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Remote MHPSS Training Manual

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Introduction

Why the Training Manual?

This training manual was developed in response to the findings of the 2021 International Medical Corps [global case study](#) on operational considerations for remote Mental Health and Psychosocial Support (MHPSS) programming in humanitarian settings. As part of the study evaluating and documenting challenges and best practices of implementing remote MHPSS services in five of International Medical Corps programs, we uncovered a need to provide more in-depth and specialized training, in addition to tools and guidelines, to alleviate some of the challenges encountered during remote implementation. Additionally, we found that the lack of engagement and interaction may have impacted the quality of learning during remote training and supervision, pointing to the importance of participatory training methods and use of interactive platforms to enhance capacity building experience.

What's Included in the Manual?

This training manual was designed as a companion resource to the [International Medical Corps Guidelines for Remote MHPSS Programming in Humanitarian Settings](#) and is intended to facilitate more in-depth exploration and learning around operationalization of remote MHPSS programming. The manual consists of six modules, and the topics and content were informed by the responses of the global case study, where MHPSS program staff and service providers identified areas that needed particular attention to facilitate effective adaptations for remote modalities. The module of the manual includes the following:

1. General Principles of Remote MHPSS Service Delivery
2. Setting up for Remote MHPSS
3. Preparing for Remote MHPSS
4. Conducting Remote MHPSS Sessions
5. Managing Suicide Risk Cases During Remote MHPSS
6. Setting up a Helpline and/or Hotline

All modules include comprehensive didactic content to provide the trainer with information needed to convey the material to the participants without requiring additional research. (If needed, trainers are encouraged to explore the resources provided in the citations for additional information.) The didactic content is complemented by exercises and group discussions in each module to facilitate engagement and interaction among participants and help improve uptake and retention of the information.

How to Use the Manual?

This training manual can be used in whole or in parts depending on the needs of the target audience. In addition, the training manual was designed primarily for in-person training settings. However, all throughout, we make notes of minor adjustments that can be made for remote training sessions. Each module provides guidelines for the length of each session. However, the lengths can be adjusted to meet the needs of the target training audience. For example, for seasoned MHPSS program staff and service providers with familiarity and experience with

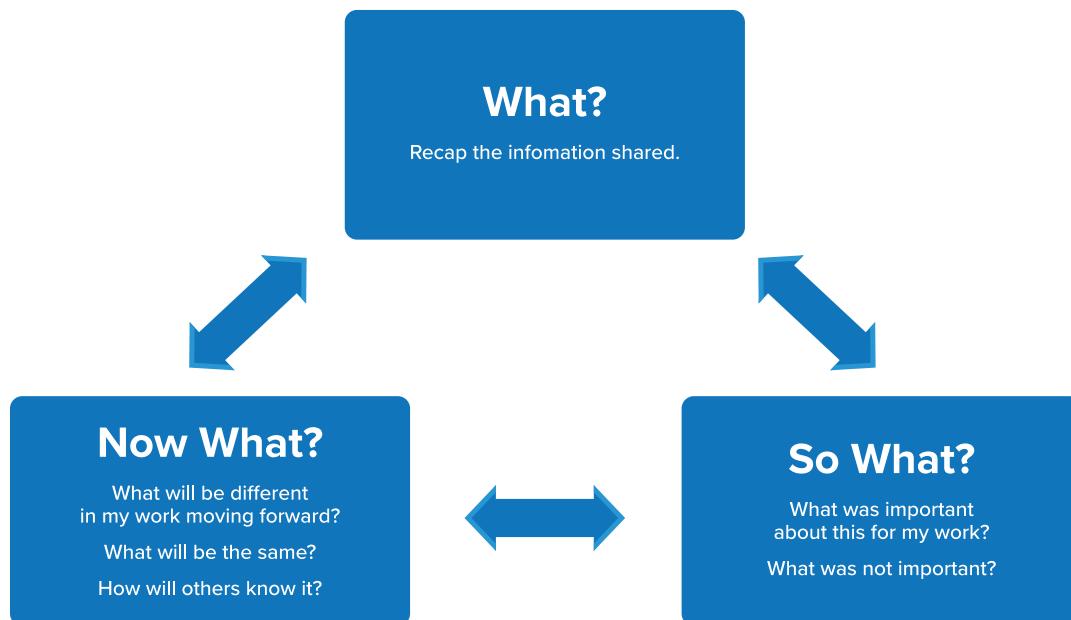
remote modalities, some of the content can be abridged and the allotted time shortened accordingly. We therefore encourage trainers to conduct a pre-training needs assessment to understand the existing knowledge and skills as well as gaps so the training content can be adjusted accordingly. In addition, the timeframes should be adjusted if the training is to be held virtually. Our experience shows that an average of 2-2.5 hour sessions are optimal for virtual environment and sessions longer than that contribute to fatigue and reduced engagement. Subsequently, trainers may need to spread the multi-day training over the span of several weeks and will need to inform the participants so they can manage their schedules accordingly.

Regardless of the experience level, all incoming trainees should be asked to review the International Medical Corps Guidelines for Remote MHPSS Programming in advance, which are available in Arabic, English, French and Spanish. If possible, the training organizers should provide hard copies of the Guidelines to each participant, because participants will be asked to reference the Guidelines as part of the training activities.

Trainings facilitator and/or trainers should prepare the necessary materials in advance, which will include flipcharts, notepads and pens, sticky notes, markers, handouts as well as PowerPoint slides summarizing the key points of each module. For virtual training environments, the trainers should familiarize themselves with interactive technologies available to facilitate exercises. These may include the Whiteboard on Zoom or [Miro Whiteboard](#), which can be integrated with any web-conferencing platforms and replicate flipchart, sticky notes and similar functionalities in virtual settings.

Finally, to reinforce learning and facilitate retention, each module should be concluded with participants sharing key take-aways. Trainers may choose the following format to facilitate this closing activity:

Share the 3 W's Takeaway Task



Who is the Target Audience?

The training is primarily intended for staff and service providers at agencies implementing MHPSS programming in humanitarian settings, including MHPSS program management staff and service providers and frontline workers. In addition, HQ technical support teams and organizational leadership at the country level may benefit from some of the modules focused on the principles and preparation for remote MHPSS programming.

Module 1: General Principles of Remote MHPSS Service Delivery

Learning Objectives

1. Define remote MHPSS services as it is practiced in humanitarian emergency settings.
2. Be familiar with the origins of remote mental health provision and evidence base supporting its efficacy.
3. Understand and articulate the benefits of remote MHPSS services.
4. Know different models available for implementing remote MHPSS services.
5. Identify ethical standards for providing remote services.

Duration: 1 hour 30 minutes

Session 1.a. Remote MHPSS service delivery defined

Remote MHPSS service delivery can include, but is not limited to, intake and assessments, case management, psychosocial support, counseling, psychological interventions, psychiatric care, treatment by mhGAP-trained healthcare staff, group support, awareness-raising, outreach and facilitating referrals conducted virtually or at a distance utilizing various technology (phone, radio, Internet, etc.). “Remote” can refer to geographical, time or even circadian distance when providing care across time zones. Recipients of remote MHPSS services can be located in any safe space with confidentiality, such as clinics, hospitals, schools, care facilities and homes. Remote MHPSS providers and staff may include psychiatrists, social workers, psychologists, counselors, and primary care providers and nurses trained on mental health.

Activity: References to “remote” MHPSS

Ask participants other terms they have heard in reference to remote MHPSS

Possible answers include: tele-MHPSS, telepsychology, tele-behavioral health, tele-mental health care, distance therapy/counseling/psychology, e-mental health services, etc. Allow 3-5 minutes for discussion.

Session 1.b. History of remote MHPSS and evidence base for the effectiveness

Activity: True or False

Give participants a minute to think about the answer and write down their responses on a sticky note. (In a virtual environment, participants can respond in the chat function of the web-conferencing platform).

Question: Remote provision of mental health and psychosocial support services is a fairly modern phenomenon.

Response: False

The early origins

At the turn of the twentieth century Sigmund Freud, Austrian psychoanalyst, used letter correspondence as the extension of his psychotherapy practice and discussed client cases with his colleagues. American counselor and founder of the person-centered approach, Carl Rogers, engaged in tele-counseling with his clients and tele-supervision using the telephone starting in the 1940s.

In 1959, the Nebraska Psychiatric Institute (United States) was using early videoconferencing technology to provide group therapy, long-term therapy, consultation-liaison psychiatry and medical student training at the state hospital.¹

First large-scale use in international disaster response

In 1988, a massive 6.8 earthquake struck the Spitak region of Armenia, killing up to 50,000 people and injured as many as 130,000 more. The disaster completely upended the local healthcare infrastructure. In 1989, the United States and the Soviet Union formed a collaboration called the NASA Telemedicine Spacebridge. The aim was to bring expert medical consultation to Armenian medical personnel, specifically in the areas of reconstructive surgery, physical and psychological rehabilitation, public health and epidemiology. For three months, hundreds of Armenian, Russian and American medical professionals from at least 20 specialty areas participated in 34 clinical conferences held remotely. The experiment represented the first large-scale use of telemedicine to respond to a natural disaster, an international sharing of medical expertise that transcended cultural and political borders.²

The Internet and the global expansion

In the 1990s, the regular use of remote behavioral health expanded across the world with increased availability and access to the Internet. Researchers worldwide began to conduct studies to establish the efficacy of telepsychiatric care and appreciate its ability to transcend political and geographic obstacles.

In 2005, following the formation of WHO's eHealth strategy, WHO conducted a global eHealth survey to obtain general information about the state of eHealth among Member States. In 2009,

¹ Orbit health (n.d.) A Brief History of Telepsychiatry. <https://www.orbithealth.com/brief-history-telepsychiatry/>

² *Ibid.*

WHO conducted another survey, which examined the level of development of four fields of telemedicine, including telepsychology in 114 countries.

The evidence for remote MHPSS efficacy

By the early 2000s, research had established that telemedicine could be equally as effective as traditional evaluation, diagnosis and treatment. Practice guidelines were established by healthcare organizations and regulatory agencies and issued for the use of telemedicine and telepsychiatry in a number of countries.³ Several large-scale studies conclusively established that remote mental health services were just as effective as in-person treatments in terms of diagnostic accuracy, treatment effectiveness and client satisfaction, while simultaneously saving time, money and effort:

- A meta-analysis of empirical research (70 studies total) before 2013 showed favorable outcomes regarding “improved access, utilization, adherence and notable cost benefits to behavioral health care delivered via telehealth” and also indicated that telemental health outcomes are comparable to those of in-person services. The review also concluded that, “telemental health services...are effective for diagnosis and assessment, across many populations (adult, child, geriatric) , and in disorders in many settings (emergency, home health).”⁴
- A randomized controlled trial of 325 individuals with major depressive disorder that evaluated the delivery of cognitive-behavioral therapy (CBT) found similar outcomes for in-person vs. phone at the conclusion of treatment. During teletherapy the therapeutic relationship was not diminished and overall the therapy was slightly more effective due to lower drop-out rates.⁵
- Telemental health literature shows evidence for effectiveness in suicide prevention and reducing suicide risk.⁶
- Systematic reviews have shown that telepsychology by video or phone for treating depression, anxiety and adjustment disorder, substance use and other problems in children and adolescents is effective. Attention-deficit hyperactivity disorder treatment by telepsychiatry has been actively studied, and satisfaction is high among all parties in a variety of settings.⁷
- The effectiveness of remote emergency consultations has rarely been studied; however, one study of clients with mainly depression, bipolar disorder and schizophrenia revealed that 65% were discharged, 16% were admitted and 19% were transferred. Guidelines on

³ The American Telemedicine Association (ATA) published telemental health practice guidelines in 2009, as has the American Association of Child and Adolescent Psychiatry.

⁴ Hilty, D. M., Ferrer, D. C., Parish, M. B., Johnston, B., Callahan, E. J., & Yellowlees, P. M. (2013). The effectiveness of telemental health: a 2013 review. *Telemedicine journal and e-health: the official journal of the American Telemedicine Association*, 19(6), 444–454. <https://doi.org/10.1089/tmj.2013.0075>

⁵ Stiles-Shields C, Kwasny MJ, Cai X, Mohr DC.(2014). *Therapeutic alliance in face-to-face and telephone-administered cognitive behavioral therapy*. *J Consult Clin Psychol*; 82(2):349-54. doi: 10.1037/a0035554.

⁶ Thomas D. Hull and Kush Mahan. (2017). *Telemedicine and e-Health*. Mar 240-247.<http://doi.org/10.1089/tmj.2016.0114>

⁷ Varker T, Brand RM, Ward J, Terhaag S, Phelps A. (2019). Efficacy of synchronous telepsychology interventions for people with anxiety, depression, posttraumatic stress disorder and adjustment disorder: A rapid evidence assessment. *Psychol Serv.*, 16(4): 621-635. doi: 10.1037/ser0000239

how to be effective in providing emergency remote mental health services require further evaluation.⁸

- Text-based mental health care lacks research regarding efficacy and may hinder clinicians from fulfilling ethical and legal obligations such as correctly obtaining informed consent, completing assessments and understanding a client's environment as well as who may have access to text based dialog.⁹

Session 1.c. Benefits of remote MHPSS support

Activity: Small group discussion

Ask participant to form smaller groups (of 3 or 4) and identify at least 4 potential benefits of providing MHPSS services remotely. Encourage participants to think about the benefits from the perspective of clients, caregivers and service providers.

Each group should identify an individual who will report on the group's discussion to the larger group.

Give participants 10 minutes to brainstorm in small groups, and facilitate a discussion afterwards in plenary for another 7-10 minutes.

In concluding the discussion, reiterate the following points about the benefits of remote MHPSS services:

Expands Access

Remote MHPSS puts mental health services within reach of men, women and children who live in rural or remote areas where mental health professionals may be scarce. Remote MHPSS practitioners also can provide services in isolation units or correctional settings when the client and clinician cannot be together.

Saves Time

Remote MHPSS eliminates a client's need for transportation, and any travel-related costs. Remote mental health also can make it easier for clients to make appointments without having to take time off from work. Clinicians may find opportunities to increase their client loads if practicing remote MHPSS eliminates or cuts back on the need to commute to an office.

Shortens Delays

Remote MHPSS services remove many of the barriers that lead to long waits to see providers. A client no longer has to choose a mental health professional from a short list of practitioners within a comfortable driving distance or place her name on a waiting list. She may choose to work remotely with a professional in a different location or even a different country.

⁸ Hilty, D. M., Ferrer, D. C., Parish, M. B., Johnston, B., Callahan, E. J., & Yellowlees, P. M. (2013). The effectiveness of telemental health: a 2013 review. *Telemedicine journal and e-health: the official journal of the American Telemedicine Association*, 19(6), 444–454. <https://doi.org/10.1089/tmj.2013.0075>

⁹ Thomas D. Hull and Kush Mahan. (2017). *Telemedicine and e-Health*. Mar 240-247. <http://doi.org/10.1089/tmj.2016.0114>

Eases Stigma

For clients concerned about appearing publicly at a practitioner's office, working with mental health care providers from home via teleconferencing, or by phone, can ease anxieties and promote acceptance of treatment.

Achieves Results

Research continues to affirm the efficacy of remote mental health services. Offering increased provider options and a multitude of convenient technological vehicles, remote MHPSS a growing and effective alternative for those delivering and receiving mental health services in geographically remote areas or low-resource settings.

Session 1.d. Models of remote MHPSS services

Remote MHPSS interventions typically fall into the following domains:

- **Health facility care/hospital/Inpatient:** Geographically remote hospitals or health facilities can connect to mental health and psychosocial support specialists through technology. For example, a psychiatrist based in a major city can use video or other telehealth technology to do a consultation in a rural area.
- **Integrated primary care:** Clients can receive mental health services through telehealth in primary care settings. For example, clients at a rural primary healthcare center could use live-video teleconferencing or telephonic calls to receive counseling from a remote psychologist.
- **Direct to client/beneficiary services:** These allow clients to connect directly to mental health and psychosocial support providers using available technology (phone, web-conferencing or other applications) from any setting, including the home.
- **Crisis lines/hotlines and helplines:** Telephonic lines can be set up to receive public calls and serve different purposes. For example, crisis or hotlines can operate 24/7 and be staffed with MHPSS specialists trained in crisis response for clients experiencing suicidality and other mental health crises. Helplines can be set up to provide as an initial screening for the cases and/or to make referrals to MHPSS specialists.
- **Radio or TV programming or use of other technology for psychoeducation:** Community members can tune into a local radio or TV station for programming specifically developed to provide psychoeducation on identifying symptoms, coping with anxiety and life stressors, and increasing their awareness of the MHPSS resources available in their communities. Alternatively, such messaging can be disseminated via the use of megaphones by community health workers in areas with no availability of other technology.
- **Mobile health applications or remote monitoring programs:** These can support longer-term interventions or management of mental health conditions. For example, clients could use a tablet, smartphone application or computer program to track medication adherence, monitor their symptoms and receive self-management education. In the absence of smart technology, text-messaging and follow-up calls by service providers can aid in progress and adherence monitoring.

Remote modalities can be used to provide the following MHPSS services:

- **Evaluation and diagnosis:** Providers can use remote technology to observe the client; administer scales, assessments and screenings; and diagnose conditions. In the absence of video-enabled technology, alternative options should be put in place to improve the accuracy of evaluation and diagnosis (e.g., involving a caregiver as long as the client has given consent and/or a community health worker present with the client to provide additional details on the client's presentation).
- **Treatment:** MHPSS programs can provide counseling and psychotherapy, case management and psychosocial support that can be delivered to individuals, couples or groups. Some programs also offer more specialized therapies. Programs may also use remote modalities to deliver interventions such as education about mental health conditions and skills coaching.
- **Medication management:** Remote services can help geographically remote clients or clients unable to access in-person services for other reasons adhere to their medication regimens. Tools used for medication adherence may include mHealth apps, telephone counseling or follow-up via text messaging.
- **Case consultation:** Geographically remote providers can consult with peers and supervisors on client cases using direct video communication, telephone or email.
- **Service provider capacity building and supervision:** Remote providers can receive training, supervision or continuing education on MHPSS (including remote MHPSS) through distance learning, remote mentoring or webinars.

Activity: Large group discussion

Ask participants to share what remote models or remote MHPSS delivery would be feasible to implement in their respective settings and why? What adaptations would need to be made to remote modalities (medication management, evaluation and diagnosis, case consultation, etc.)? Allow 15 minutes for the discussion.

Session 1.e. Ethical standards for providing remote MHPSS services

Activity: Small group discussion

Divide trainees into 4-5 small groups. Assign each group a case to review and discuss. In presenting the cases, do not disclose which ethical standards are in question. Ask each group to identify potential ethical dilemmas presented in each case and how they would address them. Each group should assign and one note taker and one reporter who will present the group's main discussion points in the plenary. Instruct participants to reference the International Medical Corps Guidelines for Remote MHPSS Programming, as needed. Each group will have 20 minutes to discuss their case.

Once the small group discussions are completed, convene the trainees for the plenary discussion. Project the case study on the PowerPoint as each group presents the case study and facilitate a discussion.

Case study 1: Fatimah, 65

Fatimah, 65, has been coming to the local health facility for weekly counseling sessions with Aminah for the past two months. Fatimah has been diagnosed with moderate depression. During her next visit, Aminah informs Fatimah that due to the recent epidemic outbreak in the community, she has been instructed to provide counseling sessions remotely. Fatimah, who is hard of hearing and does not have access to the internet at her home, has never received remote or tele-mental health services before and seems unsure about the option.

Discussion Question: Discuss the potential ethical concerns that may arise in this scenario and how the service provider should address them. Also note any additional information you may need to make a determination.

NOTE: During the plenary discussion, the following ethical considerations should be noted:

- Screening clients for receiving remote MHPSS services ([Review pages 23-24 of the Remote MHPSS Guidelines](#))
- Informed consent ([Review pages 33-34 of the Remote MHPSS Guidelines](#))

Case study 2: Joseph, 27

Joseph, 27, has been a client of Adam's for about a month following his admission to the hospital during a psychotic episode. He has been diagnosed with PTSD and is under psychiatric care for medication management. Joseph's symptoms have stabilized since then. Adam views Joseph as technologically savvy and thinks he would be a prime candidate for transitioning to remote support. During the most recent visit, Adam informs Joseph that due to deteriorating security situation in their town, his agency will be providing limited in-person service and that the majority of the clients will receive remote support. Adams lets Joseph know he will be calling him for their next appointment.

Discussion Question: Discuss the potential ethical concerns that may arise in this scenario and how the service provider should address them. Also note any additional information you may need to make a determination.

NOTE: During the plenary discussion, the following ethical considerations should be noted:

- Screening clients for receiving remote MHPSS services ([Review pages 23-24 of the Remote MHPSS Guidelines](#))
- Informed consent ([Review pages 33-34 of the Remote MHPSS Guidelines](#))

Case study 3: Rimah, 23

Rimah, 23, has been attending remote counseling sessions with Aisha for the past 6 weeks. Rimah, a mother of three, is a gender-based violence survivor and struggles with symptoms of anxiety and depression. She lives with her husband, mother-in-law and three children. Rimah connects to counseling sessions via phone when her husband is not around and the mother-in-law is occupied with children or chores. Aisha calls Rimah for their pre-scheduled appointment. Rimah picks up, but sounds somewhat hesitant and only answers Aisha in brief-, one-word replies. Aisha proceeds with the session as usual.

Discussion Question: Discuss the potential ethical concerns that may arise in this scenario and how the service provider should address them. Also note any additional information you may need to make a determination.

