



USAID
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GUIDELINES

for Remote MHPSS Programming
in Humanitarian Settings

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International Medical Corps

Address: 12400 Wilshire Blvd Suite 1500, Los Angeles, CA 90025

Website: internationalmedicalcorps.org

For any questions about this publication, please contact Claire Whitney at cwhitney@internationalmedicalcorps.org.

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About the Guidelines

What Is Remote Mental Health and Psychosocial Support (MHPSS) Programming?

MHPSS programming encompasses all elements of an MHPSS program lifecycle, from program design to program setup and management to service delivery to capacity building (training/supervision) to monitoring and evaluation, and program closeout. 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. Remote programming entails implementation of MHPSS program elements virtually or at a distance utilizing various technology (phone, radio, Internet, etc.).

Why Create Guidelines for Remote MHPSS Programming in Humanitarian Settings?

Before the COVID-19 pandemic, few comprehensive guidelines at the global level were available to guide MHPSS programming in geographically remote or inaccessible, low-resource settings. Often, humanitarian settings present significant security risks, are difficult to travel to or from, and have limited to non-existent mobile, landline or internet connections. The COVID-19 pandemic has highlighted the additional challenge of delivering in-person MHPSS services during movement restrictions and under infection control measures and the importance of adapting services to ensure continuity of care for vulnerable populations, including children, older adults, gender-based violence (GBV) survivors, and those suffering from severe mental health disorders and other disabilities. More comprehensive guidelines, tools and training materials on how to adapt or develop remote MHPSS programming in low- and middle-income countries would contribute to improved quality and quantity of remote MHPSS capacity building and service delivery. The guidelines were developed to address this gap and to help agencies and decisionmakers understand the key recommendations for implementing effective remote MHPSS programming in humanitarian settings.

How Were These Guidelines Developed, Enhanced and Evaluated?

In April 2020, International Medical Corps developed [Guidelines for MHPSS Staff Providing Tele-MHPSS to Clients during the COVID-19 Pandemic](#) to guide program teams in ensuring continuity of MHPSS services in such challenging times. The guidelines primarily targeted MHPSS program teams and service delivery, and outlined key considerations for providing remote individual support.

In 2021, International Medical Corps undertook a multi-country case study, evaluating MHPSS programs in Central African Republic, Iraq, Libya, South Sudan and Venezuela, where MHPSS teams had transitioned to remote MHPSS programming to varying degrees. The overall objective of the case study was to synthesize International Medical Corps' global experience and lessons learned from transitioning to remote MHPSS programming to inform revision and enhancement of the guidelines. The case study—conducted through 220 key informant interviews with International Medical Corps staff, frontline service providers (case

managers/psychosocial workers, psychologists, psychiatrists and mhGAP-trained healthcare staff), external stakeholders from community leadership and the Ministry of Health (MoH), and in-depth interviews with clients and caregivers—examined the following elements of remote MHPSS programming, which have been reflected in this edition of the guidelines:

- the specific adaptations made to MHPSS programming to ensure continuity of care, as well as factors that contributed to decisions taken on service adaptations;
- factors that enabled and prevented the transition to remote programming;
- the role of outreach in continuity of care;
- the benefits and challenges of remote service delivery, as perceived by service providers and clients;
- the effectiveness of remote service delivery on client well-being and functioning;
- specific considerations made for vulnerable groups in delivery of services remotely;
- adaptations, methods and overall experience with receiving and providing remote supervision; and
- adaptations made to delivering training and supervision remotely, and perceived effectiveness of remote training and supervision.

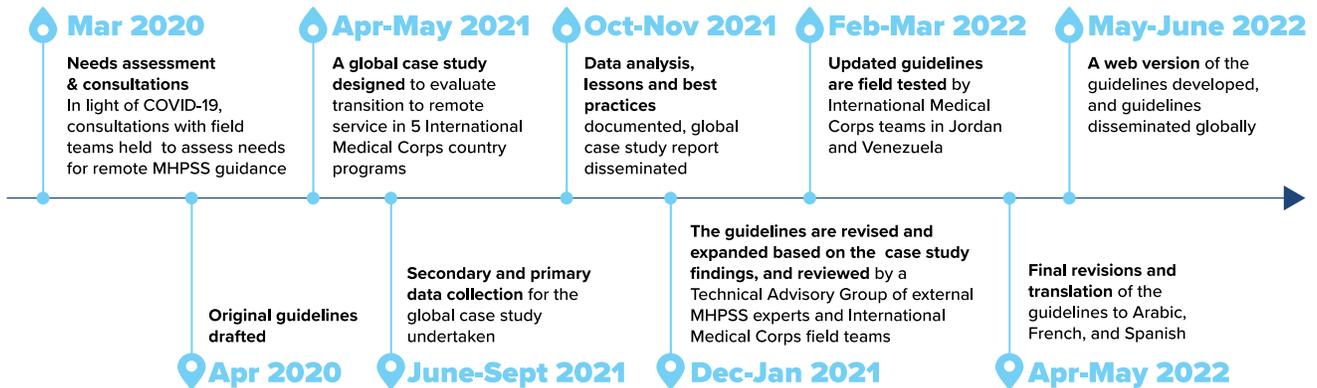
The findings and recommendations resulting from the multi-country case study informed the revision of the existing International Medical Corps guidelines to include all aspects of MHPSS programming, such as program planning and management, supervision, training and service provision. The guidelines were further enhanced to include a compendium of resources and tools to support implementation of MHPSS programming.

The draft guidelines were reviewed by external and internal stakeholders with expertise and experience in implementing remote MHPSS programming in humanitarian settings. The external reviewers included the members of the Technical Advisory Group consisting of MHPSS experts from the IFRC Reference Centre for Psychosocial Support (Dr. Michelle Engels); International Rescue Committee (Dr. Esubalew Haile); Médecins du Monde (David Tabbara); and Médecins sans Frontières (Dr. Gregory Keane); and Partners in Health (Dr. Giuseppe Raviola). In addition, MHPSS program staff from International Medical Corps' 10 country programs, including in Afghanistan, Central African Republic, Democratic Republic of Congo, Ethiopia, Jordan, Lebanon, Libya, South Sudan, Ukraine and Venezuela, provided technical review and feedback.

To further enhance the quality and ensure their practical application, the guidelines were field-tested by the International Medical Corps' MHPSS program teams in Jordan and Venezuela. The feedback from the reviews and field-testing were incorporated and the guidelines were finalized for translation into Arabic, French and Spanish, and broad dissemination among humanitarian aid actors. Refer to the graphic below for the timeline of guidelines development. The web version of the guidelines can be accessed via:

www.InternationalMedicalCorps.org/RemoteMHPSSGuidelines

Remote MHPSS Guidelines Timeline



Who Should Use These Guidelines?

