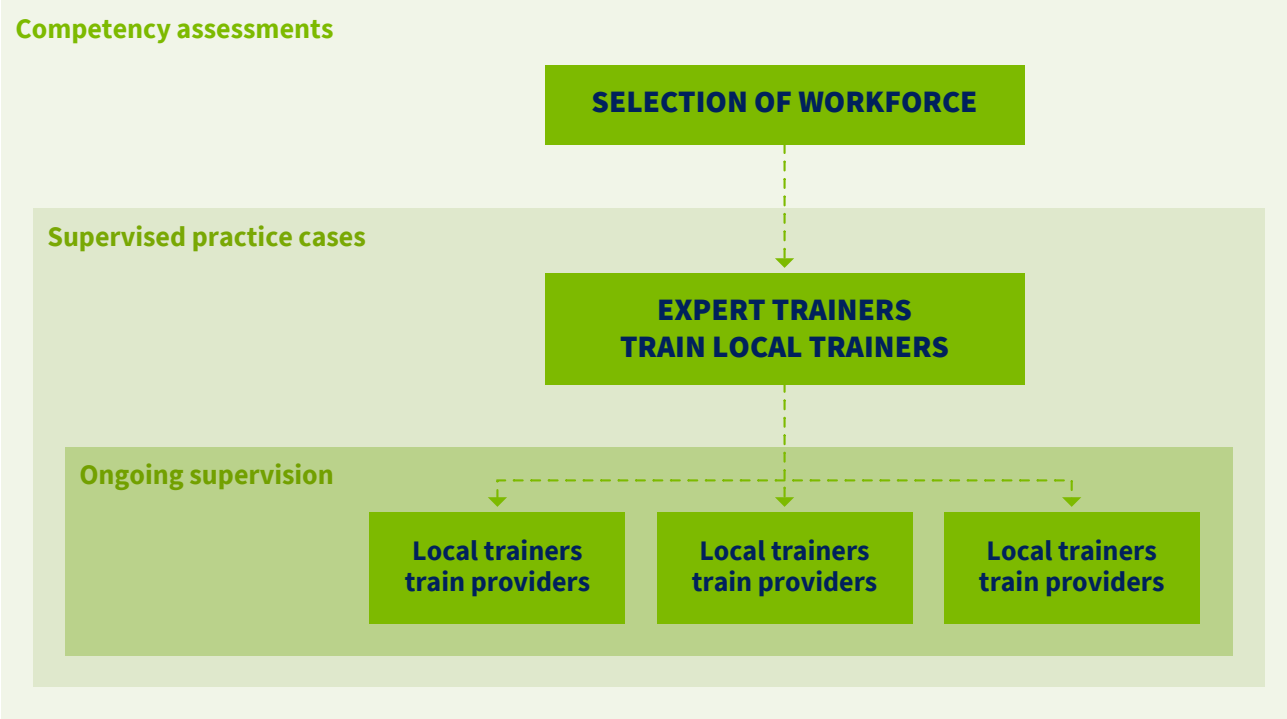
Training of non-specialist providers can be given in many ways.

- **Pre-service education** (also known as pre-qualification training): training in psychological interventions is integrated into the teaching curricula of formal education programmes for future professionals.
- **In-service training:** individuals who are already in the workforce are trained to provide psychological interventions.
- **Apprenticeship training:** apprentice providers and supervisors are given some initial training in psychological interventions, followed by on-the-job support to apply and expand their knowledge and skills through supervision, coaching and mutual problem solving (*39*). This can happen both in pre-service and in in-service settings.
- **Training of trainers:** expert trainers (often referred to as master trainers) teach the psychological intervention to a group of locally-based future trainers, who then train providers in either pre-service or in-service settings (see Fig. 4.1).

The training of trainers model (also called a cascade model training) is popular for training non-specialist providers in LMICs. It is ideally led by expert trainers who know the interventions very well, have implemented the intervention themselves and have experience in training psychological interventions. In low-resource settings, this model has also been applied to supervision, where an expert supervisor is appointed to supervise a group of local supervisors who in turn supervise individual providers.

FIG. 4.1

Components of the training of trainers model (which can also be applied to supervision)



Each model of training should use a range of training techniques, such as instruction, demonstration, discussion and reflection. Practising the intervention through role-play, both in the classroom and out of it, is particularly important to build providers confidence and competence. The classroom training will need to include being trained in the intervention protocol, but also information about mental health problems, foundational helping skills, and the rationale for each of the strategies used in the intervention. After classroom training, providers need in-field training in the form of practice cases. Supervised practice strengthens helpers' knowledge of and skills in an intervention and is essential to build the necessary confidence. Trained providers should receive ongoing support through supervision and their performance should be regularly monitored and evaluated (see sections 4.3 Supervise providers).

Whichever model of training is used, consideration will need to be given to how the training is structured and resourced; and how the impact of training will be measured.

Most psychological intervention packages include example timetables for training, based on what has proven effective in research studies. These may need to be modified for the setting or to match different levels of existing knowledge and skills. Following up with periodic refresher training can be useful, especially when informed by competency assessments that can identify gaps in knowledge and competence.

Where and when the training takes place can impact whether trainees are able to attend. Questions to think about include: will the training be done face-to-face or remotely? Is the training location easy and affordable to get to? Will trainees need to take time out of work to attend? Does the location have the space and infrastructure necessary to complete all components of training?

4.3 Supervise the workforce

Supportive supervision (also called clinical supervision) is required to ensure providers use their learning to provide quality interventions. It is also an opportunity for providers to continue developing and refining their skills.

Organizing supportive supervision is not an option. In the apprenticeship model of supervision, local supervisors are themselves supervised by an expert supervisor (*39*).

4.3.1 Components of supervision

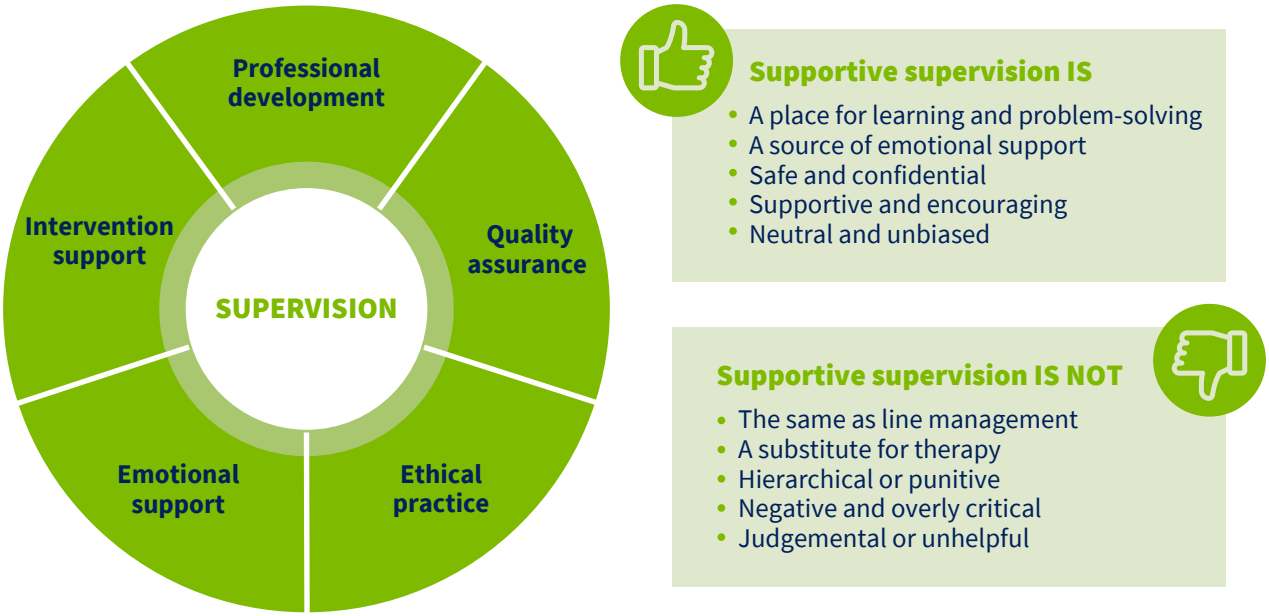
Supervision builds providers' confidence and competence in delivering the intervention. It helps ensure providers adhere to the psychological intervention and provides technical support for, and ethical oversight of, challenging clinical cases. Supervision also serves to protect and promote providers' well-being by providing emotional support and encouragement (but it should never be a replacement for mental health care). Non-specialists with little to no experience in mental health care may find it particularly stressful to deal with the distressing topics raised.