NOTE: During the plenary discussion, the following ethical considerations should be noted:

- Verifying client identity ([Review pages 21 and 54 of the Remote MHPSS Guidelines](#))
- Confidentiality and privacy ([Review pages 34-35 of the Remote MHPSS Guidelines](#))

Case study: Fabiana, Clinical Psychologist

Fabiana works as a clinical psychologist for a humanitarian aid organization and provides MHPSS services in a local health facility. Due to a recent disease outbreak, her organization has mandated limited contact with beneficiaries and asked Fabiana and others MHPSS providers to support beneficiaries remotely unless it is an emergency or a complex case. Given Fabiana's caseload primarily includes beneficiaries with mild-to-moderate conditions, she works primarily from home and at times connects with clients from the health facility. She uses her work laptop and phone when at the facility, but when at home, she connects to clients from her personal devices. She makes sure to keep client records organized both in digital and paper form when working from home (she keeps files in a desk drawer until she is able to transfer them to the facility).

Discussion Question: Discuss the potential ethical concerns that may arise in this scenario and how the service provider should address them. Also note any additional information you may need to make a determination.

NOTE: During the plenary discussion, the following ethical considerations should be noted:

- Confidentiality and privacy ([Review pages 34-35 of the Remote MHPSS Guidelines](#))
- Recordkeeping and Data Protection ([Review pages 35 of the Remote MHPSS Guidelines](#))

Note to facilitator: After the discussion, take 5-7 minutes to summarize key ethical standards to keep in mind when providing MHPSS services remotely ([Reference the Remote MHPSS Guidelines as needed](#)).

Module 2: Setting Up for Remote MHPSS

Learning Objectives:

1. Learn the minimum requirements for setting up a private and professional physical space for remote MHPSS sessions.
2. Understand the technological requirements for conducting effective remote MHPSS sessions.

Duration: 1 hour

Session 2.a. Physical setup for remote MHPSS sessions

Activity: Large group discussion

Ask participants to reflect on the most and least ideal work environments in which they have worked. What work environment factors supported and detracted from their ability to work effectively with clients?

On a flipchart (or virtual white board for remote training settings), draw two columns and list supportive and detracting factors that participants share. Once the list is generated, ask participants which of these factors would be present when providing remote services from a home environment or an office? What can be done to replicate supportive factors and what can be done to mitigate detracting factors?

Allow 20 minutes for the discussion.

Summarize the following key points about the physical setup.

Physical space¹⁰

When setting up the space for conducting remote MHPSS services, ask yourself:

- How will I ensure complete privacy in this space?
- What can I do to prevent interruptions?
- What would allow me and the client to be fully present and focused on the session?

If working from a space shared with others (such as home or shared office space):

1. Designate a specific room for taking the calls with clients. Ideally, the room will have a door that can be closed to ensure maximum privacy.
 - a. Even if the door is closed, use headphones or avoid putting the client on the speaker phone to reduce the possibility of others in the next room overhearing client's sharing.

¹⁰ International Organization for Migration (2020). Internal guidelines for remote MHPSS working modalities. <https://returnandreintegration.iom.int/en/resources/guideline/internal-guidelines-remote-mhpss-working-modalities>

2. Reduce background noise to the extent possible. Stay away from windows or close windows to reduce street noise (e.g., traffic, construction, barking dogs, etc).
 - a. If you live/work in a particularly noisy environment, consider soundproofing the room by adding rugs/carpet on the floor, thick curtains/window treatments or even investing in acoustic panels
 - b. Utilize background noise reduction features that may be available on the digital platform you are using (for example, in the Zoom desktop app, there is a “Suppress background noise” setting in Audio settings).
3. Put phones and other devices to “do not disturb” or “silent” mode to prevent interruptions such as calls or other notifications beeping during the session. Close unnecessary applications on your device to minimize distraction.
4. Put a “do not disturb” or “session in progress” sign on the door to avoid people walking into the room while you are speaking with the client. If you are working from home and have small children, arrange for the partner or another caregiver to occupy children during sessions. Have a conversation with children in advance to explain why they cannot disturb you while you’re working.
5. Ensure you have easy access to the material you may need during the session to take notes (e.g., client progress notes, checklists, assessment tools, pen and notepad, etc.).

Considerations for video calls¹¹

When connecting with clients via video-conferencing, consider the following:

1. **Lighting:** For optimal virtual face-to-face experience, conduct the sessions in a well-lit space, ensuring your face is illuminated and fully visible. Your face should be directed toward the source of light, as the light coming from behind you will create shadows and will reduce visibility.
 - a. If the sessions are held using a laptop, fairly inexpensive portable lights (e.g., LED Ring Light) can be provided by your organization that can be mounted on the device screen that are specifically designed to eliminate shadows and provide professional-looking lighting.
2. **Background:** Choose a neutral background free from clutter and personal objects (e.g., photos, religious objects, etc.) to avoid distraction. Solid/soft-colored walls or curtains serve as optimal backgrounds.
 - a. Some platforms, such as Zoom or Teams provide virtual backgrounds or the ability to blur the background depending on the device you are utilizing. If you use a virtual background:
 - ◆ Ensure your physical background is a high-contrast, solid-colored, non-reflective surface. Keep your background surface close to you (e.g., sit with your back against or close to a wall).
 - ◆ Choose something neutral for your virtual background.

¹¹ International Organization for Migration (2020). Internal guidelines for remote MHPSS working modalities. <https://returnandreintegration.iom.int/en/resources/guideline/internal-guidelines-remote-mhpss-working-modalities>

- ♦ Don't wear clothing that's the same color as your physical background or the virtual background.
3. **Appearance/Dress code:** Maintain your professionalism and dress as you would for an in-person session. To optimize image quality, avoid wearing patterned or striped clothing and consider the background color when choosing your clothing color.

Optional Activity

In a virtual training setting, divide participants into small groups of 2-3. Ask each participant to take turns to provide feedback on each other's setup and how it can be improved. Each participant should then take a few minutes to apply some of the above-mentioned tips as best as they can with what they have available at their disposal. Process briefly as a large group, by asking participants if anything was particularly challenging or easy to implement. Allow 20 minutes.

Session 2.b. Platform and connectivity requirements

Activity

Divide participants into small groups and ask them to review page 20 (*Identify Appropriate Modalities for Remote Support*) of the International Medical Corps Guidelines for Remote MHPSS Programming. In small groups, the participants should create a checklist for setting up the technology for remote MHPSS service delivery. The checklist should list items that one should consider to ensure everything is set up and functioning before commencing a remote session. Participants can organize the checklist according to the following categories: 1. Device/hardware; 2. Applications/Software; 3. Internet connection. Allow 25 minutes.

Each group will present the items on the checklist and why they are important for platform and connectivity set up. Allow 30 minutes.

Summarize key points about setting up the platform and internet connection:

Device/Hardware¹²

- Work with IT experience to seek support in the setup when the electronic is first being used.
- Make sure that the electronic medium is sufficiently charged and a nearby electricity outlet source is present.
- Set up a backup electronic that can be used in case a problem occurs. (ex: "If the video or audio call over the internet got interrupted, we can switch to using a phone.")
- Set your electronic device on a stable surface instead of having to hold it in your hand to avoid shaking during a video conference.
- When using audio:

¹² International Organization for Migration (2020). Internal guidelines for remote MHPSS working modalities. <https://returnandreintegration.iom.int/en/resources/guideline/internal-guidelines-remote-mhpss-working-modalities>

- Using earphones helps minimizing background noise and improves the audio quality for both the beneficiary and the service provider.
- Putting the beneficiary on speaker is not recommended to maintain their privacy and to avoid voice distortion that could affect a staff's interpretation of the beneficiary's tone of voice.
- When using a camera:
 - Make sure it is wiped with a clean cloth for better quality.
 - Position it at the same level of your eyes.

Software/Applications:¹³

- Ensure that the software you are using is up to date to avoid system crashes during its use.
- Choose applications that are secure and accessible to participants and free to use (e.g., Skype, WhatsApp, Telegram, Viber, Zoom, MS Teams, phone call).
- Spend time familiarizing yourself with the advanced features of the platform so you can provide technical support to the clients if needed.
- When using the share screen option in any application:
 - Try minimizing what is visible on the desktop/mobile background to avoid distraction and ensure your privacy.
 - Disable notification alerts at the time of the session to minimize distraction.
- When using online content:
 - Prepare all content that will be shared online before the session begins.
 - Compile all necessary material in an easily accessible folder on your desktop.

Internet Connectivity¹⁴

- Move the router to a central/open space, as enclosed spaces may dampen Wi-Fi signal.
- Place your primary device closer to the router.
- Disconnect/move away any other devices that may also be connecting to Wi-Fi (e.g., wireless keyboards, smart tablets, etc.).
- Consider using an ethernet cable to connect your device directly to the router.
- Check your device settings for any applications or programs that may be automatically running in the background and utilizing internet data/Wi-Fi.
- Secure your Wi-Fi connection via a password to avoid others tapping into your connection.
- Call your internet service provider to troubleshoot and seek tech support.

¹³ International Organization for Migration (2020). Internal guidelines for remote MHPSS working modalities. <https://returnandreintegration.iom.int/en/resources/guideline/internal-guidelines-remote-mhpss-working-modalities>

¹⁴ *Ibid.*

Module 3: Prepare for Remote MHPSS

Learning Objectives:

1. Know what preparation to implement accessible remote MHPSS services in a safe and confidential manner entails.
2. Learn how to adapt intake, assessment, means and methods of communication, data management and updating and maintenance of referral pathways to be feasible in a remote setting.

Duration: 3-4 hours

Note to facilitator: In addition to the usual training materials, print (or provide electronically if training is online) the following resources to facilitate the module: Appendices C-F of Remote MHPSS Guidelines (if the trainees have copies of the entire Guidelines, printing additional copied won't be needed); templates of the service users/organizations current intake and assessment forms); Referral form normally used (or if one doesn't exist—the template for IASC MHPSS Interagency Referral form), IASC MHPSS 4W Tool, International Medical Corps Remote MHPSS Guidelines adapted 4W Mapping Tool, [WHO Quality Rights self-help recovery tool for mental health & well-being](#), [Copeland Center for Recovery and Wellness Guidance on WRAP](#).

Session 3.a. Adapting communication skills and styles for remote MHPSS

Visual and non-Verbal considerations

Adapting communication skills and styles to remote MHPSS service provision requires planning and practice to ensure efficacy and not doing harm.

Planning for remote MHPSS service provision sessions involve being organized, informed and allowing sufficient time. Before engaging in remote MHPSS sessions, service providers can try to ensure that:

- All equipment and connections are working and ready for use
- The workspace is quiet and will remain so for the duration of the session, and confidentiality can be ensured
- They are informed and up-to-date on the clients' case and needs, including review of referral forms, assessments, case notes, so that time is not taken up in duplication of information already shared
- The timeframe of the session is planned as much as possible, with a plan in place to ensure adequate time is provided to address the issues and objectives envisioned
- Extra time is allocated to the session, than what would normally be allocated for in-person services. Allowing for potential start-up issues, connectivity problems, interruptions. Typically a remote MHPSS session may take more time than a regular in-person session.

- Note taking should not interfere with communication—it may seem appropriate to type notes onto the computer you are using, but this may be distracting for the client

Service providers will need to be in tune with each individual client's situation at the time of each individual service provision session/consultation, taking into account all factors which may alter regular communication and understanding, and asking about these before or during the beginning of the session, including:

- The means of communication—visual, auditory or text
- Connectivity issues or time delay
- Level of privacy for both service provider and client
- Language or dialect differences/barriers
- Age of the client, does the language need to be adapted for children, adolescent or older person clients?

Verbal communication can be adapted to improve understanding and comprehension between service provider and client, especially if videoconferencing is not possible, through mindful attention to:

- Pronouncing clearly and carefully selecting language, as well as culturally appropriate voice inflection
- Using active listening and requesting clarification for any point that is unclear
- Providing acknowledgement of statements, paraphrasing, reflective feedback and affirmation, allowing the client to correct the service provider if they have not heard or understood correctly
- Providing the client adequate time and space to think and to speak, allowing for breaks and pauses
- Providing a summary at regular intervals and at the end of the session
- Non-verbal communication, during video calls, can also be adapted to support communication and build rapport. Service providers may do this in remote MHPSS sessions using video by mindful attention to:
 - Their background, ensuring that there are no distraction and background is neutral. For example, an open window in the background behind the service provider may be distracting and decrease confidentiality.
 - Lighting, depending on the space being used, clients may not be able to accurately see the service provider if the picture coming to them is too light or dark.
 - Their body language, being aware of what the clients sees and adjusting posture and body language appropriately. This includes positioning of the camera in relation to the service. provider to ensure that the service providers face and upper body can be clearly seen by the client.
 - Their facial expressions, and how these may come across differently from expected when using video link.
 - Maintaining eye contact, as much as is possible, and if appropriate. Trying not to get distracted by other things in screen such as pop-up messages or the service providers own video box.

Activities

Activity: Large group discussion

As a group, discuss the following topics and questions in relation to remote service provision, especially in relation to the type of service you provide, the means of remote communication that is available for your clients, contextual and cultural specific factors that may help or hinder remote service provision. Please list all, as well as any potential improvisations, mitigating actions or solutions that could be used.

- Building rapport with a first-time client—what additional measures should I take to ensure the client feels comfortable receiving and continuing to receive remote services?
- Displaying and receiving/perceiving empathy—how can I ensure that I can “put myself in my clients’ shoes”?
- Challenging resistance—what will be the additional challenges when not providing the session in-person?
- Mindfulness of body language—what do I regularly communicate via body language that I may not be able to do in remote MHPSS sessions?
- Assessing affect without visual cues—what extra questions might I need to ask to make up for the lack of visual perception of the clients current state if I cannot see them?

Activity: Role play—providing and receiving a remote MHPSS service session

Divide participants into pairs and conduct the role play multiple times, with one participant taking the role of the client, and the other the role of the service provider. Role plays are to be conducted remotely, at least in different rooms, using both audio-only and video and audio methods.

- Participants playing the role of service provider are to conduct the role play in their usual service provision role, e.g., as social worker, case manager, psychotherapist, psychiatrist, mhGAP-trained.
- For the participant playing the role of service user in each role play, choose one case section for each.
- Each role play to last ten minutes.
- Switch role and partner in every second role play.
- Allow time for feedback and discussion between each role play.
- Facilitator to collect and analyze all feedback and present the main feedback points and themes to the participants at a later stage.

Case 1

For the Service Provider

Vlad is a 45-year-old male, and has been a client of your service for 3 months, who attends sessions bi-weekly and is generally talkative, attentive to conversation, and involved in making suggestions in his case. Vlad self-referred to the service at the insistence of his wife, as he had been drinking alcohol heavily for a period of over one year and has displayed anger management issues at home and at the workplace. You have also identified that Vlad is experiencing depression, which may stem from the loss of both parents the previous year. Today is your first time conducting a remote session together, as his usual means of transport is unavailable today. Today he seems distracted and subdued. Based on Vlad's non-verbal communication, you sense, via the video, that he is worried and/or his mood is not as positive as it has been in recent sessions. You ask Vlad, "How are you today?" Vlad responds, "Oh, I'm fine", but provides no more information.

For the Client

You are Vlad. A 45-year-old man, married to Lyudmila with two adolescent children. Last year, both of your parents, with whom you were very close and as the eldest child supported and cared for them, were killed in a random missile strike during the conflict. You have always liked to drink alcohol with your friends from time to time, but after your parents were killed, your thoughts often became angry due to the unfairness of what happened to them, you started to worry more about the safety of your children, wanted to move to a different area, but your wife refuses to leave her home, and you started to resent her for this decision. It became more necessary to drink more often, in the beginning it helped you to cope with your situation, but after some time it started to affect your health, and your relationship with your wife and children, as you sometimes became very angry, and they couldn't understand why. The MHPSS services have helped you to reduce your alcohol intake and you have learned some steps to take when you start to get angry. It's been nice to have somebody who listens, understands and can help. However yesterday you saw your parents friend playing with their grandchildren, and it caused you to become very sad, with thoughts of what could have been, if your parents had not died, and what now can never be. You went to the bar and stayed drinking for most of the day. On the way home you crashed the car, and it needs repairs you can hardly afford. You weren't angry when you came home, but your wife was, and this made you become angry and shout at her. Now you have the next session with your service provider, you cannot get there but they agree to have the session over WhatsApp. You want to talk, but you are afraid some of your family members will hear you speaking about very personal issues, which you would prefer that they didn't.

Case 2

For the service provider

Rebecca is a 29-year-old woman, who is a long-term client of yours. She was diagnosed with mixed personality disorder at the age of 17 and since then has gone through periods of high functioning, and almost complete dependence on her mother, Sarah. When Rebecca is functioning well, she can be very self-aware, solution oriented and organized in her life. However, when she relapses, she displays violent and abusive behavior, especially toward her mother, while at the same time depending on her for all of her needs, including accommodation,

emotional, financial, transport. You regularly have a monthly check-in with Rebecca, and sometimes also with Sarah. This month you know it will be very difficult to meet in-person, due to the current security situation, and have sent messages to Rebecca to request to have the session remotely instead. However, Rebecca hasn't responded to any of your messages or calls. Understandably you are worried and you call Sarah to arrange the session, she agrees and says she and Rebecca will be ready to join by phone call at the appointed time.

For the Client

You are Sarah, a 54-year-old woman with three children, one of whom, Rebecca, currently lives at home with you. She has had mental health issues since she was a teenager, sometimes she is great and lives independently, studies, works, socializes. But at other times, now every few years, she returns home, unable to do anything for herself, she sits in her room for hours, then comes out to shout and hit you, blaming you for the problems in her life, as this is happening again this week, and you don't know why. You feel like you've had enough now, you are getting too old to manage Rebecca's moods and abuse, you will retire soon and you want to do so in peace, but you know that it will be impossible, unless Rebecca leaves, or there is some miracle in her situation. The MHPSS services have been very helpful for Rebecca over the years and the staff are very nice. They want to have a call today as you can't bring Rebecca to the center, however she has locked her room and will not talk to you. You decide that you need someone to talk to and you have the call anyway. When they ask you how you are, you start to cry and feel like you will breakdown, and you let out all of your emotions, saying "I can't take it anymore, I can't cope, I don't know what to do and there is nobody to help me, nobody cares about me and I'm all alone now."

Session 3.b. Assessment of clients for their suitability to undertake remote MHPSS

The adaptation to and provision of remote MHPSS services can be essential in the continuation of care for MHPSS service users during times, contexts or situations where in-person service provision is not possible. However, in some cases, the continuation of regular support via remote service provision may not be suitable. To ensure the most appropriate form of continued support, as well as adhering to do-no-harm principle, clients who are unable to receive/continue receiving in-person services should be screened for suitability, and if it is deemed that remote service provision is unsuitable for certain clients, alternative arrangements will need to be provided for, whenever possible.

In situations where an individual client is unable to receive in-person MHPSS services, service providers should discuss the reasons and options with the client, in addition to consulting with and discussing the case with their clinical supervisor, using the list of considerations for screening clients for remote support, included below.

In situations where in-person MHPSS services are limited in general, all MHPSS service providers should prepare a list of their active cases, organizing them by stable (mild to moderate conditions) and severe/urgent cases, to better assess cases that can be shifted to remote modality, and those that should continue to receive in-person sessions, while discussing the reasons and options with their clients, and consulting with their clinical supervisor. In such situations, all clients should be contacted as soon as is possible, prioritizing severe/urgent

cases, then moderate cases, and finally mild cases. Where appropriate, contact caregivers of clients (e.g., for children or actively high-risk adults).

Other factors that should be considered when categorizing clients into groups who may and may not be suitable for remote MHPSS services are:

- The length of time for which remote MHPSS service provision is expected to last
- The rapport between service provider and client
- Service providers level of training in services/supports particular to the clients MHPSS needs
- Client history, existing family, and social supports
- Availability of accessible and affordable alternative in-person, in-patient and emergency MHPSS services

Examples of stable, mild-moderate cases, which in general can normally continue receiving remote MHPSS services are:

- Mild-to-moderate depression, anxiety, acute stress, PTSD, grief
- Controlled schizophrenia/psychosis with support system
- Controlled epilepsy
- Intellectual and developmental disabilities, or dementia, with support system
- Support for caregivers and parents of clients with severe or urgent MHPSS needs

Examples of severe, Urgent and complex cases, which in general may require more intensive in-person, in-patient or emergency support include:

- Active or recent self-harm or suicidality
- Active or recent psychosis
- Active or recent harm towards others
- Uncontrolled seizures
- Uncontrolled substance-use conditions
- People prone to relapse of mental health symptoms due to non-compliance on medication
- People with complications arising from intellectual or developmental disabilities, or dementia, without support system, and with protection risks
- Health referrals after ruling out any medical condition (e.g., severe health consequences due to anxiety/psychosomatic symptoms)

The following considerations and decision-making tree can be used in screening clients for their suitability for receiving remote MHPSS services:

- Is the client open to receiving remote support?
- Does client have the means to receive support remotely? (e.g., phone, phone credit, network)
- What is the client's individual skills, knowledge, and typical interaction with remote modalities (e.g., phone, videoconferencing, email, online surveys, etc.)?
- How much experience does the client have with relational communication (communication involved in personal relationships) using remote modalities?

- What previous mental health services, if at all, has the individual received? What worked well? What did not work well?
- How will culture and language affect remote service delivery?
- How easily does the individual become frustrated with or confused by technology?
- What resources could supplement remote services?

Depending on the context and availability of other forms of in-person support, the following is a list of possible options for consideration if a client is not suitable for or does not want to receive remote MHPSS services:

- Other accessible and available MHPSS services that provide in-person care
- In-patient MHPSS services
- Family and caregiver support
- Evidence-based and contextually relevant self-help materials (e.g., Self Help Plus*)
- Wellness and Recovery Action Plans

Session 3.c. Considerations for new client admissions

Intake of new clients during a period of general remote MHPSS service provision will also need to be adapted, taking into account the person's MHPSS needs and suitability for remote service provision, in addition to the time and resources available for the MHPSS department/service provider.