Intended Audiences

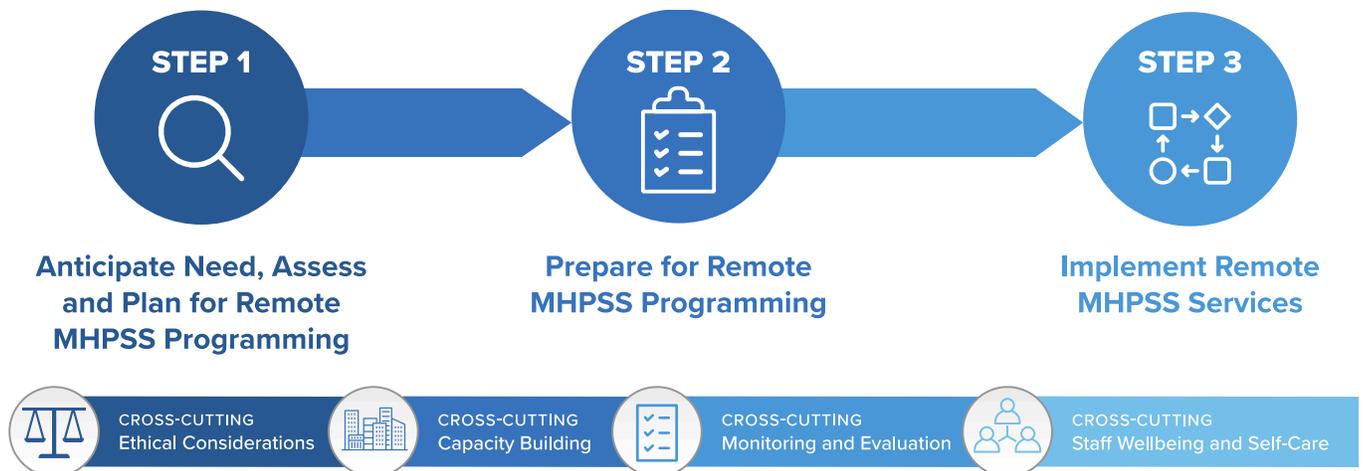
The guidelines are primarily intended for staff and service providers at agencies implementing MHPSS programming in humanitarian settings:

- HQ technical support teams
- Organizational leadership at the country level
- MHPSS program management staff
- MHPSS service providers and other frontline workers

The guidelines may also be useful for government actors and donors.

What Is Included in the Guidelines?

The guidelines provide a stepwise approach to remote MHPSS programming, with associated key guidance and resources that support each stage of programming. The steps are complemented by cross-cutting components, which highlight remote MHPSS programming considerations that need to be taken into account throughout the programming cycle.



What to Consider When Using the Guidelines?

While there are core steps and cross-cutting components that all agencies should consider, it is crucial to acknowledge that every context and experience is unique. For each situation, adaptations should be undertaken so that remote programming is tailored to (1) different existing capacities and human resources; (2) different systems and contexts; (3) cultural and linguistic considerations; and (4) specific needs and priorities that guide design and implementation of programming.

When and How to Use These Guidelines?

These guidelines can be used as early as the exploratory phase, when MHPSS program teams are considering the necessity and feasibility of implementing remote MHPSS programming and identifying the resources necessary for implementation. The guidelines can also be used throughout a project cycle of new MHPSS programs or to make adaptations to existing remote MHPSS programming. Each step of the guidelines corresponds to a stage in MHPSS programming and include:

- the what, why, when, who and how of implementing each step;
- sub-steps take make up each of the three steps to facilitate work planning and delegation of tasks among various team members;
- references tools in the appendices of the guidelines to support various tasks associated with each step;
- tips and experiences from the field to support practical application of the outlined steps;
- “Key Considerations” summarized at the end of each step that can serve as a high-level checklist; and
- “Key Resources” lists at the end of each step that provide links to guidance relevant to implementing the step.

Depending on your role in the program or the stage of implementation, you may choose to reference a specific step (and accompanying appendices) or read the guidelines in their entirety.

The sections on Ethical Considerations, Capacity Building, Monitoring and Evaluation, and Staff Well-being and Self-Care cut across all steps in the guidelines and should be referenced at each stage of MHPSS programming and by all stakeholders involved in the MHPSS program implementation.

Step 1: Anticipate, Assess and Plan for Remote MHPSS Programming

What?

This step is a building block for any remote MHPSS programming and ensures remote activities are intentionally designed; reflect contextual realities; and address the needs on the ground. **To anticipate** a need for remote MHPSS programming is to consider historical and current trends as well as likelihood of events that may necessitate remote modalities (e.g., public health crises resulting in movement restrictions, inaccessibility due to geographic remoteness or security risks, barriers to access to in-person services by clients/beneficiaries, etc.). **To assess** is to systematically collect and analyze data on the country background and context; existing government or global guidelines, infrastructure and resources, as well as needs and barriers to remote programming. **To plan** is to use the data collected from the assessment to make evidence-based decisions about remote MHPSS programming and line up the necessary resources for implementation. These processes should be participatory and include the community members and beneficiaries intended to be served by MHPSS programming.

Why?

Anticipating a need for remote MHPSS programming, understanding the need through an assessment, and planning for it reduce the surprise element and enable teams to effectively mobilize the necessary resources when the need arises.

When?

This step will ideally take place during initial program design phase, with assessments and plans for MHPSS programming revisited and updated throughout program implementation.

Who?

MHPSS management and/or lead focal points, supported by M&E, in collaboration with coordination mechanisms and other MHPSS actors.

How?

The following sections provide specific guidance on how to anticipate, assess and plan for remote MHPSS programming.

1.1 Anticipate the Need for Remote MHPSS Programming

In the design phase/program development of MHPSS programming, it should be anticipated that there may be a need, at some stage during the project, for remote programming and services. It is advised for MHPSS leads to conduct initial brainstorming and/or workshops to develop an initial and basic framework to include potential scenarios that would require remote programming or service provision. This initial brainstorming can inform the development of the assessment.