Key activities undertaken during supervision include (see Fig. 4.2):

- **Intervention support**, for example working together to solve problems in providing the intervention. This type of support may also include discussing specific cases to aid decision-making, especially on how to address issues such as imminent risk of harm and when to refer to a mental health specialist service or other support.
- **Skills development**, for example through teaching, coaching and support for independent learning so that providers can grow and develop their competencies and improve service delivery. Enabling opportunities for development can also boost job satisfaction and improve staff retention.
- **Quality assurance**, specifically by evaluating how the intervention is provided and assessing competence (see section 4.3.3. Assure quality of service provision).
- **Ethical practice**, which potentially spans a wide range of issues, including limits to confidentiality, and not requesting or accepting personal favours.
- **Emotional support**, for example supporting providers to recognize and manage their own reactions and stressors and, where necessary, referring them to external services and supports.

FIG. 4.2

Key components of supportive supervision.



The overall aim of supervision should be to support rather than police providers. It should offer a safe, confidential and collaborative space where providers can openly discuss their difficulties and be recognized for their successes; and where they can work with their supervisors to share experiences, solve problems and improve performance (*40*). It should provide a neutral and non-judgemental space where providers can learn to recognize and challenge any bias, stigma or prejudice relevant to their work (*40*).

Supportive supervision is not the place for unhelpful or overly critical feedback. Neither is it the place to deal with managerial issues such as time off, pay or disciplinary actions. And it should not be the place where providers go to receive extensive personal counselling or advice on personal issues unrelated to work.

Sometimes the person providing supportive supervision will also be the provider's line manager. In these cases it is important to ensure that supervision and management issues are kept separate.

4.3.2 Supervision format

Supervision can be delivered in many formats, for example as individual or group sessions that may or may not include direct observation (see Table 4.2). In some cases, providers come together as a group without a supervisor to support each other in mutual learning. Experience shows that with additional training and experience, non-specialist peer-led supervision is also possible *(41)*.

TABLE 4.2

Examples of different formats for delivering supervision.

FORMAT	KEY CHARACTERISTICS
Individual supervision	*One-to-one meeting between supervisor and provider.* • Activities are tailored to the individual and may include discussing specific tools, techniques and issues about the intervention as well as role-play, case presentation, progress review, skill development activities, reflection and self-care. • Particularly useful for helping new providers to consolidate their skills and to support them with difficult cases.
Group supervision	*A supervisor meets two or more providers at once.* • Activities vary depending on the group composition but, like individual supervision, may include discussions about specific concerns, role-play, case presentation, skill development activities and self-care. • Particularly useful to foster group learning and peer support. • Can be less personal and more challenging to manage in terms of confidentiality and power dynamics.
Direct observation	*A supervisor directly observes a provider deliver the intervention and gives constructive feedback on what worked well and what could be improved.* • Can be used alongside individual and group formats. • Supervisors will observe the provider's attitudes as well as their technical implementation of the intervention. • Particularly useful for ensuring intervention fidelity, and for supporting new trainees as they begin to see service users. • Requires consent from providers and service users.

Source: Adapted from IFRC 2021 (*40*).

Decisions about which format to use should be based on local context, resources and need. For example, some first-time providers may benefit from group sessions where they can share experiences with peers, receive encouragement from the group and gain confidence in the process. On the other hand, some first-time providers may be better served through individual sessions where they have more time to review their own cases and discuss specific issues.

If resources are limited it may be most cost–effective for supervisors to meet multiple providers at once in a group session over the internet. Additional opportunities for communication (e.g. through messaging platforms) outside of organized meetings can also be helpful to providers; these should have processes in place to ensure confidentiality (e.g. not using identifying information).

4.3.3 Assure quality of service provision

Quality assurance is about making sure that psychological interventions are delivered safely and effectively. It is an ongoing process of systematic assessment that starts during training and continues through supervision, often declining in frequency over time. It can involve assessment of three indicators (*42*):

- **Attendance:** the extent to which the individual turns up to sessions to receive the psychological intervention (a high dropout rate from a multi-session intervention can indicate a problem in how the intervention is being delivered).
- **Fidelity (or adherence):** the extent to which the psychological intervention delivered by a provider matches the intervention manual.
- **Competence:** the extent to which the provider can perform required competencies and activities to a defined standard.

Assessment of all three indicators is required to assure quality of care. For example, a provider can be very competent but if they do not sufficiently adhere to the intervention manual then the positive outcomes associated with the intervention cannot be assumed. Yet even if a provider adheres to the techniques described in the intervention manual, if they are not sufficiently competent then positive outcomes again cannot be assumed. And if the provider is competent and demonstrates good fidelity, the person receiving the psychological intervention can only benefit if they consistently participate in care.

Fidelity can be assessed during training and supervision through observation and feedback on practice or real cases. The trainer or supervisor observes the provider deliver an intervention and assesses the extent to which providers follow the intervention protocols, especially around the therapeutic components. Some intervention packages come with specific fidelity checklists *(43)*.

Competency can similarly be assessed during training and supervision, also through structured role plays or direct observation, for example using EQUIP (see section 4.2.1 Competency-based training) *(37)*.

Attendance can be assessed through attendance records, which are often included in programmatic monitoring and evaluation (see Chapter 6 Monitoring and evaluation).

4.3.4 Points to consider

Roles and responsibilities. Managing expectations is particularly important when trying to establish supportive supervision. Develop clear job descriptions for both supervisors and providers that ensure sufficient and protected time for supervision. It may be useful to establish a supervision agreement with information on roles, responsibilities, boundaries, limits to confidentiality, and availability outside supervision sessions.

Location. In-person supervision is preferable but not always possible. It should be provided in a quiet, private space at a convenient location for both supervisor and provider, using a standard structure for each supervision session. See Annex 2 for additional points to consider if training or supervision is being done remotely.

Frequency. Supervision sessions should take place regularly. Typically, this means every one or two weeks, depending on context and need. Some intervention packages include recommendations on frequency and duration of supervision. In general, the supervision needs of psychological intervention providers will decline with experience. But all providers may at times require extra support when there is a particularly challenging or complex case. So, for example, you may need to develop protocols for contacting supervisors when a service user appears at imminent risk of harm (see Chapter 5).

Tools. Think about what tools and materials supervisors and providers may need to support their work. For example, consent forms are required for any direct observation recordings (video or audio), which are commonly used in pre-service training. These recordings can themselves be a valuable tool for reflective learning if watched together during supervision. Supervision forms can help provide a framework for providing consistent feedback and monitoring progress (see Annex 4 for an example supervision form).

Additional support. Consider what additional support providers may need beyond supportive supervision, especially to resolve administrative problems in implementing the psychological intervention. Such support may include, for example: helping to file records; sorting out transportation issues; nurturing a positive team dynamic; addressing interpersonal issues; or fixing any logistical problems with delivering an intervention.

5

Identification, assessment and delivery

KEY MESSAGES

- Consider which approaches to use to identify potential beneficiaries of psychological interventions.
- Assess people before initiating psychological interventions.
- Informed by assessments, refer people as necessary to the services and supports they need, including beyond the health sector.
- Ensure there are protocols to assess and manage imminent risk of harm (to service users or others), including violence against children and gender-based violence.
- Ensure follow-up care for people who drop out of psychological care or have not improved by the end of the intervention.

Psychological interventions should be part of services within a wider health and social care system that includes pathways to refer people between mental health, health, protection and community services.

This chapter focuses on how to maximize the uptake of psychological interventions by ensuring a system that can successfully identify, treat and follow up potential beneficiaries, and refer people to other relevant services and supports when the available psychological intervention is not suitable or not enough.

There are lots of reasons why an individual may be reluctant or unable to seek help or attend a psychological intervention, even if these are available. Barriers to demand for care may be attitudinal or structural and include factors such as high cost, poor quality and limited accessibility, low levels of health literacy about mental health and available services, or poor previous experiences with seeking help (*2*). Addressing these issues is beyond the scope of this manual. Yet, being aware of these barriers and integrating activities to tackle these barriers will increase the uptake of the intervention.

5.1 Identify and reach potential beneficiaries

During planning, the implementation team identified the target population that should be offered psychological interventions (see section 2.1 Identify local mental health needs and capacities). Before delivering psychological interventions you will need to identify the specific individuals who could potentially benefit from receiving them (i.e. case detection). There are many ways to do this; all essentially involve some form of case detection through initial assessment or screening.