It is important that service providers have a manageable amount of work and a number of cases/clients that they can comfortably provide remote MHPSS services for, allowing enough time for service provision for each client without overburdening the service provider, ensuring that caseloads are manageable, taking into account factors that will impact normal working routines, such as:

- The amount of extra time that will be required to prepare for and provide remote MHPSS sessions
- The number of clients who will, after screening, not be deemed suitable for receiving MHPSS services remotely, and be referred for external services
- The anticipated number of new clients, or the changing trend in the volume of people, who will be referred for or request MHPSS services

Activity: Adaptation of Intake, Assessment Forms for Remote Admissions

Participants divide into pairs, and taking the template/forms they normally use for Intake and Assessment of new referrals/clients, proceed to discuss the necessary changes and adapt the forms for remote intake and assessment, according to the Considerations for Screening Clients for Remote Support in the previous section, as well as the handouts (appendices C, D, E & F of the Remote MHPSS Guidelines).

After this has been completed, groups are given five minutes each to present and discuss the changes they propose with the wider group, all suggestions are to be recorded and synthesized by the facilitator, providing updates templates for the wider group of participants/service providers to review and agree upon at a later stage.

Session 3.d. Client Data Protection

Client data protection is essential in ensuring confidentiality, privacy, safety as well as adhering to the highest ethical standards and national legal obligations, in addition to ensuring trust and rapport between service providers and clients. Without appropriate safeguards for client data, client safety can be at risk. Safeguards should be in place to keep client data both private and secure. Data privacy and information security work hand in hand. In cases or times where remote service delivery is required, all data collection, management and dissemination methods and processes will need to be adapted for remote programming and service provision. In such situations, service providers will be required to adapt their client data protection measures, taking into account the following guidance:

- If existing client files are not digitized and stored electronically, establish procedures and protocols for accessing hard-copy files by service providers working remotely, ensuring the files are not kept in unsecured places, where the client confidentiality can be compromised.
- Establish procedures and protocols for keeping client notes and other documentation once transitioned to remote modality. If possible, a secure online database should be established for service providers to store and access all client files digitally while providing remote services.
- If digital documentation and data storage is not feasible, senior management and MHPSS Coordinator should establish clear protocols and procedures for keeping paper files while working remotely (e.g., providing cabinet files with locks to the providers, clarifying when and how to transport hard-copy files to a central location, keeping a client file log and periodically performing audits, etc.).
- Similar procedures should be established for documenting and storing supervision-related files.

Security of client data can be increased using the following methods.

- Strong authentication: The platforms used should have strong authentication methods, such as unique and personal usernames and password protected logins. Strong passwords that cannot be easily guessed should be created. Service providers and/or users should log out at the end of the calls.
- End to end encryption: where possible, choose modalities with end-to-end encryption to ensure privacy and security of the information communicated.
- Regular software updates: The laptops/phones/tablets should receive regular software updates and operate with the most up-to-date operating systems.
- Avoiding scams: Educate the staff and service users on phishing messages. If staff or service users receive any messages from senders they do not know or requesting them to share personal or sensitive information, they should delete the message or the email. If in doubt throw it out.
- Online safety guidance: During training and supervision, service providers should be provided guidance on how to support the client and beneficiaries stay safe online. Service providers should be up to date with any possible scams happening and how to protect themselves and the clients.

In addition, the following ethical guidance will need to be followed.

- Clients must give their permission before their information is collected.
- Client information should not be used except for the purpose in which it was given. Data should not be disclosed to a third party, without the prior consent of the data subject, unless legally or contractually obliged to do so.
- Only information about a client that is relevant to providing care should be collected.
- All reasonable steps should be taken to ensure that client information held is accurate and up to date.
- Client information should not be kept for longer than is necessary. All out of date or redundant data should be destroyed in a secure and confidential manner.
- Security and confidentiality measures should be in place to protect personal data. All electronic data must be password protected. All paper records should be securely stored in a locked cabinet or room.
- Only share emails or messages containing client information with people when a client has given their consent and where possible remove all identifying information
- Only share emails with colleagues containing client information when absolutely necessary and remove all identifying information. Password protect all documents sent by mail and send the password to the document in a separate email.

Activity: Large Group Discussion

As a group, discuss the steps that will need to be taken by the organization/service providers to adapt the data collection, management and dissemination processes, methods and tools which are currently being used in in-person MHPSS service provision to ensure that a transition to remote service provision will not impact client data protection. Throughout the discussion, the facilitator may take notes (online or whiteboard) and include them in a MHPSS Client Data Protection Protocol template for future review. You can use the following guiding questions for the discussion:

- What are the methods and tools currently being used for data collection and management for use in in-person MHPSS service provision?
- What are the current protective measures in place and are there any current gaps that need to be filled?
- Does the organization/service providers have data protection protocols and/or Standard Operating Procedures?
- How can the methods be adapted and improved to ensure optimal client data protection?
- How can the tools used be adapted and improved to ensure optimal client data protection?
- What will need to be communicated with clients to ensure that they are aware of and understand these changes? What positive and negative feedback or reactions do you think clients may have regarding these changes?

Session 3.e. Revising service mapping/referral pathways

Service mapping is essential at all times, during regular in-person service provision, to understand what MHPSS services are available to clients and caregivers and to determine what services have or will transition to remote modalities. This also includes assessment of whether and how other actors are implementing MHPSS programming remotely, and what resources can be leveraged to support local communities. When possible, [4Ws mapping](#) should be conducted as a part of a coordination group for the MHPSS sector to document the available MHPSS services and related information, MHPSS service providers/agencies should also conduct service mapping of other non-MHPSS services available for referral also, such as healthcare, protection, legal services, NFI, shelter, etc. This template can be adapted accordingly to the context.

Module 4: Conducting Remote MHPSS Sessions

Learning Objectives:

1. Describe at least 5 best practices related to initiating, delivering and ending remote MHPSS services.
2. Describe the steps in making a client referral in the context of remote service delivery.
3. Develop skills in assessing the applicability of MHPSS interventions and measures for remote service delivery.
4. Develop skills in adapting MHPSS interventions and measures for remote service delivery.
5. Describe the adaptations needed to clinical documentation for remote MHPSS services.
6. Understand administrative considerations related for medication management
7. Understand clinical considerations for medication management.

Duration: 17 hours

Note to facilitator: It is recommended that the relevant flowcharts and annexes and intervention guidance in session '4.f. Guidance on adapting MHPSS interventions to remote modality' be made available to participants as handouts (print or electronically).

Session 4.a. Contracting and boundaries for remote MHPSS

Contracting establishes the foundation for the delivery of remote MHPSS services and is an important first step in defining boundaries, in establishing expectations for the therapy, and in supporting the development of a positive therapy relationship that includes trust and safety.

Contracting involves:

1. Obtaining informed consent
2. Establishing boundaries for therapeutic contact with the client

3. Agreeing on alternative procedures for maintaining contact in the event of a technology failure

Informed consent

Note to facilitator: Ensure that participants have read the following sections of International Medical Corps Guidelines for Remote MHPSS Programming in Humanitarian Settings: Cross-cutting Components → Cross-cutting Component: Ethical Considerations → Informed Consent and Appendix G: Informed Consent Form for Remote MHPSS.

Activity: Large group discussion

The facilitator should ask training participants the following questions: What is your current process for obtaining informed consent? What are some best practices related to obtaining in-person informed consent? What information are you required to share as part of informed consent? [Allow a 10-minute discussion]. Facilitator should then ask: How would your current process of obtaining informed consent need to be adapted for remote MHPSS service provision? Is there additional or different information you would need to share and/or obtain as part of informed consent for remote MHPSS service provision? [Allow another 10 minutes for discussion]

Guidance for obtaining informed consent¹⁵

When obtaining informed consent, the MHPSS provider should be sure to:

1. Explicitly ask for the client's consent. *E.g.: "Because we are not able to meet in person, we will provide our services through audio only or audio and video services. Do you agree to this?"*
2. Include the right to withdraw from the service at any time. *E.g.: "You have the right to end your participation in the sessions at any time. This will not affect your receiving services in the future should you wish to."*
3. Explain the importance of establishing a safety plan that includes at least one emergency contact and the closest emergency room to your location, in the event of a crisis situation. In addition, gather relevant information that will support risk management (e.g., details of a friend, family member or physician who may be contacted in times of crisis; obtaining the client's address and telephone number for use should it be necessary to contact emergency services).
4. Include having a contact name and number for situations in which the connection is lost with the client (Refer to Troubleshooting Technical Issues). *E.g.: "In certain situations, our connection may be lost due to a technical reason. In these situations, it would be helpful to have the name and contact number for someone I could call to coordinate with to reschedule our session."*
5. Ensure that the consent form also includes that recording the session in any form is not permitted to either party without the permission of the other person(s). *Suggestion: Some applications have a recording feature, recording is not permitted to either party*

¹⁵ American Psychological Association (2020). Informed consent checklist for telepsychological services. <https://www.apa.org/practice/programs/dmhi/research-information/informed-consent-checklist>

under any circumstance according to the organization’s working guidelines. It should be noted that the recording feature will be visible to the other party. Should the call be recorded a kind request will be made to stop the recording. The call will be ended if recording continues.

6. Providers should discuss the importance of having consistency in where the client is located for sessions and knowing the client’s location at the time the session is being implemented, as it impacts emergency management and local available resources. As patients change locations, providers should be aware of the impact of location on emergency management protocols. These include emergency regulations, resources (e.g., police, emergency rooms, crisis teams), and contacts.
7. The provider and client should decide on the main modality of remote working (e.g., audio only [phone] or audio-video [e.g., Skype, Zoom, Facetime]). Due to either weak internet conditions or individual preferences, the provider or client may opt for audio rather than video calls. Consider asking: “Services can be provided through phone or video calls; which would you prefer?”
8. An explanation of confidentiality and its limits as it relates to remote MHPSS service provision should be provided. This should include an explanation of limitations in the security of the modality being used (e.g., Skype, Zoom, phone, email) and efforts to protect the client’s health information.
9. Lastly, the provider should explain that if they determine that telepsychology is not or no longer appropriate and that they will refer them to in person services.^{16 17 18}

Boundaries for therapeutic contact with clients

The consent process should include discussion of session management and the MHPSS provider should have clear policies pertaining to communication with clients. These should describe the boundaries around ways in which clients can communicate with a provider, which content is appropriate to share over different technology platforms, anticipated response times, and how and when to contact a provider. Providers should identify clearly which platforms are acceptable for communication of an emergency and expected response times. In addition, expectations about contact between sessions should be discussed and confirmed with the client, including a discussion of emergency management between sessions (Refer to Managing Risk and Emergency Cases During Remote MHPSS Service Delivery).^{19 20}

¹⁶ International Organization for Migration (2020). Internal guidelines for remote MHPSS working modalities. <https://returnandreintegration.iom.int/en/resources/guideline/internal-guidelines-remote-mhpss-working-modalities>

¹⁷ Irish Association for Counseling and Psychotherapy (n.d.). Recommended approach for online counselling and psychotherapy. <https://www.iacp.ie/onlinecounselling>

¹⁸ American Psychological Association (2020). Informed consent checklist for telepsychological services. <https://www.apa.org/practice/programs/dmhi/research-information/informed-consent-checklist>

¹⁹ American Psychiatric Association & American Telemedicine Association (2018). Best practices in videoconferencing-based telemental health. <https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/Telepsychiatry/APA-ATA-Best-Practices-in-Videoconferencing-Based-Telemental-Health.pdf>

²⁰ Irish Association for Counseling and Psychotherapy (n.d.). Recommended approach for online counselling and psychotherapy. <https://www.iacp.ie/onlinecounselling>

As part of establishing boundaries for therapeutic contact providers should:

- Define when you are available and the limits of your availability.
- Inform the client of details about session booking, dates and times of contact.
- Provide information on the duration of the therapy sessions.
- Clearly define what aspects of service delivery are carried out synchronously (e.g., sessions) and asynchronously (e.g., responding to scheduling requests).
- Define which content is appropriate to share over specific technology (e.g., email and text for scheduling appointments; videoconference platform for sessions) and the difference between communication for making practical arrangements and the content material of therapy sessions. For example, using a mobile phone to confirm or cancel appointments, but not for personal or confidential communication.
- Provide information on how quickly messages will be responded to by the provider.
- Explain the importance of routinely acknowledging messages.
- Explain that online communication between the client and provider outside remote sessions will be limited to the agreed upon therapeutic contact, such as for the purposes of scheduling sessions. Connecting on social networking sites will be avoided to protect client confidentiality and maintain professional boundaries.
- Provide the client with information on how to proceed in case they are late for the session or miss it without giving prior notice (e.g., asking that the client notify you if they are running late; informing the client that if they need to cancel or change their tele-appointment, they must notify the provider in advance by phone or email).^{21 22}

Setting boundaries requires the ability to set limits while also building the therapeutic relationship.

Activity: Role play

Note to facilitator: This role play should use the Informed Consent Form for Remote MHPSS in Appendix G of International Medical Corps Guidelines for Remote MHPSS Programming in Humanitarian Settings.

Facilitator should ask participants to pair up. One participant will serve in the client role whereas the second participant will serve as the provider. The client is an adult male or female who seeking MHPSS services for anxiety. They are presenting for their first therapy session which is being conducted *through a video call (video and audio)*. The provider should first go through the process of informed consent using the Informed Consent Form for Remote MHPSS (Appendix G, International Medical Corps Guidelines for Remote MHPSS Programming in Humanitarian Settings) and thereafter explain the boundaries related to therapeutic contact. Allow 20 minutes for this role play.

²¹ International Organization for Migration (2020). Internal guidelines for remote MHPSS working modalities. <https://returnandreintegration.iom.int/en/resources/guideline/internal-guidelines-remote-mhpss-working-modalities>

²² Irish Association for Counseling and Psychotherapy (n.d.). Recommended approach for online counselling and psychotherapy. <https://www.iacp.ie/onlinecounselling>

The role play should be followed by discussion: What was the provider's experience? What was difficult and why? What was the client's experience of the provider? What was done well? What could be done differently?

A second role play should be implemented in which the pair switch roles. The client is either a male or female seeking therapy for depression. They are presenting for their first therapy session which is being conducted *through a phone call (audio only)*. The provider should first go through the process of informed consent using the Informed Consent Form for Remote MHPSS (Appendix G, International Medical Corps Guidelines for Remote MHPSS Programming in Humanitarian Settings) and thereafter explain the boundaries related to therapeutic contact. [Allow 20 minutes for this role play].

The role play should be followed by discussion: What was the provider's experience? What was difficult and why? What was the client's experience of the provider? What was done well? What could be done differently?

Alternative procedures for maintaining contact in the event of a technology failure

At the time of contracting or during the first session, the provider and client should discuss and develop an alternative plan for continuing the session in case of a technical problem with the main means of communication. This should be discussed and agreed upon as early in the therapy process as possible to facilitate and minimize disruptions to subsequent sessions.

As part of the planning, the immediate contact information for both provider and client (phone, text message or email) should be shared.

Provider communication alternative

The MHPSS service provider should communicate to the client what alternative means of communication the provider has access to and can use as an in case of technical failure with the main communication modality agreed upon. This could include:

- An extra telephone, if available (mobile or landline).
- An alternative computer or tablet, if available.

Client communication alternative

The provider and client should identify alternative means of communication that the client has access to and can use in case of technical failure with the main communication modality agreed upon.

- If the main modality is through phone call:
 - Obtain other personal phone numbers that the client owns.
 - If not, obtain an emergency contact person details, including their name, relationship to the client (trusted contact who can be either a family member or a friend), phone number, location (accessible to the client).
- Advise the client to obtain verbal agreement with that person to be able to use their phone in case of technical issues with the main means of communication.
- If the main modality is through a video call (e.g., Skype or Zoom):
 - Suggest switching to a phone call temporarily until the technical issue is resolved.

- If that fails, turn to the emergency contact person as mentioned previously.²³

Refer also to 4.c. Troubleshooting Technical Issues for a more detailed review.

Session 4.b. Scheduling sessions and communication between sessions

Scheduling sessions:

- Sessions can be scheduled through either calling or sending a text message to the client. A phone call is recommended to include clients who have difficulty in reading or writing for any reason.
- When scheduling an appointment, ask if the client requires assistance before or during the session with navigating the technology.
- Arrange with the client the day and time suitable for the sessions.
- The frequency of a client's sessions should be scheduled as it would for in person sessions. *E.g.: The sessions will occur on every Monday from 12-1pm.*
- If possible, keep spare working hours in the week for flexibility in rescheduling sessions that are missed for any reason.²⁴

In between sessions communication:

- At the end of each session, the time and date of the following session should be discussed and agreed upon.
- You can offer to send a reminder text or make a short phone call a day before the next session to remind the client of the upcoming session and/or encourage the client to note it in their calendar.
- In case an emergency situation occurs in between sessions, the client should follow the plan that the provider and client established to address emergency situations (Refer to Managing Risk and Emergency Cases During Remote MHPSS Service Delivery).²⁵

Session 4.c. Troubleshooting technical Issues

In the event of a technology breakdown, causing disruption in the session, the provider should have an alternative communication plan in place. The plan should be discussed and decided upon in collaboration with the client at the time of contracting or during the first session.³ The provider may review and revise the alternative communication plan on a routine basis. The provider may choose to remind the client of the agreed upon alternative communication plan at the beginning of each session.

²³ International Organization for Migration (2020). Internal guidelines for remote MHPSS working modalities. <https://returnandreintegration.iom.int/en/resources/guideline/internal-guidelines-remote-mhpss-working-modalities>

²⁴ International Organization for Migration (2020). Internal guidelines for remote MHPSS working modalities. <https://returnandreintegration.iom.int/en/resources/guideline/internal-guidelines-remote-mhpss-working-modalities>

²⁵ *Ibid.*

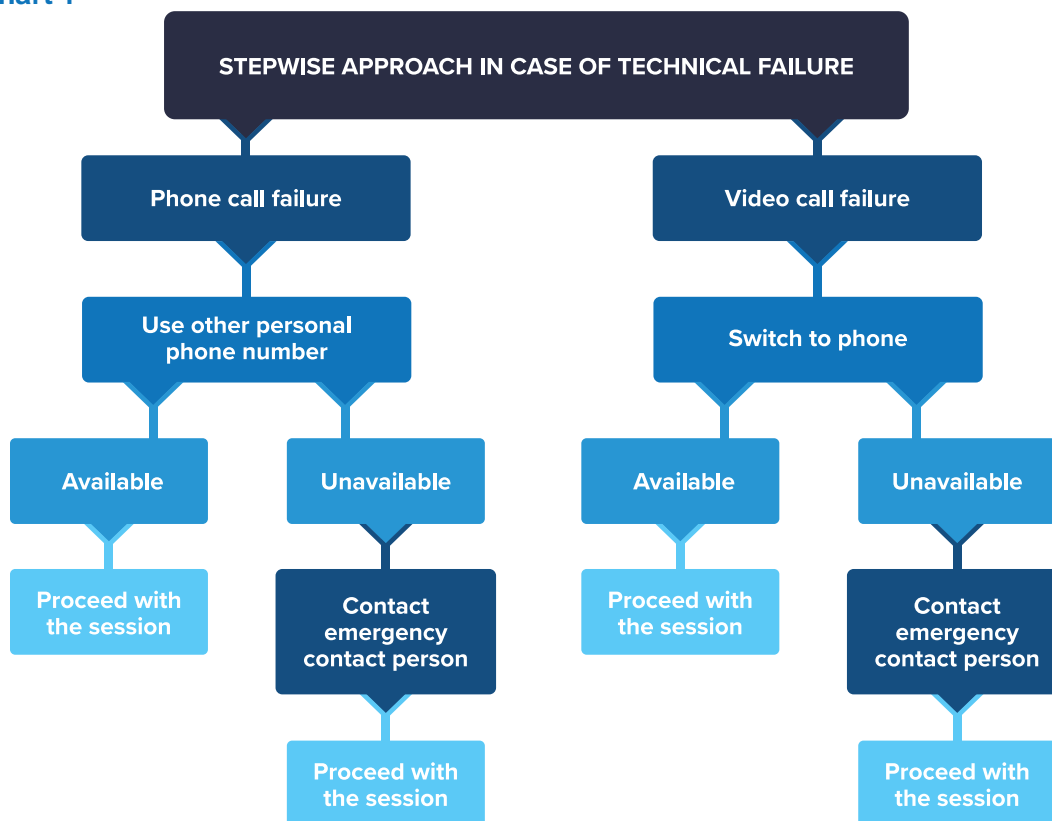
Alternative Communication Plan:

The following is an example of a plan to manage a session disruption due to technical failure:

Inform the client of the following:

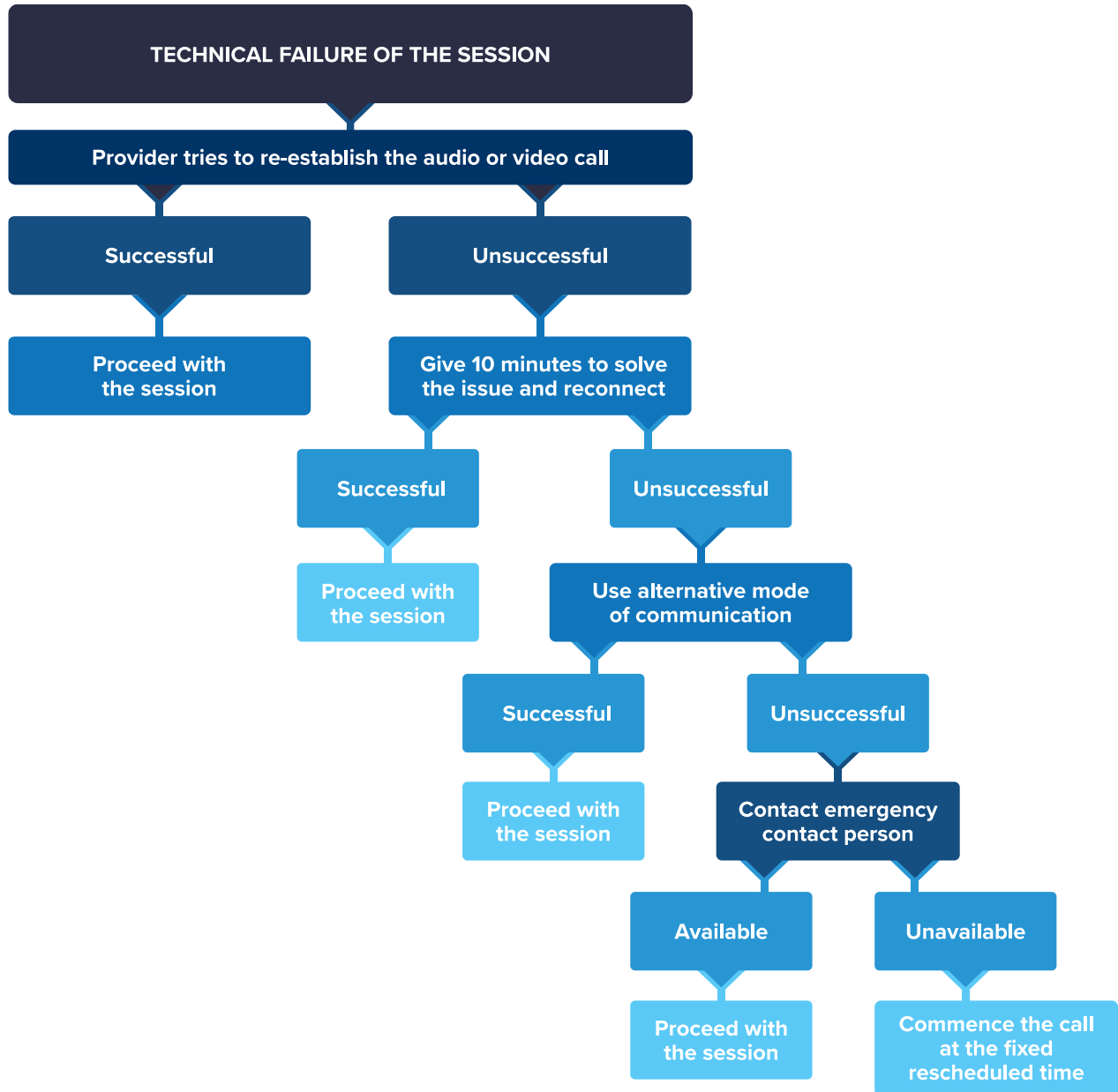
- That you will be the one to try to re-establish the connection (to avoid both of you calling at the same time).
- When experiencing a technical issue, you will try reconnecting using the main means of communication (the audio or video call three times over the course of 10 minutes)
- If unsuccessful, you will turn to the secondary means of communication (as agreed upon).
- If unavailable, you will contact the emergency contact person (family, neighbor, friend for whom you have contact information and client consent to contact in situations of technical difficulty).
- It is recommended that the client and you have a fixed rescheduled session in case of complete disruption without being able to reschedule another appointment (e.g., *“The session will be scheduled at the same time the next day.”* But you may also give a reminder call before the session).²⁶

Flowchart 1



²⁶ International Organization for Migration (2020). Internal guidelines for remote MHPSS working modalities. <https://returnandreintegration.iom.int/en/resources/guideline/internal-guidelines-remote-mhpss-working-modalities>

Flowchart 2



Activity: Developing an alternative communication plan

Case scenario examples: The following scenarios are meant to provide guidance and serve as examples. The facilitator should adapt these case scenario examples to the participants' context.