1.2 Conduct an Assessment to Inform Adaptation to Remote MHPSS Programming

Information from an assessment is needed to make evidence-based decisions about remote MHPSS program planning and design person-centered approaches. An assessment can help identify:

- **Barriers and opportunities** to providing or accessing face-to-face MHPSS services or capacity-building efforts.
- **Existing national guidelines and efforts** that support or prevent remote MHPSS service delivery.
- **Knowledge, attitudes, perceptions and needs** of clients, community members and service providers regarding remote MHPSS programming and their level of comfort working with remote technologies.
- **Actors currently working on mental health** at the national, regional and community level that need to be engaged to transition to remote MHPSS programming.
- **Capacity building needs** of staff, service providers and partners to facilitate effective transition to remote MHPSS programming.
- **Available and needed resources** at the organizational, community and national level to support the transition.

The assessment should include the following elements:

Assessment elements

- **Country-level analysis:** Undertake a quick assessment of existing policies and regulations, national MHPSS approaches and strategies, efforts and systems that may support or prohibit remote MHPSS programming. For example, are there laws or regulations on telemedicine? Does the national/local government stipulate when and how healthcare can be conducted remotely? Are government stakeholders ready and supportive of remote MHPSS programming? Have there been any relevant experiences? This analysis should also include identification of secure and accessible technological platforms to be used for remote service delivery, keeping in mind surveillance and technology bans by some governments as well as data collection and sharing by technological platforms.
- **Community-level analysis:** Conduct key informant interviews (KIs) or focus group discussions (FGDs) with community members and leaders, clients and service providers to understand their needs and concerns as well as barriers to access to remote MHPSS services. For example, do clients and their family members have the means to connect to services remotely? What existing resources can be leveraged (e.g., crisis or helplines to connect clients to services, private and safe community spaces for taking calls, etc.)? If KIs and FGDs cannot be conducted in person, consider collecting data remotely using the available technology. (Refer to the Resources List at the end of this section for guidance on remote data collection)
- **Organizational/program-level analysis:** Conduct an assessment of strengths and limitations in staff and service provider knowledge and capacity to implement and supervise remote programming. What resources, tools and training do they need to do their job effectively? Does the program budget accommodate acquiring additional resources to support the transition? A desk review of available training materials that have already been adapted and used in remote MHPSS training should also be conducted.
- **Mapping:** Identify MHPSS services available to clients and caregivers as some services transition to remote modality. 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. (See [Appendix A](#) for a 4Ws tool, which is designed to be adapted to the local context and includes guidance on mapping of existing resources).

[Appendix A](#) provides a comprehensive yet simple tool to guide the assessment process. The tool includes different frameworks to be selected based on the assessment type (country-level analysis, community-level analysis, organizational/program-level analysis, or mapping).

1.3 Develop Contingency Plans for Transitioning to Remote MHPSS programming

A number of expected and unexpected circumstances may necessitate a full or partial transition to remote MHPSS programming. Contingency planning enables teams to anticipate and put in place mitigation measures and resources before disruptions to programming and activities occur. In the context of MHPSS programming, contingency planning may include:

- Identifying scenarios that may disrupt face-to-face service delivery and overall programming (e.g., epidemics/pandemics, strikes, post-election violence, natural disasters, etc.).
- Assessing the likelihood and impact of each scenario (e.g., closure or destruction of health facilities, loss of clients' records and contact details, disruptions in referral pathways, disruptions in psychotropic medication supply chain, etc.).
- Planning a response for each scenario (e.g., having a second copy of the contact details of clients saved in a safe place, mapping of areas/affected population without access to in person MHPSS services, information sharing and coordination with partners, deploying trained response teams for remote service delivery, etc.).

[Refer to Appendix B](#) for a country-level contingency planning template, and the [Resources List](#) at the end of this section for additional contingency planning guidance.

Key considerations in anticipating, assessing and planning for remote MHPSS programming

- Staff or client willingness to transition to remote modalities should be actively inquired about rather than assumed.
- Program staff, service providers, clients, community members, partners, government and other stakeholders should be engaged in assessment and planning. In line with person-centered approach, the needs of the individuals intended to receive remote services should be at the center of decision-making, planning and designing remote modalities.
- Consider risks associated with collecting primary data in person and whether doing so would expose staff, community members and stakeholders to harm or jeopardize client confidentiality. (Refer to the Resources List for guidance on ethical standards of MHPSS data collection)
- Updated data should be used to complete the assessment. Global and national guidelines, national/local context (including security situation, disease control measures, etc.), needs/perceptions, availability of existing services are dynamic and program planning needs to reflect current trends.
- The national telemedicine policies and laws, if in place, should be taken into consideration and abided by, while adapting the guidance as needed. In contexts where these policies and laws do not exist, these guidelines should be used as the primary guidance, while taking into account normative practices, practicalities and what is acceptable within the cultural context.
- Additional financial and human resources for remote MHPSS programming may not be available at the time when remote programming is required, which should be accounted for at this stage.

Resources

- [IASC Assessment Guide](#)
(Refer to Section 4, Ethics and Principles for Using Mental Health and Psychosocial Support Assessment Tools)
- [Remote Data Collection During the Time of COVID-19: Lessons from Rwanda](#)
- [Operational Considerations for Multisectoral Mental Health and Psychosocial Support Programmes During the COVID-19 Pandemic](#)
(Refer to Sections 2.3 Considerations when Preparing Service Adaptations for COVID-19 Scenarios; and 2.6 Considerations for Remote Working in MHPSS)
- [IFRC Contingency Planning Guide](#)

Step 2: Prepare for Remote MHPSS Programming

What?

Preparation entails ensuring logistics, management and service provider teams and the communities are ready to design, implement and access remote programming.

Why?

Using remote modalities to deliver services is new for many people and requires time, investment, a holistic and strategic understanding of how to implement effective remote programming. In this step, use the information gathered from the assessment stage to advocate for the transition to remote services and for the necessary resources to implement the transition; undertake administrative, programmatic and logistical preparations; and prepare staff and other stakeholders for undertaking remote programming.

When?

Preparations should happen after the contingency planning and assessments have been completed. The assessment results should guide the preparations and adaptation of services and requisite resources.

Who?

Program leads, supported by senior management, human resources, finance and administration, MHPSS focal points and service providers.

How?

The sections below outline administrative and managerial, service provision, training, and community and beneficiary sensitization-related tasks that need to be undertaken to prepare for remote MHPSS programming.

2.1 Prepare for Administration and Management

2.1.1 Staff Sensitization

- Organize discussions with program staff to present the findings of the assessment and to advocate for the importance of remote programming.
- Run interdepartmental workshops to review and adapt contingency plans as necessary in transitioning to remote programming and service provision and incorporate all relevant and up-to-date contextual factors (e.g., changes to the security situation, government policy).