5.1.1 Case detection

Case detection for mental health conditions can be passive or active. Passive case detection waits for potential beneficiaries to present with symptoms of a mental health condition at a service. They are then assessed by trained staff who may identify a mental health condition. By contrast, active case detection methods involve proactive searching for potential beneficiaries among higher-risk individuals and groups. Different approaches to case detection are summarized below.

Routine clinical assessment. In this method, health care providers are trained to identify people with mental health conditions during routine service delivery, based on the individual's self-reported symptoms. This type of case detection requires providers to have sufficient knowledge and skills to spot and assess common presentations of mental health conditions. This is often referred to as opportunistic screening.

Education such as mhGAP training can help general health workers build the competencies they need for case detection during routine clinical assessment (see Box 5.1 Nepal: case detection gains through training). But training is often not enough to ensure that most cases get detected.

Identification in the community. This involves increasing the capacity of community workers to identify people with mental health conditions and inform them about psychological interventions. Community providers, including most social care providers and educational personnel typically do not diagnose people but they are well placed to refer people about whom they are concerned.

Awareness raising through, for example, a community event about mental health and mental health care can be a first step towards identification in the community. Training communities in using specific case detection tools can also substantially improve case identification (see Box 5.2 CIDT: a case detection tool for communities).

Online self-screening. This can involve advertising a psychological intervention online alongside a list of common symptoms with a link to an appropriate screening measure. People who identify with the listed symptoms can choose to complete the screening measure online; anyone scoring above a pre-set cut off value then automatically receives access to the intervention or a referral for further assessment if needed.

Selective screening. In this method, groups of people that are at higher risk of experiencing mental health conditions are systematically screened. Examples of this approach include: screening women for depression when they receive antenatal care or if they attend a women's shelter; screening people for depression and anxiety if they have a chronic medical condition, such as HIV or diabetes (see Box 5.3 Selective screening in South Africa); or screening people for depression if they recently lost employment.

BOX 5.1

Nepal: case detection gains through training

In Nepal, as part of a broader district plan to improve mental health care, the Programme for Improving Mental Health Care (PRIME) trained primary health care workers to detect, assess and manage priority mental health conditions using the mhGAP intervention guide. The project also included a community detection approach (see Box 5.2 CIDT: a case detection tool for communities).

Analyses of case detection in health facilities during and after the project showed that detection rates for depression improved somewhat (from 9% to 25%) six months after training and remained relatively stable for the next two years.

Source: Jordans et al, 2019 (*44*).

BOX 5.2

CIDT: a case detection tool for communities

The Community Informant Detection Tool (CIDT) is a vignette- and picture-based tool for active case detection by trusted lay members of the community.

Because the tool uses recognizable symptom presentations based on vignettes rather than a structured questionnaire, it is easy to use and can be easily integrated into people's daily work. In practice, whenever community workers identify someone with symptoms of mental health conditions as described in the vignettes, they will ask them whether their symptoms cause them any problems in functioning and whether they would like support. Answering positively to either of these questions would prompt the community informant to encourage the person to seek care.

Using CIDT for adults in Nepal led to an increase of nearly 50% in the number of people starting mental health care compared with general awareness raising and self-referral.

There is also a version of the CIDT for children and adolescents.

Source: Jordans et al, 2020 (*45*); van den Broek M et al, 2021 (*46*).

BOX 5.3

Selective screening in South Africa

In KwaZulu-Natal, South Africa, the Department of Health developed a standard operating procedure for selective screening in primary health care clinics as part of its efforts to identify early and treat common mental health conditions among people with chronic medical conditions.

Enrolled nurses were tasked with screening for mental health conditions (alongside other chronic diseases) using a validated tool. A cascade training model was then used to introduce this approach into all primary health care facilities in the province.

Data monitoring across KwaZulu-Natal revealed an overall increase in mental health screening which has helped motivate additional specialist posts. Based on initial experience, the screening protocol was changed to ensure more privacy during screening, which had proved a bottleneck to engagement in the original protocol, given the sensitive nature of responses to the screening questions.

Source: Bhana MA et al; 2019 (*47*).

Never presume that a person needs a psychological intervention just because they have had a difficult life experience or have a physical health condition such as HIV. Only if the screening is positive is the person a potential beneficiary. Even then, it is important to refer them for further assessment to decide whether they need the psychological intervention and are willing and able to receive it.

Universal screening. In this method everyone living in a certain area or attending a certain service (e.g. a primary health clinic) is invited to complete an appropriate screening measure. Those who score above a pre-set cut off value are then offered further assessment. This form of screening is often used in research studies. But it is rarely used in routine services because the number of people who would screen positive for common mental health problems is extremely high, and most services – even in high-income countries – do not have the capacity to offer good enough assessment and care to all of them.

5.1.2 Points to consider

Each method and measure described above can help identify potential beneficiaries of psychological interventions. Choosing which one to use will depend on factors such as the size of the target population, the availability of resources, and the psychological intervention being implemented.

Tools and training. There are many different screening and assessment measures available to aid case detection (see Annex 5. Example measures for screening and assessment). Any measure and pre-selected cut-off point you use should be valid for the population. Check this by looking at the evidence for the measure. If you are screening for symptoms of mental health conditions, make sure that you also consider assessing impact on functioning. Make sure that the people tasked with identifying potential beneficiaries know which tools they should use, and how to use them. In some cases this will mean providing relevant training.

Stigma. Consider whether there might be any stigma associated with the case detection methods and measures being used. This is important to ensure people are safe, comfortable, and willing to disclose any mental health problems during screening and initial assessment.

Formats. Case detection methods and measures should be relevant, and easy to use and understand, both for those doing the assessment as well as those being assessed. The format of screening and assessment tools is important. For example, if they can only be used online then they can necessarily only reach people with access to the internet.

Existing capacity. It is important to consider the workload of the people who would be doing the screening or assessment to ensure that the selected case detection method is feasible.

5.2 Assess people's needs

Once people have been identified as possibly benefiting from a psychological intervention, they should be further assessed before starting care. Assessment is an essential component of mental health care, to ensure people are getting the right support for their needs. Individuals should be assessed at the beginning of an intervention, but also throughout treatment and after it ends, to continuously monitor the individual's progress and address support needs as and when they arise.

Assessment may be done in person or remotely, by the psychological provider or by another person. It may also be possible for potential beneficiaries to do a self-assessment, as is typically the case for guided self-help.

Depending on the intervention and service, various assessment tools may be used, for example, a self-report questionnaire, a diagnostic interview or measures that focus on specific issues such as functioning and quality of life.

The choice of assessment measures is usually also guided by a monitoring and evaluation plan (see Chapter 6 Monitoring and evaluation). Assessments can be useful as a way of monitoring service users, understanding their expectations and initiating the therapeutic relationship.

Assessments can also have therapeutic value for service users if done properly.

- Completing the assessment gives the service user an opportunity to reflect on their progress, see how far they have come and think about what they still want to improve.
- Working together on assessment can improve the therapeutic relationship between service users and providers by empowering service users to participate in their care and giving them a role and measure of control in the process.
- Collecting data openly and in collaboration with service users improves trust and transparency. Service users of psychological interventions may have negative past experiences with health services and may fear or mistrust authorities. Including them in the assessment process can help mitigate some of those feelings.

During assessment, protocols for assessing and managing risk – including risk of suicide or self-harm as well as risk of harm to or from others – help keep service users safe. Some psychological intervention manuals include tools to help monitor key risks, such as imminent risk of suicide (see Annex 6 Example suicide risk form). Safety plans also help protect people from harm; these should be co-developed by providers and service users.

Providers should be trained to take immediate action if there is any concern that someone is at imminent risk of suicide or self-harm.

- A person who has a plan to end their life in the near future needs urgent care. They are typically referred to alternative sources of support, such as specialized mental health services or, when such services are not easily accessible, general health centres trained in, for example, the suicide/self-harm protocol of the mhGAP Intervention Guide.
- A person who attempts suicide at any point during the intervention will similarly need more specialized support, although they may be able to continue with the intervention if this support is available.
- A person who has thoughts about suicide but no plans to act on them can usually continue to receive the psychological intervention but will need close monitoring throughout treatment.

Concern that someone is at risk of harm from others also requires immediate action, which typically involves referring them to a relevant protection service or agency (e.g. child protection or gender-based violence services) (*48*, *49*, *22*). If at any time providers are concerned that the service user may pose an immediate risk to others, they should immediately contact relevant authorities.

5.2.1 Points to consider

Training. Non-specialists can make suitable assessors but they require training and supervision in assessment measures.