- **Case scenario 1:** The client is an adult male living in a remote area with poor internet connectivity. He has access to an old smart phone with unreliable internet capacity.
- **Case scenario 2:** The client is an adult female who lives with her husband, sister and three school aged children. She has told the provider that she can use her phone for the counselling session.

Participants should break into small groups (3-4 individuals) and together develop an alternative communication plan to meet the needs of either one of their existing clients or for a case scenario client. The alternative communication plan should take into account the context (e.g., client access to different technologies, internet stability and access). [Allow 20 minutes for the development of an alternative communication plan]. Each group should then present their alternative communication plan. The discussion should address any challenges to developing the alternative communication plan.

Managing Technical Issues:

1. Issue with the internet connection

A problem with the internet connection can manifest as follows:

- a. Repeated disconnection of the session.
- b. Time lag between what is being said and the video image (loss of lip-voice synchronization).
- c. Frozen image on the screen.
- d. Pixilation of the video image.

All of the above can be due to a slow internet connection. Refer to Session 2.b. Platform and Connectivity Requirements on how to troubleshoot connectivity issues.

If none of the actions described under Session 2.b. solve the issue, implement the alternative communication plan detailed in Flowchart #1. For technical issues during video calls, the provider can call the beneficiary over the phone and try problem solving the issue together.

2. Phone battery dies

- a. To prevent this type of technical failure, both the provider and client should ensure that their phone is charged before each session.
- b. In this situation, the provider should implement the alternative communication plan detailed in Flowchart #1.

3. Phone repeatedly disconnects

- a. As previously decided with the client, the provider will take the lead to re-establish contact.
- b. The provider should try to call back three times over the course of 10 minutes.
- c. If this fails, the provider should use implement the alternative communication plan detailed in Flowchart #1.

4. Client cannot hear the provider and/or vice versa
 - a. Ensure that the sound of the device being used is not too low and that the volume is turned up.
 - b. Ensure that neither the provider nor the client are on mute.
 - c. If this does not resolve the issue, implement the alternative communication plan detailed in Flowchart 1.
5. Client cannot see the provider or vice versa
 - a. Ensure that neither the provider or the client have disabled the camera.
 - b. Ensure that the camera lens is not covered.
 - c. If using a phone/tablet, check that the provider/client is using the right camera (selfie/rear).
 - d. If this does not resolve the issue, implement the alternative communication plan detailed in Flowchart #1.²⁷

Session 4.d. Referrals

There may be situations when a client requires additional support or more specialized MHPSS services. In such situations, the client may benefit from being referred to other service providers.

Note to facilitator: Ensure that participants have read the following section of International Medical Corps Guidelines for Remote MHPSS Programming in Humanitarian Settings: 3.4 Make referrals and follow-up.

Activity: Small group discussion

Participants should break into small groups (3-4 individuals) and discuss the following:

- What is your program's current process for referring clients to other services? Are there guidelines or protocols?
- If written guidance or a protocol exists, how should these be adapted for remote MHPSS services? [Note to facilitator: If the program has written guidance or a protocol for client referrals, then provide a copy to each participant for this exercise].
- If written guidance or a protocol does not exist, ask participants to brainstorm ideas for a protocol or guidance on client referral in remote MHPSS service delivery.

Guidance on referring a client receiving remote MHPSS services

If it is identified that the client could benefit from additional supports or services, the provider should discuss these needs with the client and obtain permission to identify referrals for the needed services and support. Thereafter, the provider should identify whether the appropriate services and supports are available. If these are delivered in person, the provider should assess if the client is able to access these. If services are delivered remotely, the provider should assess whether the client has the required technology to access the service. Inform the client of the technological requirements to access the remote service they are being referred to. If

²⁷ International Organization for Migration (2020). Internal guidelines for remote MHPSS working modalities. <https://returnandreintegration.iom.int/en/resources/guideline/internal-guidelines-remote-mhpss-working-modalities>

necessary, explain to the beneficiary how to connect with the service (e.g., if they need to download a specific app).

Checklist for referral when providing remote MHPSS services²⁸

Action	Yes	No
I (or relevant staff within my organization) have verified the availability of in person and remote MHPSS, health, GBV, child protection and education services and other basic supports through a service mapping within the relevant geographic area.		
I (or relevant staff within my organization) am in permanent contact with the relevant service providers (e.g., medical, MHPSS, emergency services) available in the area and their contact information and mode of service provision is up-to-date.		
I provided the client with information about the relevant services and how these may assist with meeting their needs.		
I gave the client different choices to put them in touch with the service provider(s), as well as alternatives for support to access these services.		
I obtained the client's informed consent and a release of information before getting in touch with the service provider(s) and making the referral(s).		
I followed the protocols for the secure exchange of client information (use of standard forms, password encryption, persons' nontraceable information, etc.).		
I have considered other choices for the client in case they refuse a referral or a referral is not possible due to the lack of services.		
I have engaged in follow up to ensure that the client was able to access the service(s) and that the service(s) met their needs.		

²⁸ UNFPA (n.d.). Guidelines for the provision of remote psychosocial support services for GBV survivors. https://reliefweb.int/sites/reliefweb.int/files/resources/GBV-Mobile-and-Remote-Service-Delivery-Guidelines_-final.pdf

Session 4.e. Working with interpreters remotely

Many of the same skills and knowledge related to working with interpreters when delivering MHPSS services in person apply to working with interpreters in remote MHPSS service delivery.

Activity: Group discussion

Note to facilitator: Ask training participants the following questions:

1. Have you worked with interpreters before in the context of delivering in person MHPSS services? What about in the context of delivering remote MHPSS services?
2. What was your experience of working with interpreters in either in person or remote MHPSS service delivery? How did it impact on the MHPSS services? What was the impact on the therapist? What was the impact on the client?
3. If you used an interpreter when delivering remote MHPSS services, what adjustments did you have to make? Were there specific challenges?
4. What information and skills do they think it's important for interpreters to have?

Interpreters should have received training in mental health interpretation. The provider should determine what training and experience the interpreter has before starting to work with them. The provider should ensure that the interpreter has received training in the following areas:

A. Mental health topics:

- Mental health terminology, including common psychiatric diagnoses
- The content of an initial clinical assessment
- The different modalities (individual, couples, family, group)

Why is knowledge in these areas important?

The interpreter will be better prepared to interpret during the session. It will impact their performance and therefore the therapeutic process. For example, if the interpreter knows that the client they will be interpreting for is experiencing acute psychosis and they are familiar with how the symptoms manifest, they will be better able to anticipate how to interpret most effectively.

It is the provider's responsibility to ensure that the interpreter is familiar with client's symptom picture and how symptoms manifest.

B. Having an understanding of the different types of mental health professionals (e.g., psychiatrists, psychologists, social workers, psychiatric nurses).

Why is this knowledge important?

Knowing about the different roles of these providers will allow the interpreter to be better prepared for the content and goals of the session. The knowledge will help their speed, comfort, and the quality of their interpretation.

The provider should inform the interpreter of what kind of mental health professional they are when they meet the interpreter for the first time and well before the first session with the client.

C. The interpreter's four roles: The interpreter should be familiar with the four roles of an interpreter and comfortable engaging in them as appropriate. The provider should also be familiar with the roles so that they know what can be expected of an interpreter.

1. **Advocate:** This is when the interpreter moves from interpreting the communication of the speaker to acting on behalf of the speaker.
2. **Clarifier:** The clarifier is expected to be able to rephrase technical terms, use words that are meaningful to the listener.
3. **Conduit:** As a conduit, the interpreter orally interprets word for word, identifying and using the closest linguistic equivalent as possible.
4. **Cultural broker:** In this role, the interpreter provides cultural information in addition to linguistic interpretation of the message given.

D. The interpreter should be familiar with common errors in interpretation (e.g., omission, substitution, condensation) so as to avoid making these mistakes.

E. The interpreter should be familiar with mental health ethical codes, including on confidentiality, truthfulness and accuracy, boundaries, professional competence, neutrality, fidelity, impartiality, appropriate manner, and proficiency.

Guidance for how to work with interpreters in remote MHPSS service delivery

1. Pre-session

Before the session or meeting with the client, the interpreter and provider should meet, either in person or virtually. If meeting virtually, it is strongly recommended that a platform that allows for both video and audio is used. This is especially important if this is the first meeting between the interpreter and provider. The provider and client should always meet before a first meeting with the client.

The interpreter should be provided with the following information to help them be prepared for the session: client name, client language or dialect, client's level of education, client's level of the language the provider will be using (e.g., English), reason for/purpose of the appointment, appointment time, how many individuals will be present at the session, if written translation will be required, what the provider's objectives are for the session, and what the provider's expectations are of the interpreter.

The provider should review the session with the interpreter before the appointment, so as to explain any terms that will be used and the content of session (e.g., assessment). If employing specific techniques, it's important to review these with the interpreter and give the interpreter enough time to translate these before the session (e.g., relaxation training, biofeedback, hypnosis). The interpreter may also need special training in these techniques (e.g., pacing, tone of voice).

The provider should make clear that during the session everything should be interpreted.

The provider should make sure that the sentences they use are short; they should avoid using technical language and asking several questions at the same time.

It's important to bear in mind that when using an interpreter everything gets slowed down. This should be factored in in terms of determining the duration of the session.

Usually during the initial session, the provider will explain their role, the limits of confidentiality, and obtain informed consent. When working with an interpreter, the added step is to allow the interpreter to explain their role, the limits of their service, and to reassure the client of confidentiality.

Lastly, when working with an interpreter in the context of remote MHPSS service delivery the provider should ensure that:

- The interpreter has access to an appropriate device
- That the device has appropriate malware protection
- That the interpreter is able to use a secure internet connection (if using the internet for the call)
- That software for the communication platform is downloaded (e.g., Skype, Zoom) and the interpreter knows how to use the platform
- The provider should practice with the interpreter using the virtual communication modality to ensure that the interpreter is comfortable and familiar with the technology.
- The provider should ensure that the interpreter is familiar with and implements best practices related to having an environment conducive to remote service delivery (e.g., ensuring that they are in a quiet and confidential location when interpreting, ensuring the lighting, video and audio allow them to be seen and heard, etc.).

2. Consecutive vs. Simultaneous Interpreting

Consecutive interpreting is recommended as simultaneous interpreting isn't conducive to creating a positive therapeutic relationship. The provider should be aware that consecutive interpreting slows down the communication and that less information may be covered during a session and should plan accordingly (e.g., plan to cover less clinical material, plan to extend the duration of the session). If additional time is necessary, the provider should discuss with the client about the feasibility of longer sessions.

3. Communication between the Provider, Interpreter, and Client during a Session

a. Video calls:

- ♦ The client, provider and interpreter should all be equally visible and their image should be of the same size on the screen.
- ♦ Eye contact: The provider should make eye contact with the client as they speak to them. During the interpretation, the provider can look at the interpreter, but should also periodically look at the client to observe behavioral responses and affect.
- ♦ The provider should refer to client in the first person.
- ♦ The provider should always address the client as this facilitates the relationship with the client. The client may address the interpreter and not the provider, but this may gradually change as the client develops a relationship with the provider.
- ♦ There might be situations when the interpreter needs to communicate with the provider (e.g., when needs clarification). In such situations, the provider must be sensitive to the triadic relationship and care must be given to avoid creating coalitions and dyads. Therefore, the interpreter must explain that they are seeking clarification from the provider and keep the client informed of the conversation

between the provider and them. The same process would be applied in situations where the interpreter needs to clarify statements made by the client.

b. Audio only calls:

- ♦ Because visual cues are missing in an audio call, all parties need to ensure that each individual is able to speak and to avoid interruptions.
- ♦ The provider should refer to the client in the first person.
- ♦ There might be situations when the interpreter needs to communicate with the provider (e.g., when needs clarification). In such situations, the provider must be sensitive to the triadic relationship and care must be given to avoid creating coalitions and dyads. Therefore, the interpreter must explain that they are seeking clarification from the provider and keep the client informed of the conversation between the provider and them. The same process would be applied in situations where the interpreter needs to clarify statements made by the client.

4. Therapeutic Dynamics

When working with an interpreter, the therapy moves from a therapeutic dyad to a therapeutic triad. This results in more complex transference and countertransference dynamics. Reactions can be between the provider-interpreter, provider-client, client-interpreter, client-provider, interpreter-provider, and interpreter-client. The provider should make the interpreter familiar with the concepts of transference and countertransference, so that the interpreter can monitor their reactions.

5. Interpreting for Support Groups and Family Support Interventions

- a. Support Group: It may be difficult to interpret word for word. The interpreter should look for main themes and summaries and convey these to the provider.
- b. Family support: As with individual therapy, everything must be interpreted.
- c. It is recommended that the provider meet with interpreter beforehand to find out how familiar and comfortable they are with interpreting in these modalities.

6. Interpreting in Difficult Situations

Examples of clinical situations that can be challenging include clients with active psychosis and clients who are angry or in crisis, clients with speech impediments, or when connectivity issues impede clarity of communication. This is where the interpreter's familiarity with how diagnoses present is important as this will impact how prepared they are to interpret. The provider should support the interpreter in preparing for sessions with clients who may have more challenging presentations. Interpreters will sometimes feel responsible for what the client says. It is important that the provider help the interpreter overcome this false sense of responsibility when repeating what the client says.

In addition, interpreter may simply repeat the gist (e.g., client swore at you) or may interpret content with the exact tone of voice (the latter is a more effective interpretation). The interpreter may provide a description of the incoherent speech in the third person (e.g., the client is tangential, she isn't making sense, her sentences aren't complete).

7. Post-session

It's very important for the provider to have regular post-session meetings with their interpreter to review any difficulties that arose around remote communication; and discuss and process transference and countertransference reactions.

Session 4.f. Guidance on adapting MHPSS interventions to remote modality

Note to facilitator: Ensure that participants have read the following section of International Medical Corps Guidelines for Remote MHPSS Programming in Humanitarian Settings: 3.3 Review Client Considerations for Receiving Remote Support.

Best practices

- Conduct the session using as many of the same principles of care as for in person MHPSS services as possible.
- Before initiating services confirm that the client’s main presenting problem is within your expertise or if the client requires a referral to another specific specialized support from the start.
- Before initiating services confirm that the client is appropriate for remote MHPSS service delivery (e.g., presenting problem can be addressed through remote MHPSS service delivery, client has access to the necessary technology).
- MHPSS interventions that should and can be integrated into remote MHPSS services include:
 - Provision of structured and practical emotional support
 - Identifying risks (e.g., suicidal thoughts) and addressing these to decrease risk
 - Building on existing client coping strategies
 - Assisting client with identifying external resources or other available resources to support coping and wellbeing
 - Equipping client with decision-making and problem-solving skills
- Focus on basic verbal communication techniques: Employ active listening, empathy, unconditional support and authenticity. Listening skills (clarification, paraphrasing, reflection and synthesis) and competencies related to verbal interactions (open questions, interpretation) are also important.
- Pay particular attention to paraverbal communication: Listen to volume, intonation, speed, clarity, pauses and silence, response latency and response proportion. In the absence of other communication elements, these tools can help you to understand the client’s emotional state and identify noticeable changes.

Consideration for adapting a MHPSS intervention to remote delivery

- Remote MHPSS interventions require that clients have access to a device that allows for simultaneous/synchronous voice or voice and video exchanges (e.g., phone, Skype, Zoom). Remote MHPSS interventions cannot be carried out via asynchronous communication or email and text. However, asynchronous communication, email and text can be used to support MHPSS interventions that are being implemented (e.g., emailing or texting the client a relaxation exercise script; forwarding a voice recording with a reminder of sleep hygiene practices; using email/text for scheduling).
- When considering an MHPSS intervention for remote delivery consider the following:
 - Has the intervention already been adapted for remote implementation? If so, is there any evidence for its suitability for remote implementation?

- Can the MHPSS intervention be implemented remotely through a video call?
 - Does the MHPSS intervention require that the client be able to see the provider (and cannot therefore be implemented if communication is audio only)?
 - Does the MHPSS intervention need to be adapted for remote implementation through a video call? If so, how?
 - Would the intervention retain its integrity if adapted for implementation on a video call?
 - What are the potential risks and harm to the client of implementing the modified intervention?
- Can the MHPSS intervention be implemented remotely through an audio call only?
 - Does the MHPSS intervention need to be adapted for remote implementation through an audio only call? If so, how?
 - Would the intervention retain its integrity if adapted for implementation on an audio only call?
 - What are the potential risks and harm to the client of implementing the modified intervention?
- When implementing an MHPSS intervention remotely, it is strongly suggested that the intervention go through pilot process and be modified based on the data collected.

Activity: Small group discussion—Adapting MHPSS interventions for remote implementation

Before the training, the facilitator should identify those MHPSS interventions that the program commonly uses (e.g., PFA, PM+, Mental Health Case Management) and collect the relevant intervention manuals. At the time of the training, participants should be assigned to small groups. Each group will receive one intervention to work on (e.g., group A is assigned PFA). Each group will be tasked with 1. Assessing whether the intervention can be implemented remotely and if implementation requires video and audio or if audio only is also feasible and 2. Specifically identify aspects that need to be adapted and develop alternatives for remote implementation. [Allow 40 minutes]

Once each group has had an opportunity make some headway on this task, each group should report back to the larger group.

Note to facilitator: It will not be possible to review the entire intervention in the time allotted for the exercise. Instead the purpose of the exercise is to develop participant’s skills in assessing whether an intervention is appropriate for remote implementation and in practicing adapting the intervention for remote delivery. In addition, the exercise may allow for some initial work on adapting MHPSS interventions that are commonly used by the program.

Note to facilitator: Ensure that participants have read the following section of International Medical Corps Guidelines for Remote MHPSS Programming in Humanitarian Settings: Step 3: Implement Remote Services.

At the start of each virtual session the provider should:

- Ensure the call is being initiated at the agreed upon date/time, by the designated person who will initiate call.

- When meeting the client for the first time, confirm the identity of the client (Refer to International Medical Corps Guidelines for Remote MHPSS Programming in Humanitarian Settings: Step 3: Implement Remote Services → Verifying client and service provider identity).
- Confirm that the client is in a confidential space for the call. If the client states that there is no confidentiality, problem solve/brainstorm to identify an alternative space, time, or date for a call.
- Confirm with the client that they remember the alternative communication plan in case of technical difficulties. If the client does not remember the plan, remind them of what steps will be taken in case you experience technical difficulties during the session.
- If needed, confirm that nobody will record the session without permission.
- If using a video call, all individuals present for the virtual session must be within view of the camera so that the provider is aware of who is participating. If using an audio call, the provider should confirm who is participating in the call, if it is more than one person.

Sample interventions for remote MHPSS services:

The facilitator can select from those interventions listed below and implement role plays with groups of participants to increase their familiarity with implementing these interventions remotely. The facilitator can choose to have participants role play using a video or audio call to the participant serving as the client to more fully mimic remote implementation of the MHPSS intervention.