2.1.2 HR and Staff Care

- Sufficient staffing levels should be planned, budgeted and recruited for remote programming.
- Work with HR to conduct orientation sessions on any changes or updates to HR processes and policies for staff.

- Conduct a training or orientation session for staff with practical tips and advice on how to effectively set up and manage remote programming, working from home or in isolation, e.g., time management, the importance of taking planned breaks, exercise and diet, stretching routines for those not used to sedentary working practices, planning the schedule for a work day from home, and setting personal/professional boundaries.
- Work with HR to update staff-care policies and practices to ensure sufficient support for staff, adapted to remote programming and the situational context.

2.1.3 Funding and Other Resources

- Advocate for the need to reallocate funds or secure new funds to provide effective remote services, which may necessitate communication with the donor about staffing levels; procuring means of remote communication to be supplied for staff, including service providers, and clients (laptops, phones, internet data, solar chargers, loudspeakers, etc.); and funding activities to support remote service delivery such as setting up mobile units, hotlines or conducting radio and TV broadcasts.
- Staff, including service providers, should be provided with the most appropriate means of communication and technology—e.g., access to platforms, using separate devices such as phones and laptops for work and not personal items, and internet/phone connection—and know how to use these technologies.
- Confirm service providers have confidential spaces to work from and can protect client privacy when connecting with them remotely. If working from home is not conducive to service provider and client privacy and confidentiality, an alternative space should be made available to the service providers.

2.1.4 Recordkeeping and Data Storage

- 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, clear protocols and procedures for keeping paper files while working remotely should be established (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.
- [Refer to recordkeeping and data storage for additional guidance.](#)

2.1.5 Cybersafety

- Data privacy is paramount and should be continuously prioritized.
- 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. One cannot exist without the other.

- Tips to increase security:
 - 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.

2.2 Prepare for Service Provision

- Service providers and their supervisors should be engaged in all stages and steps of preparation for remote services, and provide their input on the necessary resources, capacity building needs, and the needs of clients.
- Update service mapping with information on the context and situation, websites and measures by the authorities and available services. This should include information on how to contact health authorities, as well as contact details of health and mental health services. Continually review and update this information and make it available to all staff.
- Based on the updated mapping, put in place procedures for when and how to refer persons with significant psychological distress or mental, neurological, and substance use (MNS) conditions. Where referral options are not available a plan for providing support for this group as well as handling suicidality and other emergency cases should be developed. These plans/procedures should be written down and shared with all staff ([Refer to Section 3.7. Understand risk and manage emergency](#)).
- Plan for client and community sensitization on availability of remote services, including when and how to access them and prepare to address access-related and other concerns ([Refer to Section 2.5. Prepare Clients and Communities](#)).

2.3 Prepare for Training

- All service providers and their supervisors should receive specialized training on adapting their skills to remote delivery. [Reference Section Cross-Cutting Component: Capacity Building for additional guidance on remote training.](#)

2.3.1 Adapt Training Materials and Tools

- Based on the assessment conducted in Step 1.2, make further adaptations to the identified training materials and tools, as needed, including for cultural and contextual factors as well as revisions of technical content, such as how to adapt clinical skills and competencies to fit remote service provision.
- Consult with MHPSS trainers, experts, supervisors, potential participants and other stakeholders for technical review before finalizing training materials.
- Adapt training feedback form, examination and monitoring and evaluation tools for remote use, incorporating sections for feedback on the remote training modality and how it could be improved.

2.3.2 Choose and Set up Appropriate Means of Information and Communication Technology

- Choose platforms that are secure and accessible to participants and free to use (e.g., Skype, WhatsApp, Signal, Telegram, Viber, Zoom, Microsoft Teams, phone call), which also facilitate participatory activities and smaller group discussions (breakout rooms, whiteboards, etc.).
- Spend time familiarizing yourself with the advanced features of the platform so you can provide technical support to the participants if needed.
- Ensure reliable and stable internet connection, with a back-up option available, if possible.
- If possible, use additional hardware to enhance the quality of communication, e.g., external camera or microphone with higher quality definition.

Tips for Boosting Your Internet Connection

- Involve clients and caregivers in the design of remote service delivery, and prepare contingency plans for those clients unable to receive service remotely.
- 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.

2.3.3 Identify Trainers and Secure Additional Support

- Identify trainers, preferably with experience in remote modalities - to undertake a training of trainers (ToT) in remote MHPSS service delivery.

- Facilitating remote training, especially for large groups of participants, can be difficult to manage alone. If possible, consider asking for additional support in facilitation for managing technological difficulties, screening questions and/or conducting some parts of the training.

2.4 Prepare for Supervision

- [Reference Section Cross-Cutting Component: Capacity Building for additional guidance on remote supervision.](#)

2.4.1 Set Up the Supervision Relationship

- Decide if you are going to offer 1-on-1 supervision or in a group.
- If possible, match supervisors and supervisees who have complimentary personality traits, or who have established rapport so that you can build a positive and supportive relationship within the remote supervision framework.
- If possible, at least one face-to-face meeting between supervisors and supervisees should be arranged, to enable them to get to know each other and discuss the goals of supervision, which remote technologies to use and when to use them.

2.4.2 Define the Type of Supervision

- **Administrative Supervision** focuses on reviewing the supervisee documentation, recordkeeping and addressing logistic and administrative problems happening in the program including starting systems, advocacy and creating referral networks.
- **Clinical Supervision** focuses on the development of a supervisee's clinical role, skills, competence and confidence in caring for someone with an MHPSS problem.
- **Note:** Both can occur remotely but be clear which one you are doing and design sessions according to the goal. If these roles are combined in one person, mitigation measures should be put in place to prevent any potential conflict of interest and ensure clinical supervision remains a supportive space.

2.4.3 Set Boundaries, Clarify Expectations and Identify Means of Communication

- Prepare to set boundaries for supervisors and supervisees, encouraging all parties to think and plan when they will be available (only during business hours vs. as-needed) and how they will deal with emergency calls and situations.
- Identify remote technologies to which both supervisors and supervisees have regular access, ensuring supervisees feel confident about using them. Offer the supervisee some training on the chosen technology, if necessary.
- Plan for supervision sessions that focus on promoting positive well-being among the supervisees. For example, working remotely can be isolating so organize social events and support the supervisees to engage in activities that promote mental health and well-being.
- Set a timeframe for evaluation of the selected supervision strategy and be prepared to redefine supervision approach if necessary.