Confidentiality and consent. Maintaining a service user's confidentiality and data privacy is essential at all stages of psychological intervention, including before, during and after assessment. Assessments should be conducted in a private space, results should be shared with the potential beneficiary, and any notes and other data gathered by the assessor should be appropriately stored to protect data privacy.

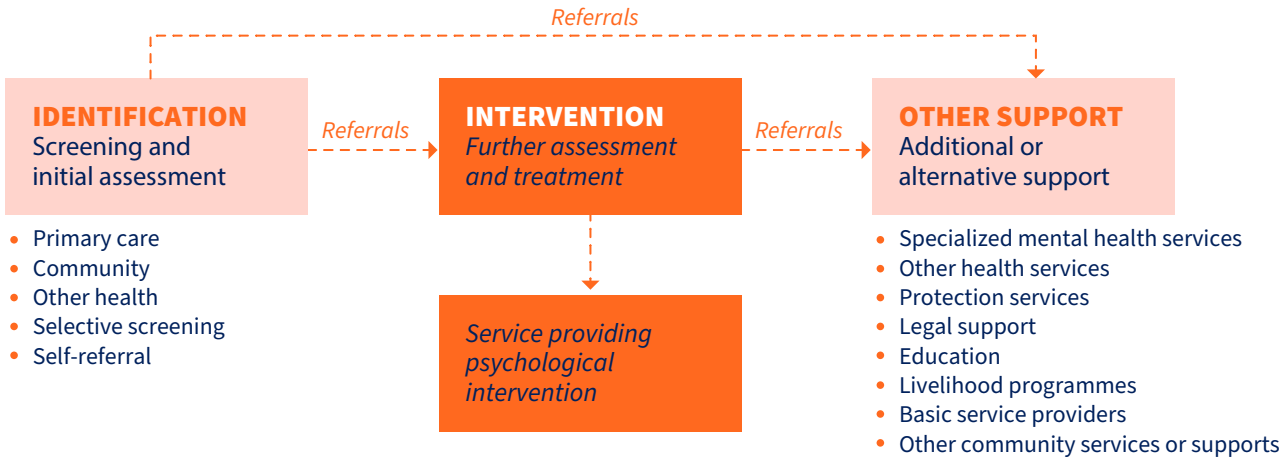
Obtaining the individual's informed consent is critical before any assessment. At the same time, assessors must ensure service users understand the limits of confidentiality and consent (for example imminent risk of self-harm or suspicion of violence against children).

5.3 Refer people to the right source of support

Anyone identified as a potential beneficiary needs to be directed, through referral, to the right source of support, which may or may not be a psychological intervention (see Fig. 5.1).

Referrals can happen at any point of contact with the individual and may involve multiple services alongside the psychological intervention.

FIG. 5.1
Linking people to the care they need through referrals.



Sometimes the assessor should refer the person to another service that is more suited to their needs. This should happen when the person does not meet the inclusion criteria for a psychological intervention, meets the exclusion criteria for the intervention, or requires extra support alongside the intervention.

Being able to direct people to the care they need relies on having the right referral options in place. Links to a wide range of multisectoral services should be available because people being assessed for (or receiving) psychological interventions can have complex and varied needs. Some may be at imminent risk of suicide or harm through intimate partner violence or abuse. Others may be struggling to meet basic needs for food and shelter. Some people may have mental health needs that can't be met by the psychological intervention alone. Others may benefit from the intervention but need additional help to access education or find a job. Some people may need medicines to manage a chronic health condition, such as diabetes or cardiovascular disease. Others may need legal support to address human rights issues. Referrals can happen at any point of contact with the individual. As with assessment, informed consent is required for any referrals.

Establishing or strengthening referral pathways is an essential component of integrating psychological interventions in existing services. In practice, referral pathways are limited by which services are available in the local setting (see 2.5 Identify associated services). Examples of useful tools include accessible up-to-date lists of contact details for referral services, as well as referral protocols and forms (*50*).

5.4 Follow up after treatment

Even before psychological interventions are implemented it is important to think about what will happen to the service user when treatment ends (or if they drop out). Dropping out from treatment is very common in mental health care. Try to collect information about why people drop out to understand if there is anything that can be done to improve adherence (see Chapter 6 Monitoring and evaluation).

While psychological interventions may help to substantially reduce the distress and impacts on functioning caused by a mental health condition, some people may continue to experience symptoms even after the psychological intervention ends. It is important to repeat the initial assessment or conduct another assessment to evaluate how people are doing Decisions on what happens next will depend on how well the person has responded to treatment, what level of support they still need and what resources and options are available (see Fig. 5.2)

After the assessment, there are typically three follow-up options available.

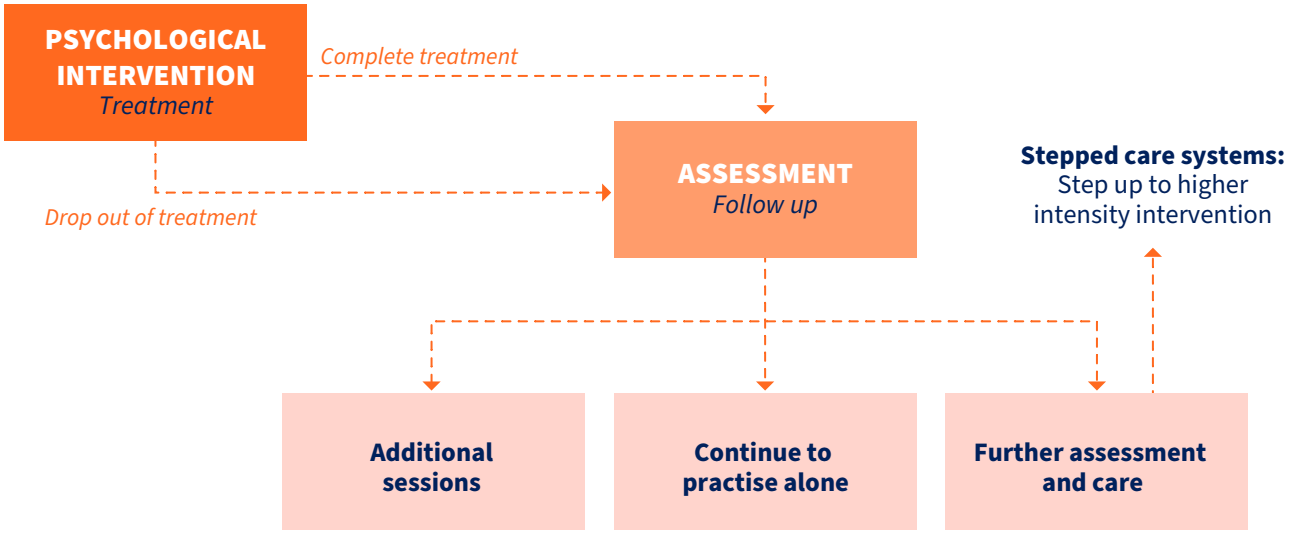
- Someone who has shown progress and is able to support themselves may be advised to continue practising strategies learned in the intervention on their own, with a follow-up session scheduled to review progress.
- Someone who has shown a little progress but could clearly benefit from continued support may be offered additional sessions to extend the intervention. For instance, a service user who has taken some time to trust the provider and begins to show improvement in later sessions may benefit from this option. In considering additional sessions, providers and supervisors will need to balance the needs of an individual with the demand from other individuals for

the service. For example, providing additional sessions to one individual may mean that someone in more need has a delay in accessing treatment. Additional sessions may be kept to a minimum.

- Someone who has not improved and is still struggling with severe distress or thoughts or plans of suicide requires further assessment and care. A specialist may need to be consulted. In stepped care systems, people who have not sufficiently improved by the end of a low-intensity intervention may be "stepped up" to a higher-intensity intervention.

FIG. 5.2

Typical follow up options for people who finish or drop out of a psychological intervention.



6

Monitoring and evaluation

KEY MESSAGES

- Use a mix of output, outcome and goal indicators to monitor and evaluate the effectiveness, acceptability, feasibility and fidelity of psychological interventions.
- Collect data continually (monitoring) and at certain points (evaluation) to inform improvements to the service integrating psychological interventions and to prevent harm.
- Involve all stakeholders, including from the local community, in monitoring and evaluation activities.
- Use means of verification (MoV) that are both appropriate and feasible to collect monitoring and evaluation data.

The terms "monitoring" and "evaluation" are often used together (M&E) but they refer to separate yet related activities. Monitoring involves continuously and systematically collecting and analysing data to assess the service's progress over time and identify challenges or areas for improvement. Evaluation involves periodically assessing specific information at specific times to determine the extent to which a service has met its objectives (*51*).