1. Relaxation techniques through remote MHPSS services²⁹

Relaxation techniques can be used to meet the following objectives:

- a. Reduce physiological activation (reactions such as sweating, trembling, etc.).
- b. Help the client focus on the present.
- c. Support in coping (e.g., decrease intrusive negative thoughts, decrease intense emotional reactions).
- d. Bring about a feeling of calm and relaxation.

²⁹ UNFPA (n.d.). Guidelines for the provision of remote psychosocial support services for GBV survivors. https://reliefweb.int/sites/reliefweb.int/files/resources/GBV-Mobile-and-Remote-Service-Delivery-Guidelines_-final.pdf

Relaxation techniques adapted to remote MHPSS services

<p>During the call (audio only or audio and video)</p>	<p>Focus on the moment and try to be relaxed.</p> <ul style="list-style-type: none"> • Ask the client to join you in a breathing exercise. First, ask them to try to breathe calmly. Then, ask her to pay attention to the air coming in and out of their body, how that air feels as it flows smoothly through their nostrils. Have the client feel how their lungs expand at the same time as their abdomen, the side of their chest and their lower back. • Ask the client to press their feet firmly against the ground. If they are sitting in a chair, ask them to place their hands on their lap and rest their feet on the ground. Have them tense their leg muscles and press their feet against the ground, as though trying to push the chair back without actually doing so. • Tell the person to look around and find something they like in their environment using anything they can see, hear or smell. Ask them what they see and hear. This will help them focus on their present surroundings. <p>Training on diaphragmatic breathing.</p> <ul style="list-style-type: none"> • Explain the benefits of deep-breathing and teach the client the technique (Refer to Annex 1). • Invite the client to use the technique regularly in their free time.
<p>During text messaging and email exchanges</p>	<p>Provide immediate support and share resources.</p> <ul style="list-style-type: none"> • If the client has difficulty communicating virtually, you can: • Share with them the instructions described in the previous section, guiding exchanges by text messages (depending on client's literacy level). • Another option is to record a voice message and send it to the client to make the process easier. To record that message, you can use the scripts and information found in Annex 1 and Annex 2 and adapt them to their needs. • If possible, share free online resources, such as yoga, mindfulness or meditation websites or other resources to help the client improve their well-being. Be mindful that shared resources should be culturally appropriate.
<p>Notes</p>	<ul style="list-style-type: none"> • Encourage the client to practice relaxation exercises. • Before recommending any of the above-mentioned options, evaluate if the user is able to learn and carry out these activities in their context. • To maximize the efficacy of this technique, it is important to explain its benefits. • Explain to the client that they will not always be able to relax immediately, but that does not mean they are doing it wrong. Explain that with practice they be able to relax more easily. • You should also explain that they must develop this habit by practicing to make it more effective.
<p>Resources</p>	<p>Annex 1: Breathing exercises for relaxation Annex 2: Diaphragmatic breathing instructions</p>

2. Psychoeducation in remote MHPSS services³⁰

Psychoeducation is based on sharing different psychological constructs and variables to explain psychosocial problems a person may be experiencing (e.g. difficulty sleeping, anxiety), as well as how those problems occur in the individual (signs, frequent symptoms). Psychoeducation also includes strategies to deal with those problems, such as sleep hygiene recommendations, self-care recommendations and coping strategies).

The objectives of psychoeducation can be to:

- a. Provide appropriate information about possible challenges the client may be experiencing.
- b. As appropriate, normalize the client's response to the challenges
- c. Make recommendations to manage challenges the client may be experiencing.

Psychoeducation

Technique	<p>Call:</p> <ul style="list-style-type: none">• Option 1. Specific problems have been identified in previous calls (e.g., difficulty sleeping, psychosomatic symptoms, anxiety in response to a situation). Schedule another call with sufficient time to deliver psychoeducation.• Option 2. Deliver psychoeducation as soon as a psychosocial problem is identified. <p>Text messages:</p> <ul style="list-style-type: none">• Psychoeducation strategies are too detailed to be explained via text messaging. Instead, WhatsApp voice messages can be used. <p>E-mail:</p> <ul style="list-style-type: none">• While this method may be less effective, you can e-mail information and then follow up with a call or messages to ask the person about any questions or reactions they might have to the information.
Notes	<ul style="list-style-type: none">• If possible, share with the client a document with the information you just gave her.• Agree on a method and follow up on the client's progress after the session.• If you deliver psychoeducation, you should encourage integration using questions ("Have you ever felt like this before? Is this similar to what's happening to you? Do you think you can do some of the activities suggested?"). Psychoeducation is not a class; it has to be participatory and based on the client's unique life situation.
Resources	<p>Annex 3: Psychoeducation: Difficulty sleeping</p> <p>Annex 4: Psychoeducation: Sleep hygiene</p>

³⁰ UNFPA (n.d.). Guidelines for the provision of remote psychosocial support services for GBV survivors. https://reliefweb.int/sites/reliefweb.int/files/resources/GBV-Mobile-and-Remote-Service-Delivery-Guidelines_-final.pdf

8. Problem solving in remote MHPSS services³¹

Problem solving techniques can help you achieve the following objectives:

- a. Help the provider identify specific problems related to their situation.
- b. Help the client gain some control of the particular circumstances of their everyday life.
- c. Guide the client during a decision-making process related to their particular situation.

Problem solving in remote MHPSS services

Technique	<p>Call:</p> <ul style="list-style-type: none">• In collaboration with the client, identify the problem.• Follow the steps described in Annex 5.• You can follow up between sessions with the client. <p>Email:</p> <ul style="list-style-type: none">• The use of this technique by e-mail is not recommended. <p>Text messaging:</p> <ul style="list-style-type: none">• The technique can be used with text messaging by following the steps described in the guide.
Notes	<ul style="list-style-type: none">• Help the client narrow down the problem or decision.• When identifying the decision or problem, ensure the client (with service provider's guidance and support) has some control over the situation and that change is possible. Otherwise, this could lead to a situation of increased anxiety and distress for the client.• This intervention cannot and should not be carried out in cases of immediate danger.
Resources	Annex 5: Problem solving support

9. Emotional regulation in remote MHPSS services³²

Emotional regulation is a key aspect of supporting an individual's psychosocial wellbeing. When focusing on emotional regulation the service provider should seek to:

- a. Normalize emotions as appropriate.
- b. Support the client with managing and decreasing negative feelings.
- c. Empower the client through emotional self-regulation that will help them better cope.
- d. Help the client with identifying positive non-harmful coping strategies.

³¹ UNFPA (n.d.). Guidelines for the provision of remote psychosocial support services for GBV survivors. <https://reliefweb.int/sites/reliefweb.int/files/resources/GBV-Mobile-and-Remote-Service-Delivery-Guidelines-final.pdf>

³² UNFPA (n.d.). Guidelines for the provision of remote psychosocial support services for GBV survivors. <https://reliefweb.int/sites/reliefweb.int/files/resources/GBV-Mobile-and-Remote-Service-Delivery-Guidelines-final.pdf>

Steps for Emotional Regulation

The following steps are the practical elements to develop emotional self-regulation:

1. **Put emotions into words.** Emotions are reactions, but they lack a physical dimension, which makes working with them much more difficult. Using specific words and identifying them in our bodies as sensations makes emotions easier to see, quantify and analyze.
2. **Identify triggers.** Identifying what causes emotional reactions will facilitate analysis and control.
3. **Interpret the situation.** Helping clients clarify the meaning they give to a situation, helps them understand their reaction to it.
4. **Develop an action plan.** Help the client identify their needs to facilitate decision-making (e.g., address triggers; identify coping strategies to address negative feelings).

Emotional regulation in remote MHPSS services

Technique	<p>Call:</p> <ul style="list-style-type: none">• Identify particular situations where the client is experiencing challenges or feelings of anxiety associated with emotional regulation.• Follow the steps described in Annex 6.• You can follow up between interventions with different situations to guide the survivor. <p>Email or text messaging:</p> <ul style="list-style-type: none">• The use of this technique by e-mail is not recommended.• You can use WhatsApp to follow up with the client after the video or phone sessions. The follow-up can focus on: getting the beneficiary to describe an intensely emotional situation and analyze what she did, based on the steps learned, and what has happened.
Notes	<ul style="list-style-type: none">• For psychoeducation on emotional regulation to be effective, the service provider should have prior training in MHPSS.• Psychoeducation requires preparation. The provider should know the information presented in this section and be able to explain the main ideas.• To facilitate the process of sharing information, and to avoid using difficult-to-understand technical jargon, the provider can write a script to explain the main terms in easy-to-understand language.• Before delivering psychoeducation, the provider should identify those situations where the client may be experiencing challenges with emotional regulation.
Resources	Annex 6: Psychoeducation for emotional regulation

5. Addressing coping strategies in remote MHPSS service³³

Coping strategies are adaptive responses an individual can use to deal with internal or external demands perceived as excessive considering his/her resources. Coping strategies are not only actions to solve a specific problem; they also refer to the capacity to manage emotions and stress.

- a. Coping strategies help the person identify those moments where they feel overwhelmed, as well as any actions that can help them deal with those situations.
- b. Individuals will usually have some coping strategies; these may be positive (e.g., exercising when stressed) or negative coping strategies (e.g., using alcohol to manage stress).
- c. The provider can help identify new coping strategies to support the client.

Coping strategies

Technique	<p>Call:</p> <ul style="list-style-type: none">• During sessions, the client may share information about emotions or situations that make them feel overwhelmed. This is where you can help them identify:• What they are feeling (emotion).• What is causing them to feel like that.• What is the impact on the client of the situation and their feelings.• What they are doing to manage the situation (and whether this is helping them or not).• Together with the client, discuss possible actions that can be adapted to help them manage the situation (See Annex 7). <p>E-mail:</p> <ul style="list-style-type: none">• If appropriate, you can encourage the client to write about everyday situations they are experiencing and how they are coping with them. Respond to the client's e-mails with suggestions. <p>Text message:</p> <ul style="list-style-type: none">• You can follow the same script used for calls.
Notes	<ul style="list-style-type: none">• As appropriate, you should normalize any emotions or actions expressed by the client (e.g., 'You are finding ways to manage a difficult situation.').• To facilitate the process, you can combine it with emotional education support—identify emotions, the situations where she feels them and the parts of her body where she feels them (Refer to emotional regulation)
Resources	Annex 7: Guidelines for working with coping strategies

³³ UNFPA (n.d.). Guidelines for the provision of remote psychosocial support services for GBV survivors. https://reliefweb.int/sites/reliefweb.int/files/resources/GBV-Mobile-and-Remote-Service-Delivery-Guidelines_-final.pdf

Session 4.g. Medication management in remote MHPSS service delivery

Medication management: Administrative considerations

1. Laws and regulations:
 - a. Providers of remote psychiatric care services must comply with national or local laws and policies, which typically define the legal certifications e.g. holding an active professional license issued by the state in which the patient is physically located during a remote consultation and define the regulations around the prescription of psychotropic and/or controlled substances based on the setting, model of care, and locations in which they are practicing and where the patient is located at the time of treatment.
2. Standard Operating Procedures/Protocols:
 - a. Adapt the SOPs for psychotropic medication and any supportive documentations (e.g., Medication Record Book, Donation Record book, Delivery Record Book, Prescription Forms) in collaboration with Medical Coordinator/ Director, Pharmacist, Supply Chain Department.
 - b. In case of lack of any SOPs for managing psychotropic medications (including controlled drugs), develop them in collaboration with all relevant departments.
 - c. Procedures should include:
 - ♦ Prescribing Psychotropic Drugs (electronic generation/paper);
 - ♦ Procurement (e.g., mail-order pharmacies): In case the prescriber is transmitting the prescription directly to a pharmacy, (s)he must ensure explicit consent of the patient, which is a mandatory requirement; and
 - ♦ Distribution and handling (e.g., clinic, pharmacy, and/or home visits).

Remote Medication management: Clinical considerations

- Prescribing Medications in remote MHPSS service delivery entails the same professional accountability as in the traditional in-person consultation.
- The Mental Health provider should gather adequate and relevant information about the client's MNS condition and arrive at diagnosis or at least provisional diagnosis before prescribing medicine through synchronous (live interactive) remote mental health consultation.
- If Mental Health provider is unable to arrive at diagnosis or provisional diagnosis, please consider in-person consultation.
- Prescribing medications via telepsychiatry also depends upon certain criteria such as:
 - the type of consultation (first/follow-up consult): if Mental health provider has not previously examined the client in person, (s)he must first evaluate the client in one of the following ways: in person, or via telemedicine using a real-time, two-way, audio-visual communications device
 - mode of consultation (text/audio/video) and
 - the categories of the medications list (controlled drugs, e.g., benzodiazepines): Prescribing practitioner must follow the national laws and SOPs for controlled drugs
 - prescribe medications with Generic Name only

- At the start of the treatment, the client (and caregivers upon client's consent) and provider should discuss the type of contact between sessions and the conditions under which such contact is appropriate. The provider should provide a specific time frame for expected response between session contacts. This should also include a discussion of emergency management between sessions.

Conditions for between sessions communication shall include, but are not limited to:

- The client/caregiver reports compliance to treatment and any challenges, as well as any potential serious side effects of medications
 - Any changes in the mental status of the client, e.g., deteriorates rapidly, despite treatment
 - Any other category that falls under psychiatric emergency (e.g., risk of harm to self or others) and/or medical emergency and/or protection issues
-
- Asynchronous consultation (based on prior video record/texting/email by another health provider,) is not recommended because both patient and Mental Health Provider need to introduce themselves to each other and the Mental health provider needs to verify the identity of the client, consultation to be given live and interactive in a real-time mode with health advice, counseling and medication. These are possible only on a live consultation (synchronous model via two-way, audio-visual communication platform or in person). However, Mental health provider can take the video evidence (only upon client consent) of seizures, abnormal behavior, signs but consultation needs to be live before prescribing the medicines.
 - The prescriber should be aware of the availability of specific medications in the geographic location of the client and should inform about existing prescribing choices. Clients receiving treatment through remote MHPSS services should have an active relationship with a prescribing professional in their physical vicinity.

Activity: Recommended Steps for Psychotropic Medication Prescription

Ahead of time, cut the boxes and arrows of the flowchart from page 30 of the Guidelines for Remote MHPSS Programming into puzzle pieces. Divide the participants into 2 groups and give them each a set of the puzzle pieces. Each group will be assigned to arrange the puzzle pieces in the correct order of the recommended steps on prescribing psychotropic medication to clients during remote service delivery (Reference to flowchart from the Guidelines, page 30). Allow 15 minutes. [Note: In remote setting the same activity can be replicated using tools such as [Miro White Board](#)).

Session 4.h. Endings/disengagement when providing remote MHPSS

Ending of remote MHPSS services should follow the same best practices as ending in person MHPSS services.

Activity: Small group discussion

Participants should break into small groups and consider the following questions:

1. How do you approach ending MHPSS services with a client? Describe your process.
2. What are some best practices related to ending MHPSS services with a client? Can these be applied to remote MHPSS services? Are there additional considerations related to ending clinical services that are relevant to remote MHPSS services? [Allow 20 minutes]

Participants may write their responses on a flipchart (in a virtual format Whiteboard may be used). Participants should report back to the entire group. Facilitator should allow time for larger group to ask questions and comment.

Guidance for disengagement/ending of remote MHPSS services

Disengagement/ending remote MHPSS services should take place once treatment goals have been achieved. Disengagement/ending of remote MHPSS services should be a planned process:

- Begin by developing a timeline for ending in collaboration with the client (e.g., two months, 4 sessions). The disengagement process may include spacing out sessions for a more gradual termination.
- Discuss the prospect of ending services and the client's reaction:
 - Provide time for the client to talk about their feelings about ending services as well as about any feelings they might have about the MHPSS service and the provider.
 - Provider should explore how the client feels about ending the MHPSS service (e.g., sense of accomplishment, sadness at prospect of ending contact with provider). The client may have mixed reactions and the provider should normalize these.
- Discuss progress toward treatment goals:
 - Invite the client to share what they see as treatment gains.
 - The provider can add other gains and these can be discussed in terms of the treatment plan goals.
 - Even if the goals have only partially been achieved, they are noted and framed in a positive manner.
 - Writing down the treatment gains and providing the client with this information (by email, text, WhatsApp) may be helpful in that the client can review this information in the future and be reminded of their strengths. If the client has limited literacy, these it might be possible to represent these gains as images.
- Discuss how gains can be maintained and relapse prevented:
 - The provider should discuss with the client strategies to maintain gains and create a plan for preventing relapse.
- If appropriate, discuss additional MHPSS services:

- If indicated, the provider may discuss additional MHPSS services that may benefit the client (e.g., self-help group, psychosocial activities). If additional services are warranted, the provider should provide a referral and follow up to ensure that the client was able to connect with the service(s) (Refer to 4.d Referral).
- Discuss remaining sessions and future contact:
 - The provider should discuss how sessions will be conducted during the disengagement process. For example, the provider may schedule the remaining sessions on a biweekly rather than weekly basis. Some clients may benefit from a follow up session several months after MHPSS services end.
 - The provider should inform the client that they are able to access MHPSS services in the future.
 - The provide should provide the client with contact information for MHPSS services should they want services in the future.

Session 4.i. Documentation

A remote MHPSS encounter should be documented similarly to an in person clinical encounter.

Activity: Small group discussion

Participants should break into small groups (3-4 individuals). Facilitator should provide each group with a copy of the following clinical documents: clinical intake, treatment plan, progress note and termination or case closing form. Participants should be asked to review the forms and discuss if the content needs to be revised to accommodate remote MHPSS service delivery and if so, how. [Allow 30 minutes for documentation review]. Thereafter, each group should share their work with the larger group.

Key documentation for remote MHPSS service delivery

1. Consent to services form (Refer to 4.a. Contracting and boundaries for remote MHPSS services)
2. Release of information form (Refer to 4.d Referrals)
3. Clinical intake
4. Treatment plan
5. Progress note
6. Case Closing note

Note: Adaptations to the documentation content for remote MHPSS service delivery are in bold.

The Clinical Intake:

The clinical intake should document the following:

- Name of provider
- Name of client or unique client identifier
- Client date of birth
- Date of clinical intake
- The originating site (i.e., where the client is located)

- The remote site (i.e., where the provider is located)
- Presenting problem
- Client background information (e.g., previous engagement with MHPSS services, assessment of daily functioning and presence of mental health symptoms, educational and occupational history, relationship history, assessment of suicide, homicide, and self-harm, assessment of coping and interpersonal supports, religion/spiritual practice, major life events including trauma and displacement or migration, substance use history, health status and medical concerns)
- Mental status (if using audio only, information that is derived through being able to observe the client may not be accessible to the provider. The provider should document these limitations to their assessment)
- Assessment of appropriateness for remote MHPSS services

The Treatment Plan:

A treatment plan documenting treatment goals should be developed for each client after completion of the clinical intake. Ideally, treatment goals should be developed in collaboration with the client. The treatment plan should be reviewed and revised at regular intervals over the course of the client's MHPSS services. The treatment plan should document the following:

- Name of provider
- Name of client or unique client identifier
- Client date of birth
- The originating site (i.e., where the client is located)
- The remote site (i.e., where the provider is located)
- Brief statement of presenting problem and relevant client background information
- Date of treatment plan
- Treatment goals
- Provider signature and date
- **Client signature and date (if required by the program).** When providing remote MHPSS services the following are options for documenting the client's review and approval of the treatment plan:
 - **Written:** Where possible, the client should print, sign, scan and forward the document to the provider. However, in situations where the client does not have access to the necessary technology, an electronic signature may be used if these are allowed in the relevant jurisdiction. Another option, is to ask the client to explicitly state that they have reviewed and approve of the treatment goals remotely by sending a text message, chat service message or e-mail.
 - **Verbal approval:** The client indicates that they have reviewed the treatment plan and approve of the treatment goals. The provider should be sure to document the verbal approval.

The Progress Note:

A progress note should be completed for each remote MHPSS session. The progress note should document the following:

- The originating site (i.e., where the client is located)
- The remote site (i.e., where the provider is located)
- Name of provider
- Name of client or unique client identifier
- Client date of birth
- Date and duration of session
- Session number
- Reasons for remote MHPSS service delivery (instead of in person)
- Session objective and summary (any limitations to interventions or adaptations to interventions resulting from remote MHPSS service delivery should be documented)
- Documentation of disruptions in treatment due to technical difficulties (e.g., dropped connection)
- Presence or absence of suicide and homicide risk should be documented
- Scheduled date and plan for the next session
- Provider signature and date

Case Closing Note:

A case closing note should be completed for each client at the time treatment ends. The case closing note should document the following:

- Name of provider
- Name of client or unique client identifier
- Client date of birth
- Summary of client presenting problem and key demographic information
- Treatment objectives and status at the time of termination (e.g., achieved, partially achieved, not achieved)
- Reason for termination (e.g., drop out, treatment goals achieved)
- Summary of the course of treatment (including total number of sessions, concerns addressed and outcomes)
- Case closing date
- Include success, pros, and cons of the remote MHPSS services for the specific client as well as any problems encountered and resolutions and if remote MHPSS services are suggested for future services.
- Provider signature and date

Administration of Screening Instruments and Monitoring and Evaluation Measures:

Before implementing either a screening instrument or a monitoring and evaluation (M&E) measure, the provider should assess whether the measure can be administered remotely.

Considerations include:

- Can the items in the measure be administered and understood on a video call?
- Can the items in the measure be administered and understood in an audio only call?
- Does the client need to see the measure (i.e., questions and rating scale) to facilitate their being able to respond and to provide accurate responses?
- Can the measure be adapted for remote delivery without impacting its integrity and accuracy?
- Are there individual (e.g., difficulty concentrating) or contextual factors (e.g., limited access to video or audio means of communication) that negatively impact the client's ability to complete the measure or provide responses to the measure when administered remotely?