2.5 Prepare Clients and Communities

- Organize workshops/conversations with communities/community leaders/peer support groups/healthcare providers/families and individuals about the need to move to remote service delivery.
- Explain what is meant by remote service delivery and how it will be organized, clarifying the necessary conditions for remote delivery (e.g., availability of private and confidential spaces for both the provider and client; connectivity; access to phones and other technology).
 - Be prepared to answer questions about the lack of resources to engage in remote services and what alternatives, if any, will be provided.
- Emphasize that engaging in remote services is voluntary, and that confidentiality will be prioritized as before. To allay potential concerns, specify what safeguarding measures are in place to protect confidentiality (Be very explicit as to pre-emptively address potential resistance, as distrust around technology is common).
- Explain how they can access remote services, why it is important that they access remote services.
- Identify if any clients or their families need orientation on how to use or access technology to connect to remote services.

Key considerations for preparing for remote MHPSS programming

- Involve clients and caregivers in the design of remote service delivery, and prepare contingency plans for those clients unable to receive service remotely.
- Communicate the need to transition to remote or hybrid modality to all stakeholders consistently, and as soon as possible.
- Broadly disseminating information about remote services may generate more demand than the program can currently meet. Manage expectations when raising awareness about remote services.
- Engage donors throughout the process to obtain buy-in and approvals for necessary program scope modifications and budget realignments. Advocate for the need to reallocate funds or secure new funds to provide effective remote services.
- Equip service providers and supervisors with the needed skills, ensuring they operate in a safe and confidential environment before transitioning to remote service delivery.
- Update service maps and referral pathways, ensuring protocols and procedures for managing clients with significant psychological distress or MNS conditions as well as handling emergency cases are adapted to remote modality.

Resources

- [IFRC guide on Supportive Supervision during COVID-19](#)
For special consideration for remote supervision refer to [page 12](#).
- [IFRC guidance on Online Facilitation in Mental Health and Psychosocial Support](#)
For guidance on facilitating remote training to enhance the learning outcomes for participants combining technical skill with social-emotional learning.

Step 3: Implement Remote Services

What?

MHPSS services can be provided using remote or partially remote modalities. These can include, but are 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 and facilitating referrals.

Why?

Remote MHPSS services can be provided due to individual choice or necessity due to contextual circumstances. Examples of such situations include poor security or conflict-related dangers of travel; expense or distance of travel; travel restrictions, such as those imposed by governments to reduce the incidence of communicable diseases; physical disability limiting travel options; and protection-related issues, stigma and other cultural barriers.

When?

Face-to-face MHPSS service provision may transition to remote delivery or remote services may be the first choice due to contextual factors (e.g., public health emergencies or security risks) or personal choice, as agreed upon between service provider and client.

Who?

Program leads, MHPSS focal points, MHPSS trainers and supervisors and service providers.

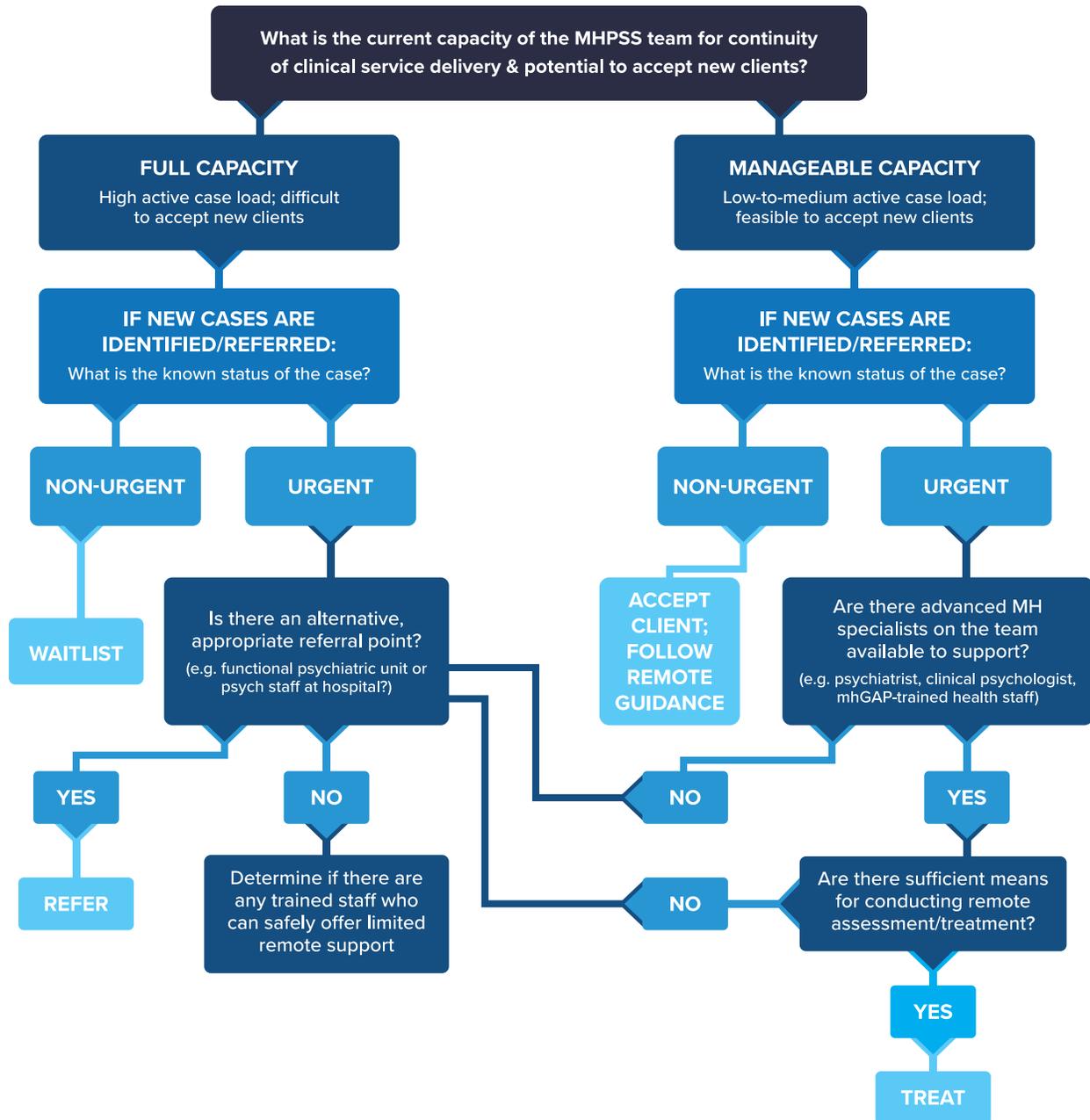
How?