This chapter focuses on the use of M&E when implementing psychological interventions outside of research studies.[6]

Including robust M&E systems and processes in services implementing psychological interventions is important to:

- ensure the intervention is not causing any harm;
- establish whether the psychological intervention is addressing the target population's mental health needs; and
- inform adaptations and quality improvement strategies for the current service and future services implementing psychological interventions.

COMMUNITY ENGAGEMENT

Local communities can and should be engaged at all stages of M&E: as planners, data collectors and partners for improvement.

Regular community or service user consultations can be used to monitor and evaluate the general feasibility and acceptability of the psychological intervention. Such consultations can also be useful forums for sharing M&E results on the impact of implementing psychological interventions and plans for future development.

Stakeholder advisory groups can help design and facilitate such consultations. They can also help review other data about the psychological intervention and provide suggestions for improvement.

[6] Various frameworks can be used to monitor and evaluate programmes, depending on how the programme is designed and what the goals and intended outcomes are. This chapter mainly draws on the IASC Common Monitoring and Evaluation Framework for MHPSS (51) in humanitarian settings as this is an inter-agency, consensus-based framework that is also relevant for development settings.

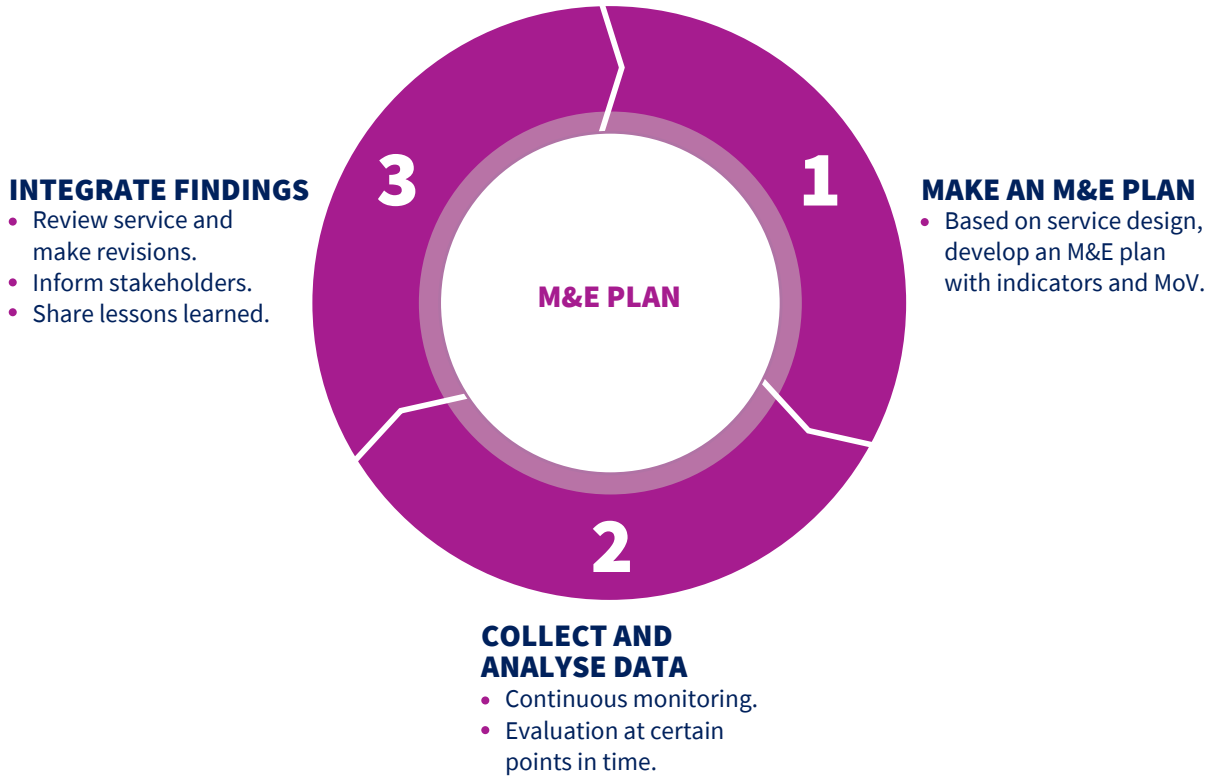
The process for monitoring and evaluating the integration of psychological interventions in existing services typically comprises three major steps: make an M&E plan based on the goals of integration; collect and analyse monitoring and/or evaluation data; and integrate findings to improve services or share lessons learned (see Fig. 6.1).

6.1 Make an M&E plan

The M&E plan identifies what needs to be monitored and evaluated, why and how. For M&E to effectively measure the impact of implementing psychological interventions, it must be carried out before, during and after implementation. An M&E plan should be developed as early as possible.

FIG. 6.1

The three phases of M&E for implementing psychological interventions.



6.1.1 Indicators and measures

The M&E plan provides a list of indicators that specify the measures of success for achieving the desired goal, outcomes and outputs of the service that has integrated psychological interventions (see Fig 6.2).

Output indicators reflect the direct results of making psychological interventions available. Example output indicators (measured over a specific time period) include:

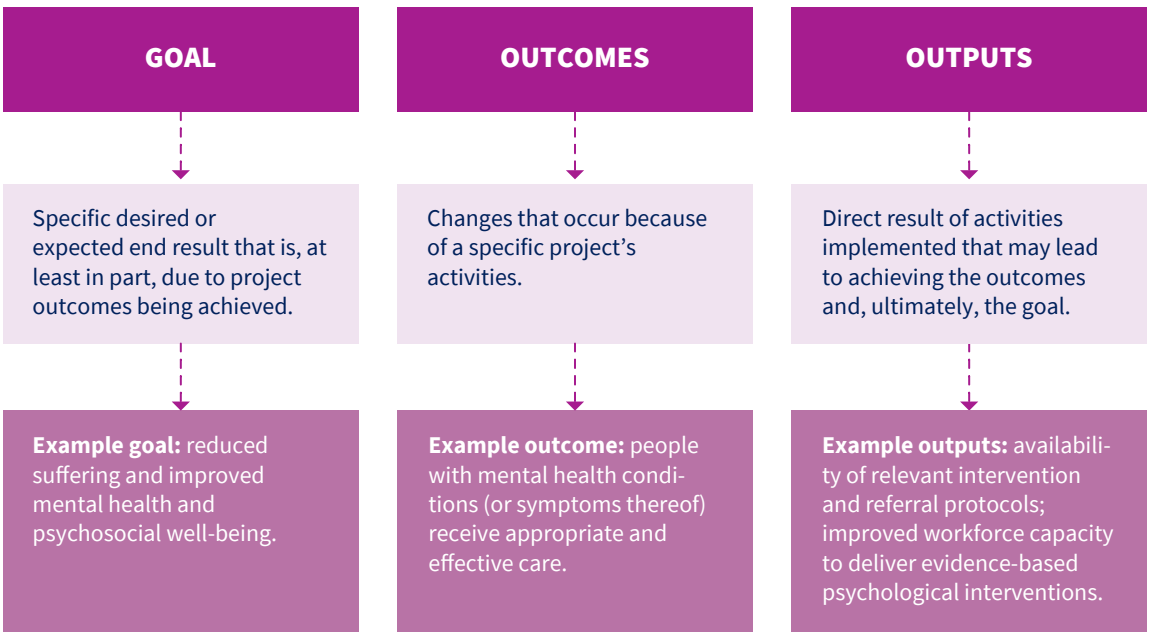
- availability of copies of locally appropriate evidence-based intervention manual and/or self-help materials;
- referral pathway and protocol established for people who need other care beyond the psychological intervention;
- number of trained providers who deliver psychological interventions;
- number of supervision sessions per provider; and
- providers' scores on competency measures.

Outcome indicators reflect the changes in care for individuals and groups that result from making psychological interventions available. Outcome indicators (measured over a specific time period) potentially include:

- number of people who receive (at least one session of) the psychological intervention;
- session attendance rates (including drop out and completion rates);
- contact coverage, i.e. the percentage of people in a given population (e.g. in a clinic, programme or geographical area) with a specified mental health condition who receive any intervention for that condition;
- effective coverage i.e. the percentage of people in a given population (e.g. in a clinic, program or geographical area) with a specified mental health condition who complete a course (or a minimally adequate number of sessions) of an evidence-based intervention for that condition; and
- number of referrals to other services.