If the selected measure cannot be administered remotely, the provider should determine if the measure can be adapted for remote administration (without impacting its integrity and accuracy) or if an alternative measure that can be administered remotely can be identified.

The administration of a measure will be facilitated in situations where the client and provider are able to use a platform that combines video, audio and screen sharing capacities (e.g., Skype, Zoom). This type of platform allows the provider to observe the client and gather both verbal and non-verbal information. In addition, in situations where it is important for the client to see the measure (e.g., view questions, view rating scale), the screen sharing feature, which allows the provider to screen share the assessment with the client, will facilitate the administration of the measure.

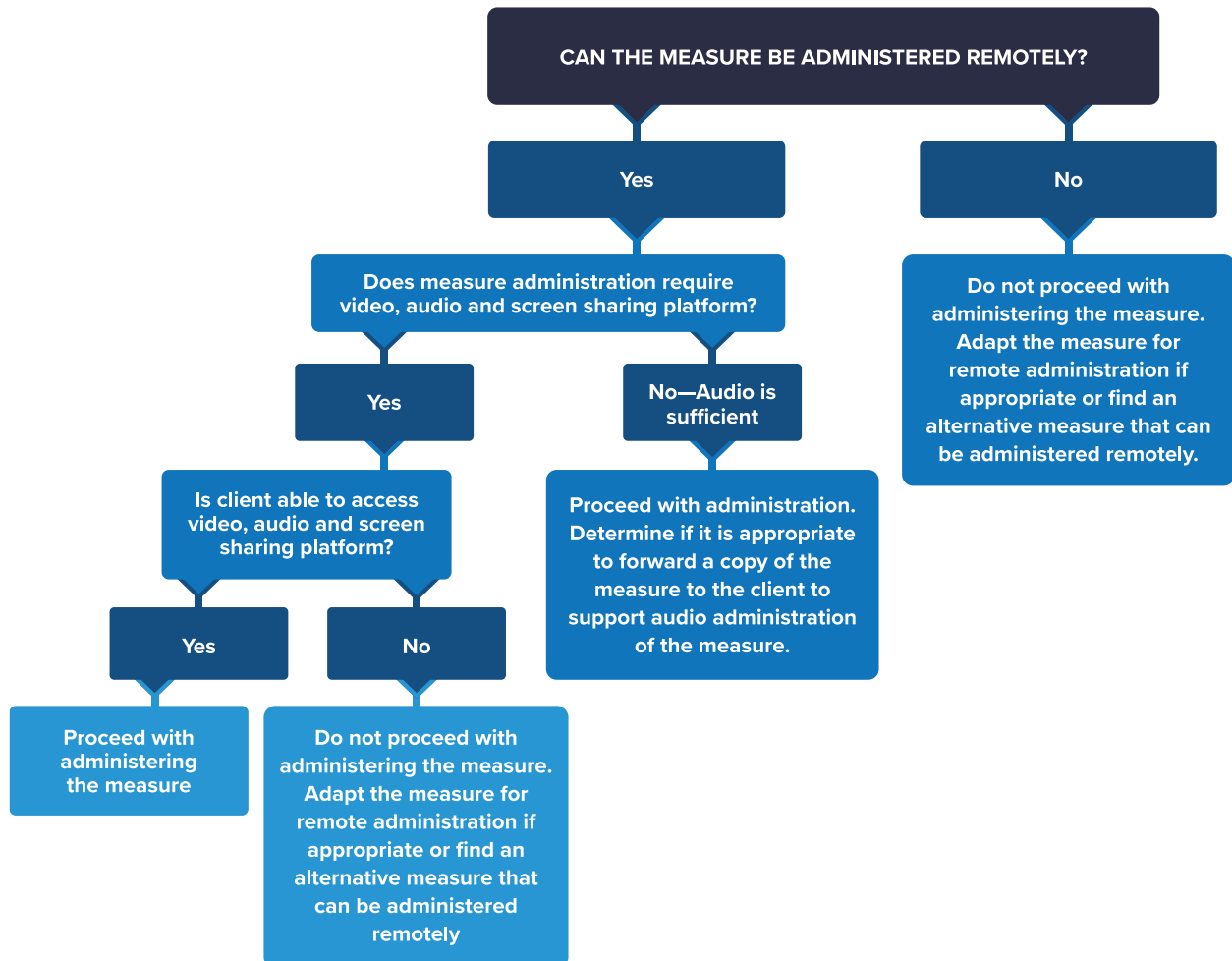
The next best option is to use a platform that combines video and audio (e.g., WhatsApp) where the provider is able to observe the client and gather both verbal and non-verbal information during the administration of the measure. In this situation, the provider should assess whether it is appropriate to email the client the measure so that they can read the questions as these are being asked by the provider. Considerations include client access to email or other document sharing platform, maintaining the security of the measure, client literacy level, potential for harm to the client resulting from sharing the measure (e.g., client becomes alarmed after reading some of the questions).

A last option is the administration of the screening instrument using an audio only platform. In this situation, the provider only has access to verbal information which may limit the accuracy of the assessment. The provider should assess whether it is appropriate to email the client the measure so that they can read the questions as these are being asked by the provider. Considerations include client access to email or other document sharing platform, maintaining the security of the measure, client literacy level, potential for harm to the client resulting from sharing the measure (e.g., client becomes alarmed after reading some of the questions).

It is **not** recommended that measures be forwarded to clients by email or some other document sharing platform for them to complete independently. Reasons include the possibility that the client may misunderstand the questions or how to respond resulting in inaccurate data, measure security and lack of control over dissemination, potential harm related to sharing the measure

(e.g., client becomes alarmed after reading some of the questions), and lastly, an independent completion of the measure precludes the opportunity for the provider to ask supplementary questions and complete a thorough assessment.

Flowchart 3 Remote Administration of Screening Instruments and M&E Measures



Data Protection and Confidentiality

Local and international laws on data protection should guide the appropriate management of client data in remote MHPSS service delivery. Policies should be developed that are specific to the legal context and to remote MHPSS service delivery.

Best practices related to data protection and confidentiality:

If client information is being recorded and stored electronically:

- Provider should always log out of the electronic system after completing their electronic records.
- Provider should ensure that the device is password protected.
- Provider should secure their device when not in use (e.g., storing the device in a locked drawer).
- Client information should be stored in a password protected electronic folder.

If client information is being recorded in writing:

- Handwritten clinical notes or files are not recommended as it is more difficult to ensure that the data is protected.
- If handwritten notes and files are used, they must be stored in a safe place with a lock and limited access to ensure the confidentiality and protection of information.³⁴

(Refer also to 3.d Client Data Protection)

Module 5: Managing Suicide Risk Cases During Remote MHPSS Service Delivery

Learning Objectives

1. Describe a minimum of five best practices related to managing client suicide risk when delivering remote MHPSS services.
2. Learn how to carry out a suicide risk assessment when delivering remote MHPSS services.
3. Know how to develop a safety plan in the context of delivering remote MHPSS services.
4. Identify your reactions when providing services to clients presenting with suicide risk.
5. Identify a minimum of three strategies to manage your reactions to clients presenting with suicide risk.

Duration: 9 hours

Note to facilitator

³⁴ IASC Reference Group MHPSS (2020). Operational consideration for multisectoral mental health and psychosocial support programmes during the COVID-19 pandemic. <https://www.paho.org/en/documents/operational-considerations-multisectoral-mental-health-and-psychosocial-support>

1. Ensure that participants have read the following sections of International Medical Corps Guidelines for Remote MHPSS Programming in Humanitarian Settings: 3.7 Understand risk and manage emergency risk and Appendix D: Remote interventions for emergency cases.
2. For this module, it is recommended that the relevant flowchart and annexes be made available to participants as handouts.
3. Ensure that participants have read or have access to the IASC MHPSS Reference Group guidelines on addressing suicide and self-harm in humanitarian settings field test version (forthcoming September 2022).

Activity: Small group discussion

Participants will organize into small groups. Each group will 1. Develop a description of their clinical approach to addressing client suicide risk when providing in person services (e.g., best practices in clinical management); 2. Identify aspects of the clinical approach that remain the same and those that need to be adapted and how for remote MHPSS service delivery; and 3. Identify challenges in managing client suicide risk when delivering remote MHPSS services and generate possible solutions.

Each group should summarize this information on flip chart paper (in virtual settings, a digital Whiteboard may be utilized).

[Allow 20 minutes]

The groups will then come together and share their responses with the larger group. Allow for a large group discussion.

[Allow 20 minutes]

Session 5.a. Guidance for working with clients at risk of suicide

Before meeting the client for the first time, the provider should have their address/location and should have identified in advance of the first session all resources and care settings (through service mapping) that can be accessed to support a client presenting with suicide risk.

Examples of care settings include specialized psychosocial services, hospitals or other emergency services with the capacity to address attempted suicide or support individuals at high risk of dying by suicide. Providers should also have the contact information of a focal point at the hospital or health center to facilitate referral and care.

Providers should discuss the importance of having consistency in where the client is located for sessions and knowing the client's location at the time the session is being implemented as it impacts emergency management and local available resources. As clients change locations, providers should be aware of the impact of location on emergency management protocols. These include emergency resources (e.g., police, emergency rooms, crisis teams) and contacts.

At the time of contracting and obtaining informed consent, the provider should obtain the name and contact information for at least one emergency contact (friend, family member; Refer to Module 4: 4.a. Contracting and Boundaries for Remote MHPSS Services). Depending on the client's presenting problems, the provider should consider the use of a "Patient Support Person" (PSP) if clinically indicated. A PSP is a family, friend or community member selected by the

patient who could be called upon for support in the case of an emergency. The provider may contact the PSP to request assistance in evaluating the nature of emergency and/or initiating the emergency care from the client's home.³⁵

High-risk clients should be prioritized for frequent contact to manage emerging concerns. In addition, providers should be proactive in reviewing and updating the treatment and safety plans for these clients.

Ensure that a clinical supervisor is available when remote MHPSS services are delivered and can be contacted in case of a client emergency.

Lines of responsibility and decision-making related to managing client risk should be clear so that providers are adequately supported, especially if working from home.

Session 5.b. Assessing suicide risk

Appraising risk when delivering remote MHPSS services can be more challenging than when providing in person services. In remote MHPSS services, information about the client may be more limited (e.g., audio only calls limit information gathered visually) which can make it harder to judge the presence and/or severity of risk, to verify whether risk is genuine or if the client is misrepresenting the level of risk and to judge the level of support available to the client through their social and family networks.

Risk Indicators When Visual Cues are Not Present

- Establishing a positive rapport in which the client trusts the provider is vital. This will help ensure that the provider receives accurate information/responses from the client to questions that relate to risk.
- When providing remote MHPSS services, the provider should be proactive and regularly assess for risk. This is especially important when visual cues are not present as a source of information about the client.
- The provider will need to be attentive to pauses, silence, changes in voice tone, and other auditory cues (e.g., sniffing) and to understand what these might mean. The provider should ask the client if they are not able to or are unsure how to interpret the pauses and/or changes in tone (e.g., *'It think I heard some hesitation and tiredness in your voice when I asked you how you are coping since we last spoke. Can you tell me how you are feeling?'* *'You have been quiet. I wonder if you might be crying?'*).
- If meeting with a client using audio only calls, the provider can explain to the client during a first session that they may ask the client questions about what they are experiencing during a session as they are not able to see the client. This can help prepare the client if the provider asks questions related to the cues described above.

When to Assess for Suicide Risk?

The objective of suicide risk assessment is to determine if a client is experiencing passive or active suicidal ideation and has a plan and the means to act on their suicidal thoughts.

³⁵ American Psychiatric Association & American Telemedicine Association (2018). Best Practices in Videoconferencing-Based Telemental Health. <https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/Telepsychiatry/APA-ATA-Best-Practices-in-Videoconferencing-Based-Telemental-Health.pdf>

A suicide risk assessment is recommended in the following situations:

- With clients where there is suspicion of suicidal thoughts.
- With clients who have directly expressed current suicidal thoughts.
- With clients who present with agitation due to active symptoms of severe mental health disorders (e.g., delusions) or behavioral disturbances (e.g., acute psychosis, manic episode).
- Where self-harm behaviors are identified during a video or audio call.

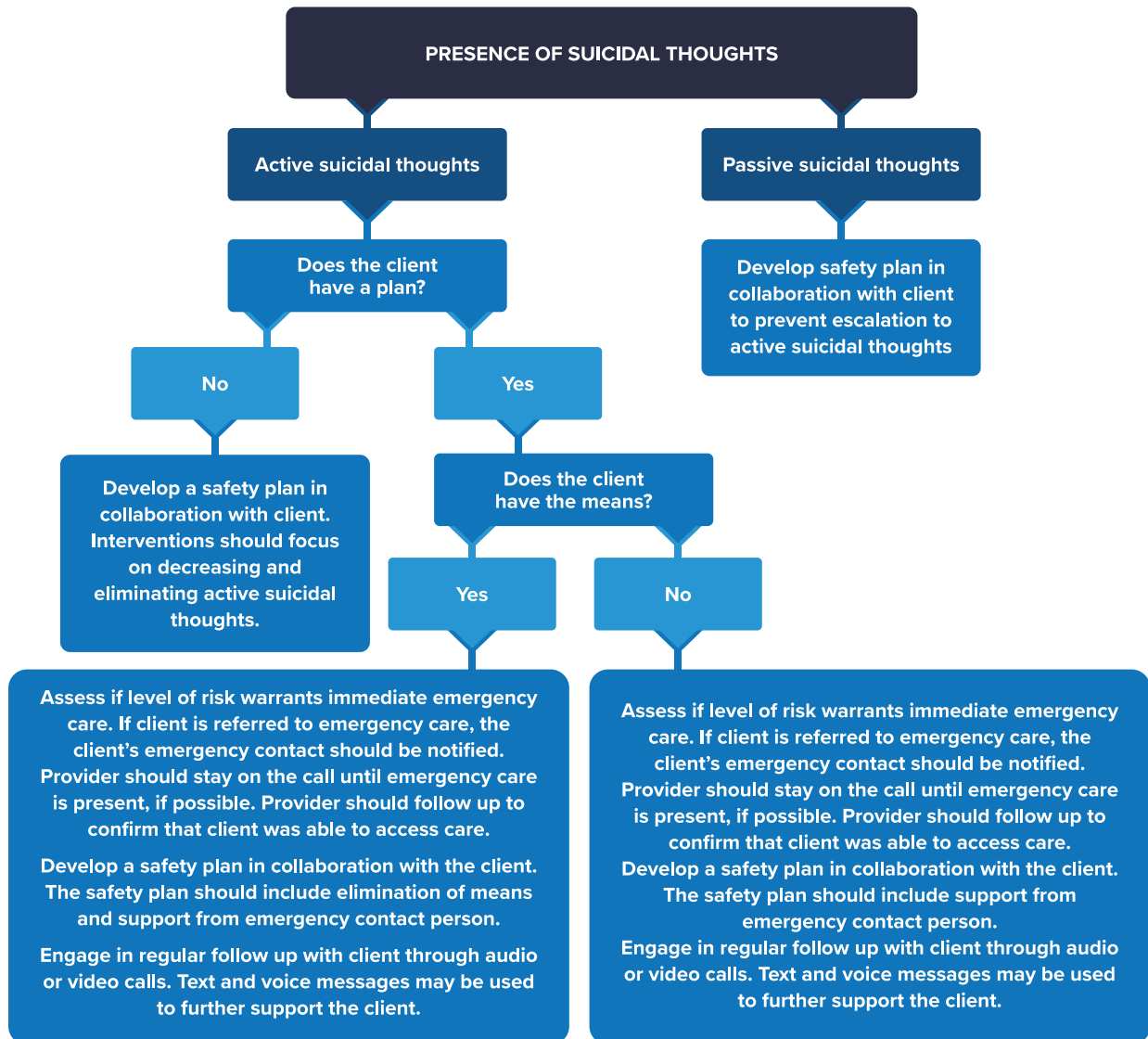
When Suicide Risk is Identified the Provider Should:

- Assess the risk (e.g., self-harm / suicide risk).
- Remind the client of confidentiality and exceptions to confidentiality in case of harm or risk of harm.
- Seek permission from client to engage emergency contact person/PSP and/or to engage emergency services.
- If appropriate, make a referral to emergency services (Refer to Module 4 → 4.d. Referral).
- Complete a safety plan during the same call, in collaboration with the client.
- Take sufficiently detailed notes during the call to enable follow up after the call and with other agencies, if necessary.
- Report imminent risks to your clinical supervisor to ensure that the risk is appropriately managed.³⁶

The provider should follow the steps below when assessing suicide risk in remote MHPSS service delivery. This assessment can be carried out on a video or audio only call. The provider should ensure that the client is in a safe place to discuss sensitive issues without increasing the risk of harm. The risk assessment should identify protective factors that can be emphasized including reasons for living (e.g., family, hope for the future, children) and deterrents (e.g., fear of injury, religious beliefs) and factors that aggravate suicidal risk (e.g., isolation, negative thoughts).

³⁶ Bosqui, T.J., Chehade, N., McEwan, F., van Wyck, S.S. (2020). Delivering psychological treatment to children via phone: A set of guiding principles based on recent research with Syrian refugee children. DOI: 10.31219/osf.io/5k3bh

Flowchart 4 Assessing risk of suicide



Note for facilitator: *If using a suicide risk screening or assessment tool when providing remote MHPSS services:* Refer to Module 4 → 4.i Documentation → Administration of Screening Instruments and Monitoring and Evaluation Measures.

Activity: Role play

The participant group should first be divided into two groups. One group will be provided with phones (this group will be the audio only call group). The second group will be provided with laptops, tablets and/or smart phones (with video capacity; this group will be the video call group).

Participants in each group should be further divided into pairs with one participant role playing the client and the second role playing the provider. The suicide risk assessment role play should

be carried out through the devices. Therefore, role playing dyads may need to be distanced (e.g., in separate rooms). The facilitator should develop some background information for the 'client' that is context specific and that is sufficiently complex to allow for the 'provider' to practice their skills in suicide risk assessment. Allow 20 minutes for the role play after which the 'provider' and 'client' should switch roles. Allow for another 20 minutes for the role play.

If time allows, groups 1 and 2 should switch devices so that each group can experience carrying out a suicide risk assessment through an audio and a video call.

Have the groups come together and discuss their experience. Questions to address in the discussion are: What did they learn? What were the challenges? What might they do differently? What went well?

Session 5.c. Safety Planning

Safety planning in remote MHPSS service delivery is in many ways the same as for in-person services.

- Let the client know that you want to develop a safety plan with them to help maintain their safety and that it will take about 30 minutes to do.
- Explain that a safety plan is a way for the client to stay safe. Answer any questions the client might have about the purpose of the plan and how to use it or any concerns related to developing a plan.
- Arrange for the client to get a copy of the plan. Clients can write it down as the provider develops it, or the provider can write it down, take a picture or scan, and e-mail or text it to the client.³⁷ When using a communication platform that allows for screen sharing, the provider can choose to screen share as they write the safety plan so that the client can see the plan being developed which allows for a more collaborative process. For clients with limited literacy, the provider and client may decide on specific images/symbols to represent safety plan content.
- Review and update the safety plan regularly. Refer to Annex 8 for a sample safety plan.

The plan should:

- Identify potential protection concerns and how these will be addressed.
- Include emergency contacts (names and contact information). The provider should ensure that these are up to date and that they are still available to help the client manage a suicidal crisis.
- Include the name and contact information for the PSP, if different from the emergency contact.³⁸
- Include reasons for living (family, hope for the future, children).

³⁷ Center for Practice Innovations at Columbia Psychiatry New York State Psychiatric Institute (n.d.). Telehealth tips: Managing suicidal clients during the COVID-19 pandemic. <https://pcit.ucdavis.edu/wp-content/uploads/2020/04/Telehealth-Tips-with-Suicidal-Clients.pdf>

³⁸ IASC Reference Group MHPSS, 2020. Operational consideration for multisectoral mental health and psychosocial support programmes during the COVID-19 pandemic. <https://www.paho.org/en/documents/operational-considerations-multisectoral-mental-health-and-psychosocial-support>

- Identify specific coping skills that can distract from suicidal thoughts and de-escalate crises, taking into account limited access to resources.
- Identify social supports that can help distract from a suicidal crisis.
- Identify professional emergency contacts that are currently available.
- Reduce access to lethal means. The provider should discuss increased access to lethal means (e.g., stockpiles of medications) and if there is someone who can help secure lethal means.³⁹

Activity: Role play

Participants should first be divided into two groups. One group will be provided with phones (this group will be the audio only call group). The second group will be provided with laptops, tablets and/or smart phones (with video capacity; this group will be the video call group).

Participants in each group should be further divided into pairs with one participant role playing the client and the second role playing the provider. The safety plan role play should be carried out through the devices. Therefore, the dyads may need to be distanced (e.g., in separate rooms).

The facilitator should develop some background information for the 'client' that is context specific and that is sufficiently complex to allow the 'provider' to practice their skills in developing a safety plan. Allow 20 minutes for the role play after which the 'provider' and 'client' should switch roles. Allow for another 20 minutes for the role play.

If time allows, groups 1 and 2 should switch technology so that each group can experience carrying out developing a safety plan through an audio and video call.

Have the groups come together and discuss their experience. Questions to address in the discussion are: What did they learn? What were the challenges? What might they do differently? What went well?

Ongoing Follow-up and Monitoring

- Assess for suicide risk at every contact for those clients at elevated risk.
- Review any changes in risk or protective factors at every session (e.g., changes in physical health in the individual, new access to lethal means, interpersonal conflict, social isolation and feelings of loneliness).
- Review and update the safety plan as needed.
- Get permission to continue providing follow-up through video or audio calls. Schedule the next contact at the end of each session.

Documentation

- Document all client interactions including the presenting problem(s) addressed, the intervention(s) implemented and the outcome.

³⁹ Center for Practice Innovations at Columbia Psychiatry New York State Psychiatric Institute (n.d.). Telehealth tips: Managing suicidal clients during the COVID-19 pandemic. <https://pcit.ucdavis.edu/wp-content/uploads/2020/04/Telehealth-Tips-with-Suicidal-Clients.pdf>

- Consult with supervisors and clinical peers on challenging clinical decisions and document the consultations.