This section outlines the steps to be taken when implementing remote MHPSS services.

3.1 Undertake Awareness Raising and Outreach

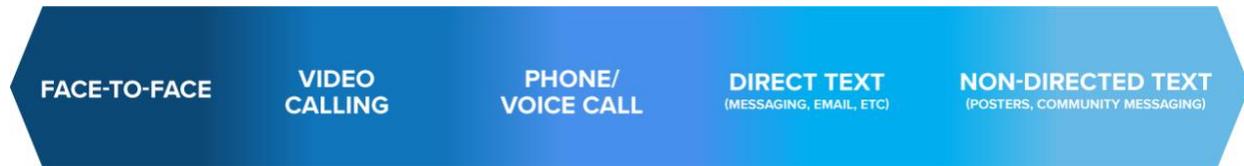
- Consider using innovative means for the provision of awareness raising and outreach. Include these in the contingency planning stage and adapt as necessary based on the situation which requires remote programming.
- Outreach workers should share contact details for services and referrals within the community and in all MHPSS service entry and referral points. If necessary, provide orientation to identified referral focal points, such as healthcare providers, teachers, police.
- Consider using the available means of communication for awareness raising, such as social media, hotline/helpline, messaging services, radio, newspaper and television.
- Develop additional information, education and communication (IEC) materials for dissemination in service entry points, such as posters with updated information on how to contact remote MHPSS services or tips and techniques for managing stress.
- If possible, appropriate and with the consent of the recipient, use a postage service to send materials directly.

Note: Broadly disseminating information about remote services may generate more demand than the program can currently meet. Manage expectations when raising awareness about remote services. Use the following case-load decision tree to determine if your team might be able to accept new clients, working with a supervisor to determine whether you are at full or manageable capacity.



3.2 Identify Appropriate Modalities for Remote Support

The Spectrum of MHPSS service modalities



Modalities of communication that provide the richest amount of detail (i.e. verbal and nonverbal communication) and live opportunities for exchange of information are the most effective. For remote support multiple communication methods are often useful and can strengthen the quality of the interaction, for example video calling a client after arranging a time over a messaging service such as WhatsApp (ideally a business account to enforce professional boundaries) or Viber, or following up on a call with materials sent to a client via email. The method used may vary from client to client taking into consideration issues around privacy, familiarity, availability of the modality, access to a functioning network/internet connection and literacy, including IT literacy. Video and phone calls should not be recorded as a way of documenting consultations.

If possible, consider using a hybrid modality, utilizing in-person and remote modalities as appropriate. If a hybrid modality is to be used, consider meeting in-person for initial sessions in order to establish the relationship and build rapport, moving to remote modalities in consultation with a supervisor and taking into account client needs. [See Section 3.3 for guidance on client considerations for remote support.](#)

Staff should adhere to the principles of 'Ensuring Privacy' when conducting calls or communicating with the clients via other remote means outlined below. [Refer to Cross-Cutting Component: Ethical Considerations for more details.](#)

3.2.1 Video Calls/Conferences

- Select the most secure and viable platform and create a separate work account, ideally on a work device and not on a personal phone or computer. Remember the importance of online security and safety.
- Where possible it is recommended to conduct the first session in person. If not, it is recommended to conduct the first remote support session over video if the client feels comfortable doing so (invite the client to share while emphasizing that is optional and there is no pressure to turn on video).

Verifying client and service provider identity

At the beginning of every remote MHPSS session:

1. Verify that the person you are speaking to is the correct person.
2. Let the person know that you are the correct service provider.

Do this by:

- Asking for their full name and verifying information such as date of birth, place of residence, father's name or family name.
- Give your name and role to the person and lay out expectations and goals from the session to ensure that you are both expecting the same things.

At the end of the session:

1. Explain that you will only contact the person at the times and dates you have both agreed to. If anyone else contacts them claiming to be from the team they should treat that communication with distrust and ignore.
2. In case of an emergency, agree on a plan for contacting each other and stay in touch in a way that suits both parties.
3. If the client wants to contact the service provider, explain your availability and the working hours of the service and communicate within those hours (except in the case of emergencies).

- Staff should follow clients lead when choosing to share their video, i.e. if a client selects to show their video then the staff member should do the same. Where this is not considered appropriate or is uncomfortable for the staff member this must be discussed with their supervisor.
- Video calls can compromise call quality if the internet connection is poor. In these circumstances verbal communication should be prioritized and services providers should revert to voice or phone calls.
- If the internet connection allows for video calls, then service providers should feel confident using verbal communication, looking out for nonverbal communication cues and, if helpful, use visuals such as holding up charts or visuals about different treatment interventions (such as diagrams from Self Help Plus or PM+ manuals) to enable the clients to engage fully with the support being offered.

3.2.2 Phone Call

- Where possible, staff should use work phones and, if at all possible, should not share their personal numbers, so that professional boundaries and confidentiality can be respected.
- Client's identity should be established at the beginning of every call. If there are additional privacy concerns, consider agreeing on a safe word or pass code with the client.

3.2.3 Text Messaging

- Providing support to clients over directed text (i.e. text messaging, email) is most appropriate for agreeing on times to talk and sharing information from an approved source to reinforce the content of support provided over phone or video conferencing.

- Where a client cannot use phone or video conferencing options, directed text can act as a back-up for checking-in with your client.
- Directed text is not recommended as the only method of remote support, particularly for high priority clients.
- If the clients are not literate then do not rely on text messages and use voice calls instead.
- In exceptional circumstances where the client requests support but cannot use voice or video calls, for example due to privacy or protection concerns, text messaging can be used. Ensure and confirm with the client that all messages are deleted immediately after the conversation/session has ended. Service providers should do the same.
- No confidential or sensitive information should be shared in a text message. For example, no identifying information about the person, their family or their presentations.

3.2.4 Voice Notes

- Voice notes can be used in the same way as text messages and can be used to send reminders to clients about adherence to medication, or to remind clients of psychosocial interventions such as breathing or body scans, goal setting and more.
- Where literacy levels are a problem, then voice notes can be used to send clients reminders of the dates and times of sessions
- However, it is important to note that they are used as an add on to the remote care and not a replacement. For example, sending a voice note cannot be recorded as providing an MHPSS consultation.
- No confidential or sensitive information should be shared in a voice note.

Stored information over text or email or voice note could present a risk to client confidentiality. Staff should not send any sensitive information to clients over directed text. The risks present in using directed text should be discussed with the client and agreement made about whether the staff member should use this method, what type of information if any can be sent and storage or deletion of information.