FIG. 6.2

Example results framework for making psychological interventions available in services.



Source: based on IASC, 2021 (*51*).

Goal indicators reflect the goals of offering psychological interventions to people across a defined population in a clinic, programme or geographical area. These goals often focus on reduced suffering and improved mental health and psychosocial well-being, and they are often referred to as impact indicators. Goal indicators (measured before and after the intervention is made available) potentially include:

- average reduction in distress/mental health symptoms of one (or more) mental health conditions across service users;
- number and percentage of service users reporting a clinically meaningful response (e.g. at least 50% decrease in symptoms) or remission (e.g. scoring below cut off);
- number and percentage of service users with a specific mental health condition reporting reduced symptoms;
- presence or absence of a mental health condition among service users;
- reduced prevalence of the mental health condition across service users;
- average improvement in functioning across service users;
- number and percentage of service users whose functioning improved;
- average improvement in subjective well-being across service users;
- number and percentage of service users whose subjective well-being improved; and
- number and percentage of service users who improved on personally-defined problems.

For each indicator listed in the M&E plan, the tools and/or data sources required to measure the indicator (i.e. the means of verification) should be identified (see Table 6.1). The plan should also indicate when these measures are to be used (i.e. the timing of monitoring and evaluation activities) to encourage timely M&E that is done as part of implementing integrated psychological interventions; and who will use them.

Means of verification are wide ranging. They can be for individuals, groups or whole populations. And they may be quantitative (e.g. health records, measures of clinical outcomes) or qualitative (e.g. interviews, open surveys and focus group discussions) (*51*).

Clinical information may be used to monitor services and their effectiveness, but other M&E means of verification are still needed to monitor other elements of services (e.g. quality of services, service user opinions, community acceptability or extent to which service providers receive supervision).

TABLE 6.1

Example means of verification for indicators.

EXAMPLE INDICATOR		EXAMPLE MEANS OF VERIFICATION
Output	Number of supervision sessions per provider	• Weekly supervision records
	Percentage of providers that score competent on a competency measure	• ENACT (EQUIP) (*37*)
Outcome	Number of people who receive the intervention	• Service use records from information systems
	Percentage and number of facilities with staff trained on psychological interventions	• Facility records
	Number of people that have completed intervention	• Facility records
	Level of satisfaction of people regarding the intervention they have received	• Patient satisfaction questionnaire
Goal	Improved subjective well-being	• WHO Well-being index (WHO-5) (*52*) • Service user interviews (including focus groups)
	Improved functioning	• WHO Disability Assessment Schedule 2.0 (WHODAS-12) (*53*)
	Decreases in personally defined problems	• Psychological Outcome Profiles (PSYCHLOPS) (*54*)
	Decreased symptoms of depression	• Patient Health Questionnaire (PHQ-9) (*55*)
	Number of people with a mental health condition (eg depressive disorder)	• Score above the validated threshold for likely mental disorder on a symptom measure (eg. the PHQ-9 for depressive disorder)
	Number of individuals with depression reporting reduced symptoms	• Health-care facility records • Patient records with relevant questionnaires • Patient Health Questionnaire (PHQ-9) (*55*)

6.1.2 Points to consider

Efficiency. Plan data requirements and use with resource efficiency in mind. Can the same means of verification (e.g. service user records or interviews) be used to collect data for multiple indicators? Only collect data that will be used.

Comprehensiveness. Good M&E plans are comprehensive and integrate qualitative and quantitative methods to provide a depth of information that cannot be achieved by either method alone.

Demographic data. Include plans to collect a few demographic data to allow for deeper analyses, disaggregated by gender, age, etc.

Feasibility and acceptability. Is it feasible and acceptable to collect the intended data in the local context?

Reliability and validity. Check the extent to which each means of verification is reliable (i.e. consistently measures what it is intended to measure) in the context you want to use it. Also check whether it is a valid measure (e.g. a measure for depression). Remember that measures may need to be adapted before use (*51*).

Monitoring. Although most goal indicators are only measured before and after completing the intervention, some may be used to monitor treatment over time. For example, Group IPT starts each session with participants completing a brief depression assessment measure (*34*). And each PM+ session starts with completion of a measure of personally defined problems (*56*). Session by session symptom monitoring to guide care is also a key aspect of the collaborative care model.

Record keeping. Consider how data will be collected, stored and protected for privacy. Will paper copies be used and input to an electronic system? Will an existing electronic health record system or other data capture tool be used? Are there data privacy or data retention laws to adhere to? During planning, outline all the processes to be used for collecting data and ensuring its safe keeping (either electronically or in paper form). Consider checking whether there are other local or national platforms that could be used to make data collection easier (especially data from assessments or case records). This may include planning for data entry, analysis and similar.

6.2 Collect and analyse data

Collect data for M&E before psychological interventions are integrated into the service (to establish a baseline) and throughout the service's provision of psychological interventions.

Depending on the indicators and means of verification chosen, data can be collected as part of routine care or as a stand-alone activity over selected periods of time.

Once data collection starts, collected data should be regularly reviewed to ensure they are complete and usable. If there are large amounts of missing data, investigate why and take action to address root causes.

6.2.1 Points to consider

Ethical considerations. When collecting and using M&E data on psychological interventions – much of which involves personal information – be considerate of ethical issues and address any concerns, especially around proper use of data, confidentiality and informed consent. Set up secure systems for storing and managing personal data if they do not exist already.

Gender and other personal characteristics. Gender-disaggregated analysis should be part of any data analysis. Depending on the context, disaggregation by other characteristics, such as age or disability status, may be beneficial for service monitoring.

6.3 Integrate findings

M&E findings can support learning, contextualisation, adaptation and accountability that can be used to drive continuous improvement and sustainability.

All M&E data, whether collected through routine care or as a separate activity, should be routinely analysed, reported and integrated through a collaborative process that involves relevant stakeholders, including local communities.

Make someone responsible for reporting. This person should be competent to analyse and interpret quantitative and qualitative data, and to draw conclusions and recommendations using participatory processes with local stakeholders. In some cases, personnel may require training in M&E, including in data collection, management, and analysis to integrate results and improve programming.

Where possible, M&E reports should identify specific problems that might ultimately compromise the quality of psychological interventions being delivered. This may include problems with the content of the psychological interventions (e.g. language or imagery) or the logistics of how they are provided (e.g. timing, location, staff, length of sessions etc). Problems may also be identified with how providers are trained or supervised.

Reports should provide concrete recommendations for addressing those problems to achieve continuous improvement (see Table 6.2).

Share M&E findings with relevant stakeholders, potentially including service managers, supervisors and providers, advocates and civil society, service users and communities. This may be a summary of monitoring results, or a time-specific evaluation report. Ensure that M&E information is presented in a way that is relevant and understandable for the target audience. This may mean reporting the same information in different ways, such as one way for professionals, another way for community providers and yet another way for people with lived experience or others in the community. Good M&E reports are excellent tools to support learning and accountability. They provide:

- transparency on the service's performance;
- a roadmap for action to improve the service;
- a real-world case to advocate for investment; and
- a wealth of data and experience for others to learn from.

TABLE 6.2

Example M&E findings of problems with the service; and recommendations for improvement.

EXAMPLE FINDING	EXAMPLE RECOMMENDATION
High dropout rates mean too many people are not completing their treatment.	• Investigate why people are not coming back for sessions and address root causes.
Attendance records show a gender disparity in people receiving treatment.	• Investigate root causes, including through community engagement. • Adapt the intervention to be more relevant and acceptable to the excluded group.
Service user feedback forms show people find the sessions too long.	• Shorten the length of individual sessions without losing the key components of the intervention. • Adjust session scheduling to provide shorter but more frequent sessions.
Measures of clinical outcomes do not show a decrease in symptoms of anxiety.	• Add extra sessions to the intervention that repeat previously covered coping strategies for anxiety.
Service user interviews show people are feeling isolated or socially disconnected.	• Add optional group sessions to the intervention to create opportunities for peer support and social connections. • Establish links and referral pathways to social initiatives that service users can be directed to for additional support.
Fidelity and competency checks show that providers don't follow and are not competent in the treatment protocol.	• Offer refreshment training and regular supervision sessions to improve competency and fidelity to the treatment protocol. • Use EQUIP (see section 4.2.1 Competency-based training) as part of supervision to improve providers competence.

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Further reading

A chapter-by-chapter list of resources.

Chapter 1. Introduction

- mhGAP operations manual. Geneva: World Health Organization; 2018.