Session 5.d. Managing service providers' anxiety in relation to risk

When working remotely, it is important to tend to one's physical and mental wellbeing. Remote work can result in increased professional isolation. Peer consultation groups and regular supervision meetings using a secure platform can help for clinical consultation and support.

- It is normal to experience a range of emotions and thoughts as a result of working with clients who are at risk. Examples of emotions are anxiety, anger, fear, helplessness and sadness and examples of thoughts are blaming the client and negative beliefs about being able to help the client. A client's suicidal risk may be triggering for some providers depending on their personal history.
- It is important that the provider has the skills and clinical support to be able to identify these reactions. It is also important that these reactions are normalized and that the provider identifies strategies to address (decrease or eliminate) these reactions.
- Ongoing and regular consultation with a clinical supervisor or peer is vital for the provider to both identify and manage their responses to clients who are at risk. Supervisors and peers should help normalize the reactions the provider is experiencing and support the provider in finding strategies to manage or decrease these feelings so as to not impact the clinical work.
- Strategies to tend to the self include:
 - Adequate sleep, appropriate nutrition and exercise.
 - In the context of clinical consultation, identifying the specific sources of any negative feelings and thoughts and finding strategies to address these and obtaining clinical support with working with the client.
 - Engaging in activities that decrease negative feelings and thoughts and support rest, relaxation and positive mood (e.g., exercise, meditation, time in nature, art, relaxation exercises, positive self-statements).
 - Engaging in therapy/counselling.
 - Taking time off. Providers may not feel that they can take time off when working with clients who are at risk. However, preparing the client for the provider's leave, having a clear coverage plan that is reviewed and discussed with the client well ahead of the provider's time off and having the client meet the covering provider can support the provider and client with feeling comfortable with the provider taking leave.

Activity: Large group discussion

Participants should be asked to reflect on their clinical work with clients who presented with suicide risk and to identify their thoughts and feelings. Participants should be invited to write these down (they do not have to share this information). Participants should then be invited to share their responses should they wish to. The goal of participants sharing their reactions is establish a shared experience and to normalize the fact that providers have thoughts and feelings in response to working the clients who present with risk. Participants should then consider what has helped them manage these reactions in the past and any new strategies they think might be helpful but that they may not have used. Participants should write these down

(they do not have to share this information). Participants should then be invited to share their ideas should they wish to. The goal of participants sharing their strategies is to allow the group to gain strategy ideas from each other and to generate a discussion of approaches to taking care of oneself when working with clients who are at risk.

[Allow 30 minutes]

Module 6: Setting Up A Helpline and/or Hotline

Learning Objectives:

- Know how to differentiate between a hotline and a helpline, and define the purpose and scope for each.
- Understand the resources needed to set up and operate a hotline or a helpline.
- Be familiar with the minimum ethical standards and guidelines of operating hotlines/helplines.
- Be aware of the operational and logistical aspects of running a helpline/hotline and know the resources to consult when setting up these services.

Duration: 1 hour and 30 minutes

Activity—Hotline vs. a Helpline

Facilitate a group discussion and ask participants to share their views on what a helpline is and what a hotline is. Allow 5 minutes for the discussion. Following the discussion, provide the following information on hotlines and helplines.

Session 6.a. Hotline and Helpline Defined

“Hotline” and “helpline” are often used interchangeably to denote phone services set up to provide information or assistance to the public. However, there are distinctions between these services and distinctions also vary from setting to setting. Generally, hotlines are phone services available to the public for immediate assistance. They are usually staffed 24/7 and can serve more on a permanent basis (e.g., a suicide prevention line set up to provide support and crisis counseling) or on temporary, needs basis, such as a hotline set up during an emergency to provide information and services to the population. Helplines, on the other hand, generally function to provide information on how to access services and are not necessarily always staffed around the clock. Both hotlines and helplines can be set up as direct phone lines (i.e., phone calls), text-messaging, real-time chat functions or as a combination of all three. Helplines can also be set up as e-mail services and online questionnaire forms since immediate response is not expected.

In the context of MHPSS service delivery, both helplines and hotlines can be utilized depending on the needs identified in a particular setting. For example, an MHPSS helpline can be set up to serve as a directory and referral point for beneficiaries to inquire about available MHPSS

services in their area and how to access them. Helplines can also be set up as scheduling services for existing or prospective clients to connect to services. In some instances, if the staff are properly trained, helplines can serve an initial screening and intake function before referrals are made to appropriate specialists. Hotlines, on the other hand, can be set up to provide crisis support, psychoeducation, and potentially basic counseling and would need to be staffed with personnel with more specialized training.

Activity: Small group discussions

Ask participants to form 3-4 small groups and discuss: What makes an effective helpline/hotline? Have they ever used a helpline/hotline? Why? Was it helpful—if not, why not? Allow 10 minutes for the discussion.

Facilitator notes: Before deciding to set up a helpline or hotline it is important to identify the gap in services or value add that a helpline/hotline can provide. For your consideration it is always important to think if the helpline/hotline will complement existing services? Or is it to create new remote services?

Session 6.b. Determining the Need, Purpose, Scope, and Target Audience for a Hotline or a Helpline

Before setting up a helpline or a hotline it is important to conduct a needs assessment to determine the purpose, scope, as well as the resources needed to operate the line. Where existing hotlines and helplines exist, it is important to build on and leverage these resources instead of duplicating effort. In addition, a mapping of existing MHPSS services should inform how the hotline or the helpline will link with these services and operate in the broader MHPSS services ecosystem.

Purpose

As you prepare to set up the hotline or helpline, including community representatives in the process, ask⁴⁰:

- What is the specific community need or needs we are meeting with this hotline or helpline?
- How will we/have we validated this need with the community?
- How are we coordinating with national and local MHPSS actors to include hotline/helpline data and feedback to adjust the response and services?

⁴⁰ WHO. (2018). Preventing Suicide: A Resource for Establishing a Crisis Line. <https://apps.who.int/iris/bitstream/handle/10665/311295/WHO-MSD-MER-18.4-eng.pdf?ua=1>

Scope

To determine how the hotline or helpline meet the stated need, ask⁴¹:

- Is providing and collecting information enough, or do we also need a referral system?
- Do we only take calls, or should we reach out proactively to some (vulnerable) groups?
- Do we need to call people back after a period of time?
- What other platforms and services are we using to ensure we are reaching and listening to our target audiences?

Target Audience and Considerations for Vulnerable Groups

Knowing who the target audience for the helpline and hotline will help determine the staffing and training needs. In particular, consider how the helpline or hotline will address the needs of vulnerable groups⁴²:

- Older people;
- People who do not speak the national language(s); or have cultural practices that may have an impact (such as different comfort levels in talking to strangers and/or authorities);
- People with lower access to telephone services;
- People who are hard of hearing or deaf.

Session 6.c. Determining the Resources Needed to Set up and Operate a Hotline or a Helpline

During this preparatory phase, consideration needs to be given to governance, recruitment, training, development of practice tools and guidelines, quality assurance and building of local relationships with other service providers. Planning, budgeting and sustainable funding are needed to ensure the long-term success of a helpline or a hotline.⁴³

Ask the following questions when preparing for the setup of a hotline/helpline:

- How many staff and supervisor do we need to recruit? Are we going to engage volunteers? What are the best avenues for recruitment?
- What resources do we need for building capacity of helpline/hotline staff? (Implementation of an initial training program, refresher training sessions and upskilling)
- Can we secure premises that provide a safe and secure place for workers to operate and that can be safely accessed during operating hours (e.g., 24 hours a day, 7 days a week for a crisis line).

⁴¹ WHO. (2018). Preventing Suicide: A Resource for Establishing a Crisis Line. <https://apps.who.int/iris/bitstream/handle/10665/311295/WHO-MSD-MER-18.4-eng.pdf?ua=1>

⁴² *Ibid.*

⁴³ WHO. (2018). Preventing Suicide: A Resource for Establishing a Crisis Line. <https://apps.who.int/iris/bitstream/handle/10665/311295/WHO-MSD-MER-18.4-eng.pdf?ua=1>

- What technology and other infrastructure are needed and how much will it cost? (Installation of telephones and other technology, e.g., computers and software, as maintenance costs)
- Will we operate the helpline/hotline ourselves or in partnership with other organizations? Who are potential partners and how can our commentary resources, organizational capabilities and experience be leveraged for effective operation of the helpline/hotline?
- How do we engage local (or national) authorities in preparing to set up the helpline/hotline? Are there any laws and regulations that may inhibit the types of services to be provided over a helpline/hotline?
- Are there legal registration costs?
- Do we need to secure liability or other insurance?
- How will we raise funds to establish and maintain the helpline/hotline?

Session 6.d. Ethical Standards and Guidelines in Operating Helplines/Hotlines

Respect for diversity and inclusion toward all callers irrespective of the callers' gender, sexual orientation, age, ethnicity, religion, political views, disability status and other forms of marginalized identity constitutes the cornerstone of ethical operation of helplines and hotlines. Ethical guidelines should be documented and provided to all helpline/hotline staff as part of their onboarding and ongoing training. Clear procedures should be established and communicated to all on how ethical violations would be addressed. At a minimum, the ethical guidelines should include the following⁴⁴:

- Non-discrimination;
- Respect for caller confidentiality;
- Protection of caller privacy and data;
- Prohibition of imposing personal values and beliefs on callers;
- Maintaining professional boundaries (e.g., not meeting with callers privately, exchanging personal information, establishing personal relationships, etc.);
- Charging callers for services that are otherwise free or making referrals to services for the sole purpose of financially benefitting the call operator or their associates.

Session 6.e. Operating a Hotline/Helpline

Operating hotlines/helplines requires extensive logistics and management. Depending on the type, purpose and scope of the line, the following will need to be taken into consideration:

- **Staffing structure and delineation of role and responsibilities:** Potential roles may include helpline/hotline manager(s); hotline/helpline supervisor(s) of operators; call operators; scheduling coordinator(s); trainer/training coordinator; community focal point(s); administrative staff; ICT support staff; quality assurance/M&E coordinator; and so on.

⁴⁴ WHO. (2018). Preventing Suicide: A Resource for Establishing a Crisis Line. <https://apps.who.int/iris/bitstream/handle/10665/311295/WHO-MSD-MER-18.4-eng.pdf?ua=1>

- **Recruitment:** To find enough qualified staff and volunteers for your team, you may need to partner with organizations that have strong volunteer programs as well as with higher education institutions.⁴⁵
- **Capacity building of personnel:** The scope, purpose and type of the line will very determine the training needs of the personnel. For example, crisis line operators will need to receive specialized training in crisis counseling and problem-solving. Whereas a training for helplines designed to provide referrals and general information would place emphasis on training the operators on how to listen and clearly identified the callers need and connect them to the resources and information in understandable and easy-to-follow steps. The training will also include reviewing ethical standards as well as phone scripts and protocols that provides detailed steps on collecting information from callers and providing information to them. In addition, operators will need to be trained on emotional intelligence skills, including empathy, patience, a service-oriented attitude and active, non-judgmental listening. A training on cultural sensitivity and implicit bias will ensure respect for diversity and inclusion among operators.
- **Call management:** To manage calls, techniques such as phone queues or automated call routing are sometimes used to ensure the shortest waiting time for callers. Choosing the right technology will depend on the size of the population to be served and the funds available. Also, a system to monitor the number of calls should be put in place to help in planning and evaluation of the service.⁴⁶
- **Quality assurance and M&E:** Procedures should be put in place to ensure quality and caller satisfaction as well as to prevent harm. This may include practices such as supervisors monitoring calls and providing constructive feedback to the operators and anonymous caller surveys gauging their satisfaction (e.g., automated phone surveys callers can respond to after the call or outreach to a sample of callers from time to time to solicit their feedback).

For practical guidance on how to operationalize different types of helplines and hotlines, refer to the following resources:

- Preventing suicide: A resource for establishing a crisis line. World Health Organization, 2018.
<https://apps.who.int/iris/bitstream/handle/10665/311295/WHO-MSD-MER-18.4-eng.pdf>
- Child Helplines and Mobile Operators: Working together to protect children’s rights—a practical guide. GSMA and Child Helpline International, 2015.
https://www.unicef.org/csr/files/CHI_GSMA_A-practical-guide_WEB.pdf
- Hotline in a Box. British Red Cross, 2002.
<https://www.communityengagementhub.org/guides-and-tools/hotline-in-a-box/>
- WHO Setup and management of COVID-19 hotlines
<https://apps.who.int/iris/handle/10665/336027>

⁴⁵ WHO (2020). Setup and management of COVID-19 hotline. <https://apps.who.int/iris/handle/10665/336027>

⁴⁶ WHO (2018). Preventing Suicide: A Resource for Establishing a Crisis Line.
<https://apps.who.int/iris/bitstream/handle/10665/311295/WHO-MSD-MER-18.4-eng.pdf?ua=1>

Activity—Setting up a Helpline and Hotline

Divide participants in to two groups. Ask one group to plan for setting a helpline serving a rural community with limited MHPSS services and resources. Ask the other group to plan for setting up a hotline in an active emergency setting. Groups are encouraged to fill in other contextual details as needed (e.g., based on an actual context they may be working in or a hypothetical context).

Ask each group to discuss and address the following questions about:

1. Define who will be accessing the helpline/hotline, why and what their expectations of the helpline/hotline may be. Defining the scope well will help keep the quality of the helpline/hotline high as you can tailor training and roles accordingly.
2. Define and think how will you fund your helpline/hotline? Do you have grant funding, through fundraising or will it be self-funded?
3. Who will deliver your helpline/hotline service, staff, volunteers or a mixture? What training and supervision would they require?
4. Have you identified the key policies you need to have in place to protect the organization, staff, volunteers and the people using the service for example confidentiality, consent, staff wellbeing?
5. What safeguards do you have in place to make sure that your planned service is sustainable?
6. What Standard operating procedures do you need to ensure that helpline/hotline staff can manage emergencies and people with high levels of risk?
7. How will people contact your service and access support? By phone, email, text or webchat?
8. Will your helpline be based in a single location or will people work remotely?

Allow 20 minutes for group work and 10 minutes for debrief. During debrief, one representative from each group will present the key points of their discussion.

Annexes

Annex 1: Breathing exercises for relaxation⁴⁷

The objective of breathing techniques is to learn how to control our breathing so we can get to a point where we can do it naturally even in the most stressful situations. Controlled breathing techniques are easy to learn and can be used in any situation to control physiological activation.

Controlling our breathing is one of the easiest strategies to address stressful situations and deal with the increased physiological activation levels produced by them. Good breathing habits are really important to provide the body with the oxygen it needs to function properly. Low blood oxygen levels can produce increased states of anxiety, depression and fatigue. Typically, most of us engage in incomplete, shallow breathing, which only uses a limited amount of the lungs' functional capacity.

In situations of stress or tension, our breathing tends to be either very rapid and shallow or too deep. This form of breathing can eventually lead to the appearance of somatic symptoms such as difficulty breathing, palpitations, chest pain or tightness, dizziness, tremor, etc. Breathing correctly, on the other hand, will help the person feel better both physically and mentally. Most people only breathe by expanding and contracting their chest (thoracic breathing), and sometimes they even lift their shoulders to fill the upper part of the lungs (clavicular breathing). However, these forms of breathing do not use the diaphragm and are insufficient and inappropriate.

Diaphragmatic or abdominal breathing allows for an efficient and effortless exchange between the oxygen we breathe and the carbon dioxide we exhale. The diaphragm is a vault-shaped muscle located at the base of the lungs that separates the thorax from the abdomen. At rest, the diaphragm muscle is bell-shaped, but during inspiration, it flattens out. When we practice abdominal breathing, the vault formed by the diaphragm flattens out during inspiration to allow more air to get into the lungs. When we exhale, the diaphragm returns to its original bell-shaped position and lungs contract.

When our lungs are filled with air, the diaphragm flattens out, activating the vagus nerve of the parasympathetic autonomic nervous system (ANS) and producing relaxation. The average person breathes 12-16 times per minute if he/she is not excited or is deeply relaxed. When we breathe deeply and keep air in our lungs, on the other hand, our body maintains its CO₂ levels in the blood. This will reduce the exchange of oxygen and result in lower levels of muscular activation in our bodies. Combined with the distraction of trying to control how we inhale and exhale, this form of breathing will help us diminish our negative thoughts in moments of stress. The purpose of this controlled breathing technique is to achieve a slow, regular and not too deep breathing. This technique can be used to deal with anxiety and, in general, reduce physiological activation. Controlled breathing, like any other technique, is something we can all learn. As with other techniques or skills, frequent practice is needed to master it. If you practice

⁴⁷ UNFPA (n.d.). Guidelines for the provision of remote psychosocial support services for GBV survivors. https://reliefweb.int/sites/reliefweb.int/files/resources/GBV-Mobile-and-Remote-Service-Delivery-Guidelines_-final.pdf

it, you will achieve good results in a short time. However, you must understand this improvement will be gradual.

Annex 2: Diaphragmatic breathing instructions⁴⁸

The following are the steps to be followed to learn the controlled breathing technique:

1. Choose a moment to practice when you know you will not be interrupted. Find a calm place without distracting lights or sounds.
2. To begin, adopt a **sitting position**. If you feel you cannot breathe correctly, you can begin with a reclined or lying position, for example, by sitting on a recliner or lying down on a bed. Once you have learned how to breathe in this position, you can practice breathing in a sitting position.
3. Loosen your belt or any tight clothing, especially around the waist or abdomen. Adopt a **comfortable position** and place **one hand on your chest and another on your abdomen, with the little finger just above the navel**.
4. **Breathe in through your nose**, as this will make the air you breathe warm and wet. Air will also be filtered and cleared of harmful particles. **Breathe out through your nose or mouth**. If you have any difficulty breathing through the nose, use your mouth, but don't open it too much.
5. **Breathe in through your nose for 3 seconds using the diaphragm**. You will feel your abdomen expand against the hand placed on it. Do not lift your shoulders or move your chest.
6. **Breathe out slowly through your nose or mouth for 3 seconds**. Your abdomen will return to its original position. Take a brief pause before breathing in again. If you breathe in and out for 3 seconds and make a pause before breathing in again, you will breathe between 8 and 10 times per minute. If this pace is too slow for you, you can increase your pace to 12 breaths per minute, but reduce the breathing in and out time to 2 seconds. Once you do that, you should be able to gradually go down to 8 or fewer breaths per minute.
7. **Do not breathe too deeply**, as doing so may result in hyperventilation, but your breathing should not be so shallow that it makes you feel uncomfortable. The depth of your breathing should be such that you can breathe almost effortlessly after some practice.
8. Here are some useful tips you can use while practicing:
 - a. Repeat mentally a phrase like **"calm down"**, **"relax"** or **"take it easy"** every time you breathe out.
 - b. **Focus on the air coming in and out** with every inhalation and exhalation.
 - c. **Feel how your tension goes away** every time you breathe in.
 - d. **Do a mental count** of 8 during your breathing cycles (3 to breathe in, 1 in the first pause, 3 to breathe out and, again, 1 before beginning the next cycle).
 - e. **Make an audio recording of these steps, if possible** and use it to practice your breathing.

⁴⁸ *Ibid.*

9. **Practice controlled breathing two/three times a day**, for 10 minutes each time.
10. For the **first four days, practice with your eyes softly closed**. Then, do it with your eyes open.
11. If you have difficulty breathing slowly and regularly, you can do the following: breathe in slowly but a little more deeply, hold your breath for approximately 5 seconds and then breathe out slowly for approximately 10 seconds. Repeat this exercise once or twice and then return to the controlled breathing procedure. After a couple of weeks, you can practice controlled breathing while standing and while walking. You can then practice in situations with many distractions (for example, places with a lot of noise) or after exercising. Finally, you should practice the technique every time you experience physical or emotional tension in order to reduce it. You can start by practicing this technique in less stressful situations then, as you become better at it, gradually apply it to more stressful situations. Of course, you don't need to use the controlled breathing technique all day long, but you should practice it often and use it as a strategy to deal with stressful situations. In these situations, you may not be able to breathe slowly and regularly in the beginning, but don't worry. Remember this is a gradual process that requires practice.

Annex 3: Psychoeducation—Difficulty sleeping

Instructions: This is a script for use in a psychoeducation session. It can serve as a guide to conduct a session to address sleep problems.

Sample Session

Step 1: Prepare and adapt the sleep diary BEFORE the session!

Step 2: Explain. “On average, a person sleeps from six to eight hours a day. Sleeping gives our body and mind the time they need to rest, boosts our energy levels and helps us feel fresh in the morning. But having difficulty sleeping is a common challenge in moments of tension, uncertainty and anxiety. After a moment of crisis, it is common for people to experience difficulties in their sleep. Many factors can easily lead a person to sleep problems. Sleep problems can manifest and be identified through different signs.”

Step 3: Identify Signs of Sleep Problems.

- Ask the client if they have any of the following signs:
- They wake up repeatedly at night (interrupted sleep)
- They wake up very early in the morning and cannot sleep again (early morning waking)
- They have difficulty falling sleeping
- They feel sleepy throughout the day
- They sleep but do not feel rested due to a lack of sleep
- Fatigue
- Mood swings
- They feel irritable and in a bad mood
- They have difficulty concentrating, lose focus and attention
- Anxiety
- Headaches

- Lack of energy
- They are more prone to making errors

Step 4: Explain the Relationship Between Sleep and Health

“As you can see, there is a clear connection between mind and body. If our body doesn't get enough rest, it affects our mind and functioning.”

Let's talk about the things that can prevent us from getting a good night's sleep:

Step 5: Ask About the Causes

“In your opinion, what things might be preventing people from sleeping well?”