A reminder on promoting cyber safety:

- Remember to use platforms that ensure authentication.
- Ensure the platforms have end-to-end encryption.
- Keep the machines clean and ensure all laptops, tablets and phone are regularly updated and use the most up to date operating systems.
- If there is any communication from unknown sources or emails/messages seem confused, from strange numbers or email addresses then delete it.

3.2.5 Limited Communication Options

Where a client has no access to any remote communication methods, the case should be discussed with a supervisor, identifying how the level of prioritization of the client and your service capabilities for seeing that client face-to-face on a reduced schedule in a way that maintains the client's and service provider's safety. [See the next section for further guidance.](#)

3.3 Review Client Considerations for Receiving Remote Support

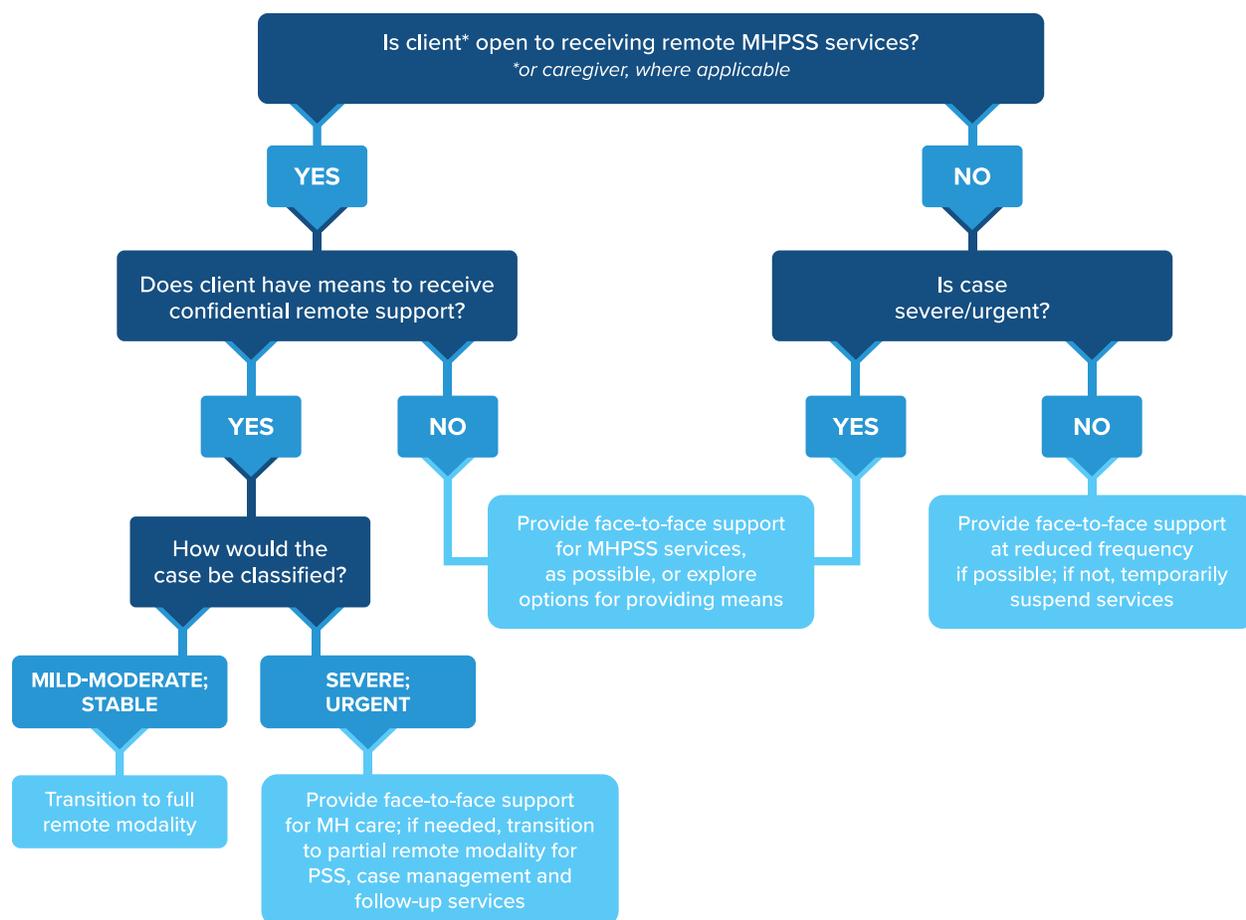
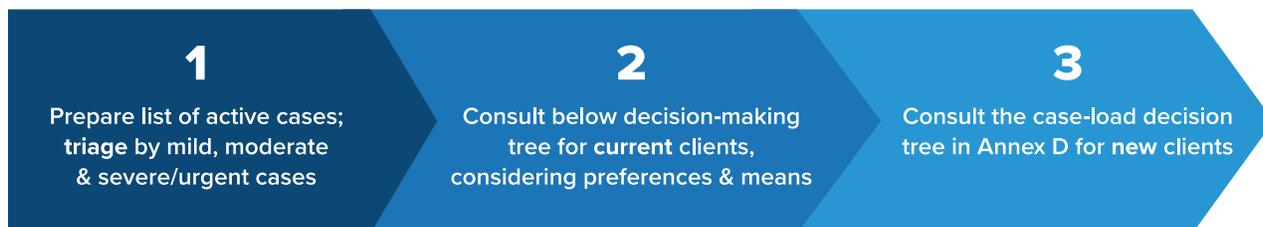
In consultation with a clinical supervisor, all MHPSS service providers should prepare a list of their **active cases**, organizing them by stable (mild to moderate conditions) and severe/urgent cases, to better assess cases that can be shifted to remote modality, and those that should continue to receive in-person sessions.

| Examples of Stable, Mild-Moderate Cases | Examples of Severe, Urgent & Complex Cases |
|---|--|
| <ul style="list-style-type: none"> • 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 | <ul style="list-style-type: none"> • 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) |

All clients should be contacted, 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). To review key considerations working with children and adolescents, [see Appendix C](#).

The following decision tree for active cases can support efforts to reflect upon key client considerations for potentially receiving partial or full remote MHPSS service delivery:

Review client considerations for receiving remote support



3.3.1 Considerations for Screening Clients for Remote Support

- 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?

3.3.2 Additional Considerations during Public Health Emergencies for Client Prioritization

- People in medical isolation units;
- People who are isolated and without an adequate support system or those with supportive networks that have the potential to be harmful;
- People with severe pre-existing mental health conditions who develop significant health symptoms.