Chapter 2. Planning

- Assessing mental health and psychosocial needs and resources: toolkit for humanitarian settings. Geneva: World Health Organization and United Nations High Commissioner for Refugees; 2012.
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Chapter 4. Workforce

- Integrated model of supervision handbook. Copenhagen: International Committee of the Red Cross and Red Crescent Societies Reference Centre for Psychosocial Support; 2021.
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Chapter 5. Identification, assessment and delivery

- Assessing mental health and psychosocial needs and resources: toolkit for humanitarian settings. Geneva: World Health Organization; 2012.
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Chapter 6. Monitoring and evaluation

- The DIME program research model: Design, Implementation, Monitoring and Evaluation. Baltimore: John Hopkins Bloomberg School of Public Health; 2013.
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Annexes

Annex 1. Checklist for implementing psychological interventions

IMPLEMENTING PSYCHOLOGICAL INTERVENTIONS: KEY ACTIVITY CHECKLIST

Develop an implementation plan

- ☐ Appoint a multistakeholder implementation team with clear roles and responsibilities.
- ☐ Identify local mental health needs and capacities.
- ☐ Specify target mental health conditions and populations, and expected outcomes.
- ☐ Choose evidence-based psychological interventions.
- ☐ Decide setting for delivery, ideally within an existing community-based service.
- ☐ Organize the system for delivery, e.g. collaborative or stepped care.
- ☐ Identify and coordinate all associated services and referral options for care across sectors.
- ☐ Identify human resource needs and specify groups of workers to deliver, train and supervise psychological interventions in practice.
- ☐ Choose format for delivery, e.g. individual, group or self-help, delivered in person or remotely.
- ☐ Establish a budget and secure resources for all implementation activities.

Adapt the intervention materials

- ☐ Set parameters of adaptation.
- ☐ Review the literature.
- ☐ Do a rapid qualitative assessment.
- ☐ Translate the intervention and do an expert read-through.
- ☐ Review materials with stakeholders.
- ☐ Agree on adaptations.
- ☐ Re-evaluate, test in training and pilot the adapted intervention.

Prepare the workforce

- ☐ Specify criteria and process for selecting providers, supervisors and trainers.
- ☐ Appoint providers, supervisors and trainers.
- ☐ Choose a model for training providers (and if needs be supervisors), e.g. training of trainers.
- ☐ Define how the training will be structured and how the impact of training will be measured.
- ☐ Train the workforce using a competency-based approach.
- ☐ Clarify supervisors and providers' roles and responsibilities for supportive supervision.
- ☐ Define the structure, frequency and format of supervision sessions.
- ☐ Prepare tools and materials for supportive supervision, e.g. supervision forms.
- ☐ Secure human resources to give providers administrative and other additional support.

Deploy the intervention

- ☐ Specify roles and responsibilities for case detection and assessment.
- ☐ Select screening and assessment measures to use when identifying potential beneficiaries.
- ☐ Develop tools to refer people to the right source of support, e.g. referral protocols and contact lists.
- ☐ Establish a protocol for follow up after drop out or when treatment ends.

Monitor and evaluate

- ☐ Make an M&E plan.
- ☐ Identify output, outcome and goal impact indicators and measures.
- ☐ Collect and analyse data.
- ☐ Produce an M&E report with recommendations for improvement.
- ☐ Integrate findings using a collaborative process.

Annex 2. Points to consider for remote delivery

This annex outlines important points to consider when delivering interventions remotely. Remote delivery can be done using many technologies, including the telephone, as well as smartphones, computers, videoconferencing, online messaging and similar.

For more information on delivering interventions remotely, see:

- EQUIP: Providing remote psychological care (https://equipcompetency.org/en-gb).
- Guidelines for remote MHPSS programming in humanitarian settings (https://internationalmedicalcorps.org/remotemhpssguidelines/).
- Consolidated telemedicine implementation guide (https://www.who.int/publications/i/item/9789240059184).

Points to consider for remote delivery

Suitability. Before choosing remote delivery, consider whether it is suitable for the target population. Key questions include:

- Is the target population willing and able to access interventions remotely?
- Do service users have access to a quiet and private space (or can such a space be created for them)?
- Do service users have, and know how to use, any hardware (telephone, smartphone) and software (messaging or video platform) they need to access interventions remotely (and if not, can they be provided with technical support)?
- Do they share the device, and if so, can they use it privately and confidentially?
- Are telecommunications available and reliable in the area?
- How will the safety of people in high-risk situations (e.g. imminent risk of suicide) be managed remotely?
- What other barriers might hinder people from receiving remote psychological interventions (and how can these be overcome)?

Technology. When deciding which device and/or software to use, consider the likely needs and resources available for technological support. Many interventions can be delivered over a simple mobile phone or smartphone. If delivering group interventions online, ensure the technology can support potentially relevant aspects of the group (e.g. small group discussions in breakout rooms), or adapt the intervention accordingly. Both providers and service users need access to reliable networks and devices (their own or shared) at no or minimal cost.

Intervention adaptation. If an intervention has been developed for in-person delivery, it will likely need adapting for remote delivery.[7] This may include: running shorter, but more frequent, sessions than recommended in the original manual; adapting the format of group discussions; and ensuring supportive materials (e.g. pictures, discussion aids) are easily available in relevant formats.

7 For an overview of remote adaptation during COVID-19 see: McBride KA, Harrison S, Mahata S, Pfeffer K, Cardamone F, Ngigi T, et al. Building mental health and psychosocial support capacity during a pandemic: the process of adapting problem management plus for remote training and implementation during COVID-19 in New York City, Europe and East Africa. Intervention J. 2021;19(1):37–47. doi:10.4103/INTV.INTV_30_20.

Supportive space. Make the space where interventions will be delivered remotely as comfortable and supportive as possible. Try to minimize interruptions. For example, if you are working in a room where other people can walk in, lock the door or put a don't disturb sign on it. Try to minimize background noise and when using a video ensure the background is free from disruptions (eg. animals) and personal information you are uncomfortable with sharing.

Confidentiality and consent. Consider additional checks and balances to protect confidentiality and consent during remote sessions. For example, to confirm the identity of the person receiving treatment, ensure they are in a safe and private space, and are attending the session freely and of their own choice. No electronic device is 100% secure from hacking but measures can be taken to minimize the risk of confidential information being leaked. Some countries have legislation governing the use of communication software in health care. If psychological interventions will be delivered remotely, review local laws and best practices to ensure the plan for remote delivery meets relevant standards (for example on encryption). Because remote interventions are often delivered outside the office, take extra care when handling written information. Keep notes in a safe and locked place and use identifying numbers instead of names on documents.

Communication. One of the main challenges with delivering interventions remotely is the need to adapt communication styles and methods. Ensure clarity around communication, including in case of technology failure, to help manage expectations and ensure sessions run smoothly. Communication rules may also define if and how providers and service users can communicate in between sessions (e.g. through text messages, audio messages, email, or phone calls).

Risk management. Intervention providers can feel anxious when considering how to manage risk remotely. To support them in this task, consider developing policies and protocols to manage risk remotely, including guidelines and/or training for how to:

- create a safety plan in the first remote session where required;
- establish where the person is during a session and if they are safe; and
- respond to emergency situations such as imminent risk of suicide (for example having contact information for referral services, such as emergency health services or an mhGAP trained clinic).

Self-care and professional boundaries. It can be harder for providers to maintain good self-care and professional boundaries when delivering interventions remotely, especially if they are working from home. Setting ground rules around communication can help protect providers and service users. Example ground rules include: do not communicate via personal social media; keep separate work and personal devices; adhere to normal working hours and session schedules; and wear appropriate clothing.

Points to consider for remote training and supervision

Location. Remote supervision offers unique opportunities for less intrusive or distracting direct observation because a supervisor can join sessions unseen or unheard. For example, the supervisor can attend a session without their video or audio turned on. In such cases, inform the service user that the session will be monitored for supervision purposes (and get their consent). Take extra care to protect confidentiality when sharing and storing any recordings.

Communication. Remote training requires a slightly different communication style to face-to-face training. For example, in remote training sessions it is often necessary for trainers to speak more clearly and slowly

than they normally would, and to tolerate longer pauses than usual because they are operating in a less natural environment. They may also need to establish a different mechanism for giving and receiving feedback.

Engagement. Remote trainees are more likely to get distracted. Extra effort may be needed to keep trainees motivated and involved. Keeping trainings small (e.g. 8–10 trainees) or having shorter sessions (e.g. half days) can help participants engage in remote activities. Learning methods that enable real-time interaction among group participants – e.g. through an online chat, live messaging system or collaborative online boards – can similarly help keep trainees actively engaged during training sessions. Setting ground rules for the training can also help avoid distractions, e.g. keeping cameras on, muting yourself when there is background noise, trying to avoid doing other things on laptop/smartphone, turning off notifications on your device.