Step 6: Put Together a List of Causes and Factors and Then Share the Summary Verbally

If the client cannot identify any causes, you can help them with some examples and explanations:

- The experience of traumatic incidents can result in negative thoughts and feelings that make sleeping difficult.
- The excessive use of sleep drugs, alcohol use and excessive smoking can lead to a lack of sleep.
- Medical problems, particularly those that cause pain, shortness of breath (for example, due to heart failure) or urinary tract infections that cause frequent urination, as well as stomach pain and psychosomatic symptoms.
- Changes in the environment or a bad sleeping environment: frequent changes in our sleeping environment or changing sleeping locations can make sleeping difficult. There are also environments that, due to existing conditions (limited space, number of people) are not suitable for sleeping.
- Long-term insomnia.
- Poor sleeping habits: routine consumption of alcohol, nicotine or caffeine, taking frequent naps during the day, eating a heavy meal before going to bed, insufficient sleep time or a sedentary lifestyle.
- Worrying too much about our sleep, anticipating we won't be able to sleep: Sometimes we worry so much about not being able to sleep that we cannot stop thinking about it, anticipating how bad we will feel the next day. And this only makes sleeping even more difficult. This situation may result in a cycle where going to bed every night will make the person nervous.

Step 7: Summarize the Factors Identified

“We have found that there are many reasons that can make sleeping difficult. The purpose of this session is to understand why we have trouble sleeping, and share some tips to start dealing with that problem. We will discuss more details in the next session.”

Daily Sleeping Exercise

Step 1: Introduce the sleep diary

“This week we will start keeping a sleep diary. But before learning and practicing different ways to sleep better, we need to have an idea of how you will sleep next week”.

Step 2: Explain how to create a sleep table

Sunday	Monday	Tuesday	Wednesday	...
Time I went to sleep				
Time I woke up at night and what caused me to wake up				
Time I woke up the following day				

Step 3: Share practical tips

Explain that the client should try to follow at least two of these tips during the week. For example:

- Not taking any naps during the day.
- Start engaging in some physical activity during the day, but not close to bedtime.
- Stress that the practice of these tips should be constant throughout the week.

Annex 4. Psychoeducation: Sleep hygiene

Instructions: This is a script for a psychoeducation session. It can serve as a guide to conduct a session to address sleep problems.

Sample Session

Step 1: Introduction

“In the last session, we discussed the reasons why some people cannot sleep well. Do you remember any of them? Have you identified any of them in you?” (Note: You can develop interventions around the reasons the client reports for poor sleep. For example, anxiety).

Step 2: Go Over the Sleep Diary

Going over the diary is the first step in motivating the client to change their sleeping habits and identify any adjustments needed. If necessary, explain that people often think they sleep less than they actually do. “On many occasions, people think they sleep less than they actually do.”

Step 3: Continue

“Today we will learn different strategies to help you sleep...”

Step 4: Explain the Concept of Sleep Hygiene

When explaining sleep hygiene, you should bear in mind the challenges the client is experiencing and try to adapt the explanations to her environment.

“Just like we take care of ourselves and our loved ones to avoid getting sick, we eat regularly and take showers, we also need to take care of our sleep. Let’s now talk about the main non-medical interventions to solve sleep problems. There are several steps that can improve the process of developing and maintaining good sleep patterns. Sleep hygiene consists of the following strategies:

- Sleep as much as you need to feel rested. Don't stay in bed if you are no longer sleepy.
- Keep a consistent sleep schedule. Go to bed and get up at the same time every day. Don't try to force yourself to sleep. Go to bed only once you feel you're ready to sleep.
- If you don't fall asleep within 20 minutes, get up and try some relaxation techniques until you're ready to go back to sleep.
- Use your bed only to sleep; not to work, eat, talk or stay during the day.
- Do not drink caffeinated drinks or other stimulants in the afternoon or evening.
- Do not drink alcohol before going to bed.
- Don't smoke, especially at night.
- If possible, change your bedroom environment to be sleep-inducing.
- Avoid watching TV in bed, especially 30 minutes before sleeping. (Adapt this as needed)
- Don't go to bed hungry and avoid eating foods that can cause acid reflux.
- Exercise regularly, but not 4-5 hours before going to bed.”

Step 5: Closing and commitments

After the conversation with the client, ask her to write down or draw on a piece of paper or notebook any leisure activities they will engage in and the tips they will practice.

Annex 5. Problem solving support⁴⁹

The following describes methodology service providers can use to provide support and help clients make decisions to solve a problem. It is important to remember that the service providers' role is to help the client make decisions. Service providers should not give advice or pressure the client to choose a particular solution or influence their decision-making process by expressing their own opinions or perspectives.

Introduction to the problem-solving methodology

As explained later in the document, this technique requires several steps. The provider has 3 options for applying this technique remotely with the client:

Option 1. Carry out all the steps specified below in one session. Keep in mind that these will require at least 45 minutes.

Option 2. In case it is not possible to do it in a single session, divide the process into three stages of 15 minutes over three consecutive days.

1. Definition of Problem Solving; Flexible and non-flexible ways of doing it.
2. Identifying a problem to work with.
3. Applying the problem-solving technique to the chosen problem.

Option 3. In case the problem is already defined, or the client has already identified it but lacks the skills required to make a decision, it is suggested to work with the provider only on the

⁴⁹ UNFPA (n.d.). Guidelines for the provision of remote psychosocial support services for GBV survivors. https://reliefweb.int/sites/reliefweb.int/files/resources/GBV-Mobile-and-Remote-Service-Delivery-Guidelines_-final.pdf

decision-making component (steps 2 and 3 within this annex). This option is very suitable for empowering the client to make a decision.

Definition

Problem solving is an explicit and active process to identify and apply a solution or deal efficiently with a situation that is producing (or may produce) negative or undesirable consequences. The problem-solving process is a response/action to minimize the negative consequences that make the person feel uncomfortable and maximize the benefit. Weighing those negative consequences and benefits is something strictly personal to the client. The way a person perceives problematic situations and the passive or active role they assume in response to these situations can mainly adopt two forms:

- Think OF a concern: in this scenario, the person starts to brood over the problem. This causes the person to worry about it, but they don't know how to act upon it, is not willing to try or cannot do it.
- Think ABOUT a concern: in this scenario, the person actively and practically analyzes what is making them feel uneasy (the problem) and attempts to solve it. The person perceives the situations that are making them feel uneasy as problems that have a solution.

If you find that the client is feeling uneasy because they are having trouble making decisions or engaging in problem solving, stress the fact that:

- The client is doing the best they can in a difficult context.
- Decision-making is a process that can be learned, and the service provider can help the client learn how to do it.

To address this topic with the client, you can use cooking as a metaphor: *“Sometimes we learn how to cook something by watching others, or we can learn intuitively, and the result can be good. Or we may decide to follow a recipe, but the result is not good and we don't know why. But then, somebody may share with us a few tips for that recipe and, with it, we will do a better job. And the more we practice, the better we will get at it.”*

Decision-making and problem-solving skills and techniques

Problem solving requires perceiving those situations that make us feel uneasy as problems that can be solved. Problem solving requires decision-making skills and techniques. The following are the different steps or activities required for effective problem solving. Note that this definition implies a losses and gains balance in the sense that any problem solving process, which inherently requires making decisions, means ‘something will always be left aside’. And this is precisely the aspect that can make the person feel uncomfortable.

1. Problem formulation and definition

Objective: To shift from a general and vague definition to a concrete definition of the problem. To this end, we recommend helping the client to:

- a. Find all the information related to the problem.
- b. Formulate an operational definition of the problem in clear and specific terms.
- c. Identify the truly relevant variables to solve the problem.

- d. Attempt to determine the causes that led to the emergence and persistence of the problem.
- e. Formulate and set specific and realistic objectives.
- f. Who are the persons involved? What is happening? Where? When? How? How do I feel? What do I want?

2. Identification of alternatives

Objective: To identify the largest possible number of alternatives.

We suggest identifying more than one alternative. The service provider plays a key role in the process of helping the client to identify solutions. When discussing the different alternatives, you should observe the following principles:

- a. **Deferred judgment principle:** At this moment, you are not trying to assess if the alternative is good or bad, adequate or inadequate. This is only a brainstorming exercise to identify any alternatives the provider can think of. Assessing whether an alternative is good or bad, adequate or inadequate, and discarding those alternatives that are not suitable will be done at a later stage.
- b. **Principle of quantity:** In line with the previous principle, at this stage the objective is to identify the largest number of alternatives possible. The larger the number of alternatives, the more options you will be able to explore. One common problem during the decision-making process is that the person may have already discarded alternatives before assessing whether they are suitable, which makes the decision-making process difficult. In this stage, our priority should be to give free rein to our imagination and identify the largest number of alternatives; their suitability will be assessed at a later stage.
- c. **Principle of variety:** Whereas the principle of quantity refers to the number of alternatives, the principle of variety refers to the different elements required for each alternative, for example: Is this something we can implement on our own or do we need somebody else's help? Do we need any resources? As with the principle of quantity, in this case, we are only trying to come up with alternatives. The determination as to whether they will meet the client's needs will be made at a later stage.

3. Decision-making

Objective: To select the most appropriate alternative(s).

Once you have selected one or more alternatives to solve the problem, you should discuss how to transform those ideas into actions with well-defined stages. In this regard, the service provider can help the client to:

- a. Assess the short, mid and long-term positive and negative consequences of each alternative.
- b. Compare and assess the potential outcomes of each alternative against the initial objectives.
- c. To reduce the time it takes to analyze the pros and cons of each alternative, we suggest discarding:
 - ◆ Those alternatives that cannot be put into practice due to a lack of resources.

- ◆ Those alternatives that are likely to produce negative consequences.
- d. During the process of identifying alternatives and actions to solve the problem, we suggest that the service provider talks to the client to help them assess each alternative against the following criteria:
 - ◆ Conflict resolution: to what extent the alternative can solve the conflict.
 - ◆ Emotional well-being.
 - ◆ Time-effort relationship.
 - ◆ Individual and social well-being.
- e. Upon selecting the best alternative, you should bear in mind that some problems may not have an ideal solution. In these cases, the service provider's main role is to provide psychosocial support. By the end of this stage, the client should be able to answer the following questions:
 - ◆ Can I solve the problem?
 - ◆ Do I need more information before deciding what to do?
 - ◆ What solution or combination of solutions is the best for me?

4. Implementing the decision made and verifying the results

- a. **Implementation:** Determine if the solution is feasible. Does the client have the resources, time and skills required? Here, the service provider's role is to assist the client during the process and support their efforts to change.
- b. **Self-observation:** Watch the client's behavior during the implementation. In this stage, the service provider can help the client analyze their achievements, obstacles and changes, and learn coping strategies or strategies to deal with similar problems.
- c. **Self-evaluation:** Compare results achieved vs. expected results:
 - ◆ If the result is satisfactory: Acknowledge the effort.
 - ◆ If the result is not satisfactory: Analyze the reason for the failure so the client can understand they not the problem, but there is something else making it difficult to solve the problem. If possible, identify barriers to solving the problem and if alternative approaches to address the problem can be identified.
- d. **Self-reinforcement:** Once the change has been made, the decision has been implemented and the problem is over, we suggest the service provider discuss with the client the successes and achievements made during the problem-solving process. This will contribute to the client's learning and empowerment.

Ineffective ways of deciding or ways “not to decide”

This section demonstrates some common situations that are not very efficient because they do not meet the ultimate goal of effective decision-making. To help the client carry out an effective decision-making process, it is important that providers know how to recognize and prevent these situations. It can also be helpful to show the client that ineffective decision-making can negatively impact the problematic situation and that by learning new ways of making decisions, they will feel better.

1. **Implement two problem-solving strategies and see which has the best result.**

It has been mentioned before that identifying several strategies can be part of the decision-making process. However, the proper process is: apply one; evaluate if it has been effective; if it is not, apply the second. Sometimes, instead of following this process, people apply both options at the same time. The consequence of this is that decision-making is delayed while the two options are implemented.

2. **Get very nervous and show signs of very intense emotional responses every time the person has to make a decision.**

There are two reasons why this can happen:

- a. **Naturally:** The person does not know/is not used to making decisions. This reaction is completely natural and the more times the person is exposed to making a decision, the less intense the response will be.
- b. **Instrumental:** The person has a very intense emotional reaction, and the people in their social circle react by taking away their agency in decision-making. As a consequence, the person does not learn to make decisions and instead they learn that an intense emotional reaction can prevent the decision-making process.
- c. **Thinking about the problem for too long until nothing can be done.**
Most decisions have a deadline after which none of the alternatives can be put into action. The classic way of not-deciding is to postpone the decision until this deadline without reaching any conclusion. In this case, the person delays the decision until they avoid it.

Annex 6. Psychoeducation for emotional regulation⁵⁰

This annex offers a script for emotional regulation support to clients. The content of the script and the methodology can be adapted to the context. You can also include participatory exercises.

Step 1: Session introduction

We suggest starting the session by explaining the topics to be covered:

- What is an emotion?
- What is its function?
- How to achieve effective emotional regulation

You can give a few examples of ‘bad’ emotional regulation, so the client can become familiar with the topic of the session.

“What is there in common between:

- A person who overeats every time she gets nervous,
- A person who always denies her emotions and one day explodes in anger because she cannot take it anymore, and

⁵⁰ UNFPA (n.d.). Guidelines for the provision of remote psychosocial support services for GBV survivors. https://reliefweb.int/sites/reliefweb.int/files/resources/GBV-Mobile-and-Remote-Service-Delivery-Guidelines_-final.pdf

- A person who is so worried that she cannot help brood over a problem, but does not make any decisions about it?
- All the persons in the examples are having trouble dealing with their emotions.”

Step 2: Definition of emotion

1. Share with the client the definition of the word emotion.
2. Explore the nature of emotions with the survivor.
 - a. In this session, we are going to explore how we can identify and control emotions. The more we know about our emotions, the better we will be able to manage them.”
3. Explain that emotions are natural and involuntary.

Exercise:

The purpose of this exercise is to explore everyday situations experienced by the client, but not situations that involve trauma.

1. Help the client identify situations that have made her feel uneasy and situations that made them feel well.
2. Help the client identify the emotions they felt in those situations, give them a name and determine the part of their body where they felt them. You can use the following questions:
 - a. “What did you feel in this situation? If you had to live that situation again, would you be able to identify where exactly in your body (your chest, stomach) you felt that emotion?”
 - b. Did the intensity of that emotion vary depending on the situation? Can you give me an example of a really intense situation?”
 - c. What happened in that situation?”
3. End the exercise.

“As you can see, your body and mind were preparing for, and reacting to, the different situations. You were doing the best you could to handle them. So now let’s talk about why you, or your emotions, are not the problem.”

Step 3: Emotions as a problem

1. Explain the following to the client:

“Emotions as such are not the problem; the situations that create them and what we do about them are. Emotions alert our body to the fact that something is affecting us. Therefore, if we understand what our emotions tell us, we can fix/change the things that affect us, instead of ignoring the emotion, which is not the problem. Emotions can become a problem if we try to ignore, eliminate or inhibit them, and we can do that in different ways. But doing so would be ignoring the message, because we would ignore what that emotion is trying to tell us out of fear we won’t like it or we won’t know what to do with it.”
2. Conduct the following exercise:

To conduct the exercise, give a few examples of negative coping strategies (for example, using psychoactive substances, locking yourself at home and not going out if you feel sad), and then ask the survivor if she has used any of these strategies in the

past. It is important to give her a few minutes to think before engaging in the conversation.

After sharing these negative coping strategies, explain the following:

“In these circumstances, it is normal for a person to feel overwhelmed. When faced with an emotional reaction, we can focus on two things:

- a. Addressing the situation that created it.
- b. Eliminating our emotional response.

If we try to eliminate an emotion instead of using it as a guiding tool, what will happen is the following:

- a. The situation that created the emotion will remain the same
- b. Paradoxically, the emotional response you are trying to eliminate will only grow in intensity.”

Step 4: Emotional Regulation

1. Introduce the topic of the session: *“One of the most difficult aspects of emotional management is putting it into practice. The basic idea consists of dividing a complex skill, such as emotional management, into multiple easy-to-follow sub-actions.*
2. *Introduce the steps to emotional regulation.*
3. Based on the situations used as examples, review and analyze possible actions based on the steps to emotional regulation previously explained.
4. Next, stress that you are only practicing and do a recap of the client’s bodily responses to the different basic emotions. The service provider can take notes and then prepare a table of the client’s emotions to share it with them.

In this part of the session, you can guide the client with the following questions:
What kind of reactions do you notice in your body when this particular emotion occurs? Can you be more specific? Do you feel any pressure in the chest, tension in your shoulders, a heavy feeling in your arms, a dull ache in your temples or have an upset stomach? What changes do you notice in your behavior? For example: Do you speak louder, walk faster or avoid making eye contact?

[In preparation for this session, we recommend putting together a document with a brief description of the steps to emotional management that can be shared with the survivor by email/WhatsApp. If the survivor does not know how to read, you can prepare a document with images that represent each of the different actions. Send it to the survivor before the session so she can associate each step with an image.]

5. Next, explain that, *“The adaptive function of emotions helps us identify what we need to be able to deal successfully with major events in our lives. They are like a compass. However, if our emotional language is limited to saying 'I'm fine' or 'I'm not OK', then our choices to understand and manage our emotions are limited. Unless we give our emotions a name, the physiological sensations that take over our body will be a tangle of incomprehensible reactions. And we won't know why they occur in our body or what causes them. If we want to become better at managing our emotions, the first thing we need to do is understand what they are all about. The steps we need to follow to identify*

and measure our emotions are the following: first, we must give them a name so we can understand them through the use of language, and second, we need to identify our sensations and locate them in our body.”

Step 6: Closing the Session.

Before closing the session, you should do a recap of the main points covered and the most important concepts and teachings. We suggest first asking the client to summarize the content of the session. The service provider can then do a brief summary and emphasize the most important points.

“In this session we covered important aspects, such as what emotions are. We also learned that identifying and working with our emotions can help us understand our needs and the changes we can make. We also mentioned that poor management of our emotions can have a significant impact on our well-being. It is important to bear in mind that this is a learning process, and the first step is to identify these emotions. Practicing these steps can help us understand what is happening in our body and give it a name. To do that, you can use a small emotional diary. You may find it difficult in the beginning, but you shouldn’t feel discouraged by that. Emotional management is a process that requires time but, in the long run, can produce great benefits. We will continue to analyze other situations so that, little by little, you can feel more comfortable doing it.”

Annex 7. Guidelines for work with coping strategies⁵¹

This annex offers a sample script the service provider can use with a client to explain and reinforce coping strategies.

Sample Script

“To develop and identify appropriate coping strategies, we must be able to identify the impact a particular situation is having on us:

1. Without judging how we feel or feeling pressured to do it in a particular way.
2. In the most concrete form possible. By identifying the name of our emotions, the feelings in our body and our actual concerns.
3. Frequently. Considering we experience many different emotions throughout the day, we should pay particular attention to how these emotions occur and affect us throughout the day. Something that can be helpful in this regard is writing down how we feel, particularly in those moments where we’re having strong emotions, but we don’t really know what’s happening to us. If you don’t feel like writing, one alternative is to discuss the issue with somebody you trust. The idea is to start putting how we feel into words so we can identify what we need. Once we understand what we need, we can take action accordingly.”

⁵¹ UNFPA (n.d.). Guidelines for the provision of remote psychosocial support services for GBV survivors. https://reliefweb.int/sites/reliefweb.int/files/resources/GBV-Mobile-and-Remote-Service-Delivery-Guidelines_-final.pdf

Sample Coping Strategies

The following are some needs you may find during your remote work and how to meet those needs. Use this list as a reference to discuss with the client the most appropriate coping techniques in their context. It can also be used to help the client to identify the actions they can incorporate into their routine activities.

Need	Action
<p>Evasion: Focus on more relaxing things instead of focusing on the problem</p>	<ul style="list-style-type: none"> • Physical activity • Relaxation techniques • Distracting activities: talking to a friend, playing with your children, engaging in a fun activity • Singing/listening to music • Spiritual practices (praying, attending church)
<p>Emotional relief: Release accumulated tension</p>	<ul style="list-style-type: none"> • Write down how you feel in a journal • Write a letter to somebody you hold dear and tell him/her how you feel • Take advantage of the moments of communication with the service provider to express how you feel • Talk to a trusted friend or family member
<p>Interaction: Feel supported, understood and active</p>	<ul style="list-style-type: none"> • Talk to somebody you trust about everyday things • Look for opportunities to have fun with persons who are safe and trustworthy • Reconnect with persons you haven't talked to in a long time
<p>Uncertainty: Identify potential scenarios and actions to deal with the uncertainty of the situation</p>	<ul style="list-style-type: none"> • Think of actions that can help you improve your situation • Seek advice to make decisions
<p>Control: Improve the perception of control over your own reality</p>	<ul style="list-style-type: none"> • Create order in your immediate environment (change spaces in the house, make repairs, move things around in the house). • Identify and focus on areas where you exercise control in your life

Annex 8: Sample Safety Plan

Safety Plan

Warning signs (thoughts, images, feelings, behaviors) that a crisis may be developing:

- 1.
- 2.
- 3.

Coping strategies—things that I can do to take my mind off my problems without contacting another person (distracting and calming activities):

- 1.
- 2.
- 3.

People and social settings that provide distraction:

- | | |
|-----------|---------------|
| 1. Name: | Phone number: |
| 2. Name: | Phone number: |
| 3. Place: | |
| 4. Place: | |

People I can ask for help with the crisis:

- | | |
|----------|---------------|
| 1. Name: | Phone number: |
| 2. Name: | Phone number: |
| 3. Name: | Phone number: |

Professionals or agencies I can contact during a crisis:

- | | |
|--------------------------|--------|
| 1. Clinician name: | Phone: |
| 2. Clinician name: | Phone: |
| 3. Local hospital: | |
| Address: | |
| Phone: | |
| 4. Hotline phone number: | |

Making the environment safe (removing or limiting access to means):

- 1.
- 2.

The two things that are important to me and worth living for are:

- 1.
- 2.

Adapted from: Safety Plan Template (2008) Barbara Stanley and Gregory K. Brown