Human resources. Ideally there should be two trainers. Because remote training can be affected by a wide range of IT issues, it's also important to plan for additional resources. A technical assistant can address issues with connectivity, answer technology-related questions and facilitate breakout rooms. Trainers should have a contingency plan in place in case technological faults and failures cannot be resolved.

Role-playing. As with face-to-face training and supervision, remote training should include role-playing. These should include role-playing common scenarios as well as crises, for example when there is imminent risk of harm.

"Screen fatigue". It is important to mitigate risk of screen fatigue. This can be done by including frequent breaks, alternating learning activities and focusing on practical exercises rather than didactic lectures.

Expectations. In remote training it is essential to set clear expectations about time investment required and often time spent in virtual trainings are perceived as flexible.

Annex 3. Example adaptation monitoring form

This is an example of a monitoring form that can be used when adapting interventions. The actual content of the form will vary depending on the intervention and type of adaptation. This form can be adapted to include other aspects such as adaptations to the delivery model.

STAGE OF ADAPTATION	TEXT OR ILLUSTRATION CODE	PROBLEM WITH SOURCE CONTENT	PROPOSED CHANGE	JUSTIFICATION FOR CHANGING ORIGINAL CONTENT	NOTES	CHANGE AGREED	DOCS UPDATED
☐ Literature review and qualitative assessment ☐ Translation and expert read-through ☐ Review with stakeholders ☐ Evaluation during provider training ☐ Pilot testing				☐ Not accurate ☐ Not understandable ☐ Not acceptable ☐ Not relevant ☐ Other		☐ Yes ☐ No	☐ Done
☐ Literature review and qualitative assessment ☐ Translation and expert read-through ☐ Review with stakeholders ☐ Evaluation during provider training ☐ Pilot testing				☐ Not accurate ☐ Not understandable ☐ Not acceptable ☐ Not relevant ☐ Other		☐ Yes ☐ No	☐ Done
☐ Literature review and qualitative assessment ☐ Translation and expert read-through ☐ Review with stakeholders ☐ Evaluation during provider training ☐ Pilot testing				☐ Not accurate ☐ Not understandable ☐ Not acceptable ☐ Not relevant ☐ Other		☐ Yes ☐ No	☐ Done

Annex 4. Example supervision form

This is an example form that providers can fill out before, and after, each supervision session, to help guide discussions with their supervisor and ensure consistent feedback. In general, it is best not to include any information on this form that could be used to identify a participant (e.g. do not include participant names).

Date and time:

Supervisor:

Provider:

Number of completed sessions/contacts so far:

General note about presented symptoms and problems:

General note about person's progress:

What has gone well so far:
e.g. something you feel particularly confident about, progress reported by the person

Questions or difficulties that you would like help with:
e.g. a particular problem the person has, a technique/exercise or a practical issue

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[To complete after supervision session]
Discussion notes:
Key points discussed within the supervision session and feedback from supervisor

Plan for next session/contact
e.g. recommendations from supervisor on next steps

Annex 5. Example measures for screening and assessment

Source: IASC common monitoring and evaluation framework for mental health and psychosocial support in emergency settings with means of verification (version 2.0). Geneva: Inter-Agency Standing Committee; 2021 (https://interagencystandingcommittee.org/iasc-reference-group-mental-health-and-psychosocial-support-emergency-settingsiasc-common-monitoring-and-evaluation-framework-mental-health-and-psychosocial-support-emergency, accessed 16 January 2023).

The following quantitative measures of distress/symptoms are examples of measures that may be considered for screening and assessment. They are suggested for consideration by the Inter-Agency Standing Committee, which selected them based on their:

- accessibility (i.e. most of them are free to access and use);
- multi-site relevance (i.e. they have been used in a low-resource setting and in at least one other language other than the one they were created in);
- feasibility (i.e. they are quick to administer and there is guidance available for scoring and interpreting data); and
- appropriate measurement properties (i.e. they have been shown to be adequately reliable and valid in at least two settings).

EXAMPLE FINDING	EXAMPLE RECOMMENDATION
6–11 years	Child Psychosocial Distress Screener (CPDS)
	Strengths and Difficulties Questionnaire (SDQ)
	Revised Child Anxiety and Depression Scale-25 (RCADS-25)
12–17 years	Child Psychosocial Distress Screener (CPDS)
	Strengths and Difficulties Questionnaire (SDQ)
	Alcohol Use Disorders Identification Test (AUDIT)
	Revised Child Anxiety and Depression Scale-25 (RCADS-25)
18 + years	Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)
	Patient Health Questionnaire (PHQ-9)
	Generalized Anxiety Disorder (GAD-7)
	PTSD Checklist for the DSM-5 (PCL-5)
	Psychological Outcome Profiles (PSYCHLOPS)

Annex 6. Example suicide risk form for non-specialists

Source: Self-Help Plus (SH+). Geneva: World Health Organization; 2021 (https://www.who.int/publications/i/item/9789240035119, accessed 12 January 2023)

Providers should follow the procedures of their organization for assessing imminent risk of suicide. The example protocol – below written for non-specialists - can also be adapted by organizations for their own contexts.

Protocol for assessing imminent risk of suicide

Go through the questions with the person and record the answers immediately on the form below. If the person has already clearly provided enough information to answer a question below, you do not need to ask the question again.

Example script for introducing the risk assessment questions:

I'm glad that you're telling me about this. Sometimes when people are very upset or feel hopeless, they have thoughts about death or ending their own life. These thoughts are not uncommon, and you should not feel guilty or ashamed about having such thoughts if you do. I would like to ask you some more questions to better understand how things are for you. Is that okay? Can we continue?

Guidance for asking about suicide or self-harm

Ask direct, clear questions:

- When asking questions about suicide, avoid using less direct words that could be misunderstood.
- Direct questions help the person feel that they are not being judged for having thoughts or plans of suicide or for having made suicide attempts or self-harmed in the past.
- Some people may feel uncomfortable talking with you about suicide, but you can tell them that it is very important for you to clearly understand their level of safety.
- Asking questions about suicide will not cause the person to take action to end their life, but often helps them feel understood and less distressed.

1 In the past month, have you had serious thoughts of ending your life, or a plan to end your life? Or have you taken any actions to end your life in the past year?	☐ YES	☐ NO
	If yes, ask the person to describe their thoughts, plans or actions taken. Write details here:	

If the person answers "no" to Question 1, thank them for answering your questions and you can end the assessment.
If the person answers "yes" to Question 1, please continue with Question 2.

2 Are you currently thinking of ending your life, do you have a plan of ending your life, or are you currently taking any steps to end your life?	☐ YES	☐ NO	☐ UNSURE
	If "yes" or the person is "unsure", ask the person to describe their thoughts, plan, or actions to you. Write details here:		

If the person answers "yes" or "unsure" to Question 2, they may end their life in the near future. Follow the steps below.

- **If the person answers "no" to Question 2 but is extremely agitated, violent, distressed or not communicating, they may end their life in the near future. Follow the steps below.**
- If the person answers "no" to Question 2 and they are NOT extremely agitated, violent, distressed or not communicating, they are unlikely to have a plan to end their life in the near future. No immediate action is required. You do not need to follow the steps below, but tell the person you will inform your supervisor to discuss any additional support that may be helpful.
- **In case of any doubt about a person's safety, talk to your supervisor.**

Steps to immediately take if the person may end their life in the near future:

- **You must always contact your supervisor immediately. Explain this to the participant.** For example: *From what you have described to me, I am concerned about your safety. As I mentioned before, if I believe that you are at risk of ending your life, I must contact my supervisor. This is very important, so we can get you the best kind of help for these problems as soon as possible. I am going to do this now, okay?*
- **Stay with the person at all times**, or have another facilitator stay with the person.
- Contact someone the person trusts. For example, you could say: *I would also like to contact someone in your community to ensure that you can be kept safe. Who would that be?*
- Create a secure and supportive environment. If possible, offer a quiet space while waiting for a supervisor or trusted person to arrive.
- Ask the person if they have access to any means of self-harm. Discuss ways to remove these items from their home environment.
- Attend to the person's mental state and emotional distress.
- Explore reasons and ways to stay alive.
- Focus on the person's strengths by encouraging them to talk about how earlier problems have been resolved.

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