Experience from the field

Based on the International Medical Corps 2021 global case study evaluating transition to remote MHPSS programming during the COVID-19 pandemic, supporting the following types of clients and conducting the following types of MHPSS services were found to transition more naturally to remote services whereas in other scenarios it was more challenging.

Less challenging transition to remote support

Clients: Existing clients; clients with mild-to-moderate MNS conditions; clients who have been previously assessed in-person for medication prescription.

Services: Follow-up sessions with existing clients; psychoeducation; and simple counseling interventions for mild-to-moderate cases.

More challenging to support remotely

Clients: New clients, including those requiring psychiatric evaluation; clients with severe and complex conditions (e.g., active suicidality/self-harm or psychotic symptoms); children; clients with no privacy (including GBV survivors); deaf clients or those with hearing impediments.

Services: Crisis intervention, assessment of new clients (especially without video-capable technology to allow for observation), medication prescription for new clients, advanced counseling interventions; other specialized techniques.

Clients who may face challenges effectively accessing remote support should be discussed with a supervisor, and appropriate arrangements should be made. Where feasible, the arrangements should include support to accessing available services identified during the mapping and referral pathway exercise, and according to emergency management and referral protocols. In addition, if a person is not suitable for remote support, consider providing additional remote support and guidance to the caregiver or family member ([See Section 3.8 for further details](#)).

3.4 Conduct Remote Intake

Traditional procedures for conducting an intake session should be modified when transitioning to a remote modality. A sample checklist that outlines each of the key steps and considerations in providing remote support is presented in [Appendix D](#), and should be adapted and made available to all staff delivering remote support.

3.4.1 Collaborative Agreements

All agreements about when and how to hold remote support sessions should be established in collaboration with the client. The agreement must include consideration of:

- Establish and document consent to receive remote services and conditions of confidentiality (via consent form).
- Modality of contact.
- Time, date and duration of contact.
- Confirmation that both helper and client will take the call in a private, confidential space (unless a caretaker/family member's presence is requested).
- If reminders are necessary and how they should be given, for example by text message, email or phone call.
- Who should initiate the contact.
- What to do if a client does not call/respond to a call at an agreed time.
- What to do if there is a network failure and a call is cut off/not able to be made.
- What to do if there is uncertainty of the identity of the individual who responds using the client's device/platform account.
- Procedures for coordination of care among multiple service providers as part of MHPSS team.

Tips for establishing client identity during remote sessions

Involve clients and caregivers in the design of remote service delivery, and prepare contingency plans for those clients unable to receive service remotely.

- When calling a client withhold the reason for your call until you have established you are speaking with the correct person.
- Consider agreeing on a password to ensure the correct identity, especially if video calls are not possible.
- Postpone the appointment if you cannot establish the identity of the responder.

3.4.2 Registering New Clients

- A system should be in place to confidentially issue a unique identification number for the case and avoid using names or other identifying information.
- Staff should have access to and complete the relevant documentation package when registering new clients.

- If staff have access to an organizational laptop they should complete an electronic copy of the relevant documentation package and store the copy securely ([see principles of data protection and recordkeeping sections](#)).
- If staff do not have access to an organizational laptop, they should have access to printed copies of the relevant documentation package and store completed forms securely ([see principles of data protection and recordkeeping sections](#)).

Communication skills in remote service delivery

The fundamental principles of good communication should be adhered to during remote support as they would in face-to-face contact. Whether or not to talk or communicate using one of the remote methods is the client's choice. As with all interventions and approaches a client should never be forced or pressed to share their feelings or concerns.

A person-centered, empathic, non-judgmental and collaborative approach in which a service provider uses all their skills of active and reflective listening, open, closed and clarifying questions, and regular summaries, are essential to provide effective support. The service provider should also endeavor to ensure that non-verbal communication that would be noted in a face-to-face session is verbalized on a remote call. For example, the client should be encouraged to describe their feelings and sensations (e.g., "I felt my temperature rise, and I closed my fists when you mentioned that").

For tips on adjusting communication skills to remote delivery consult [IOM Internal Guideline for Remote MHPSS Working Modalities](#) (pages 8-13).

3.5 Make Referrals and Follow-up

3.5.1 Referrals

- Service mapping, referral pathways and contact details should be kept up-to-date.
- Liaise with MHPSS and other sectors coordination bodies for updated service mappings and referral pathways developed externally.
- If [interagency referral forms](#) are being used, updated templates for remote referrals should be used.

3.5.2 Follow-up

Checking In

- Check-in can occur through messaging, phone or video calls to briefly touch base with clients in between scheduled and routine follow up sessions.

Scheduled and Routine Follow-up Sessions

- Verify that you are talking to the correct person and in a remote modality that suits them. Make sure you verify with the person that you are the correct service provider as well by introducing yourself and your role, verifying the person's name and any identifying information. Discuss what can be expected from this session.
- During follow-up, it is important to establish whether or not there has been any major change in their mood or situation.

- Has their well-being deteriorated and should they be considered for face to face support and/or a referral to specialized care?
- Have they improved? If so, should their treatment be modified?
- Do they need any referrals to support their recovery needs?
- At the end of the follow-up sessions agree on a time and date for the next follow-up session but explain that in between that time they can contact you on your professional numbers during working hours.
- Agree with them if you will use any check-in methods to support their needs such as text messages, voice notes or calls.
- In the case of people whose wellness has deteriorated, work with family members and caregivers, based on the previously established understanding and agreement with the client, to ensure that they receive the support they need.

3.5.3 Referrals

- Discuss which referrals are recommended or available to the person during a follow-up session.
- If the client consents to be referred then explain what to expect from the referral process, including how long it will take, how they will be introduced to the new service, what is required from them and how to support them to engage with new services.
- Describe to the client how you will follow up on those referrals during follow-up.

If the transition to remote MHPSS services has occurred due to a temporary but necessary scale-down of face-to-face services, referrals to local face-to-face social and health organizations can be very helpful to keep clients engaged until a time that face-to-face support can be reinstated.

Referrals to local social and health services can also be useful as part of creating a person-centered and holistic package of care.

3.5.4 Closing Cases/Discharge

- If after regular follow-up the client has demonstrated improved well-being and functioning, and treatment goals have sufficiently been achieved, consider closing the case and discharging the client from the service.

3.6 Manage Medication

- 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. In case of lack of any SOPs for managing psychotropic medications (including controlled drugs), develop them in collaboration with all relevant departments.
- Procedures should include:
 - Prescribing psychotropic drugs (electronic generation/paper);
 - Procurement (e.g., mail-order pharmacies); and
 - Distribution and handling (e.g., clinic, pharmacy and/or home visits).

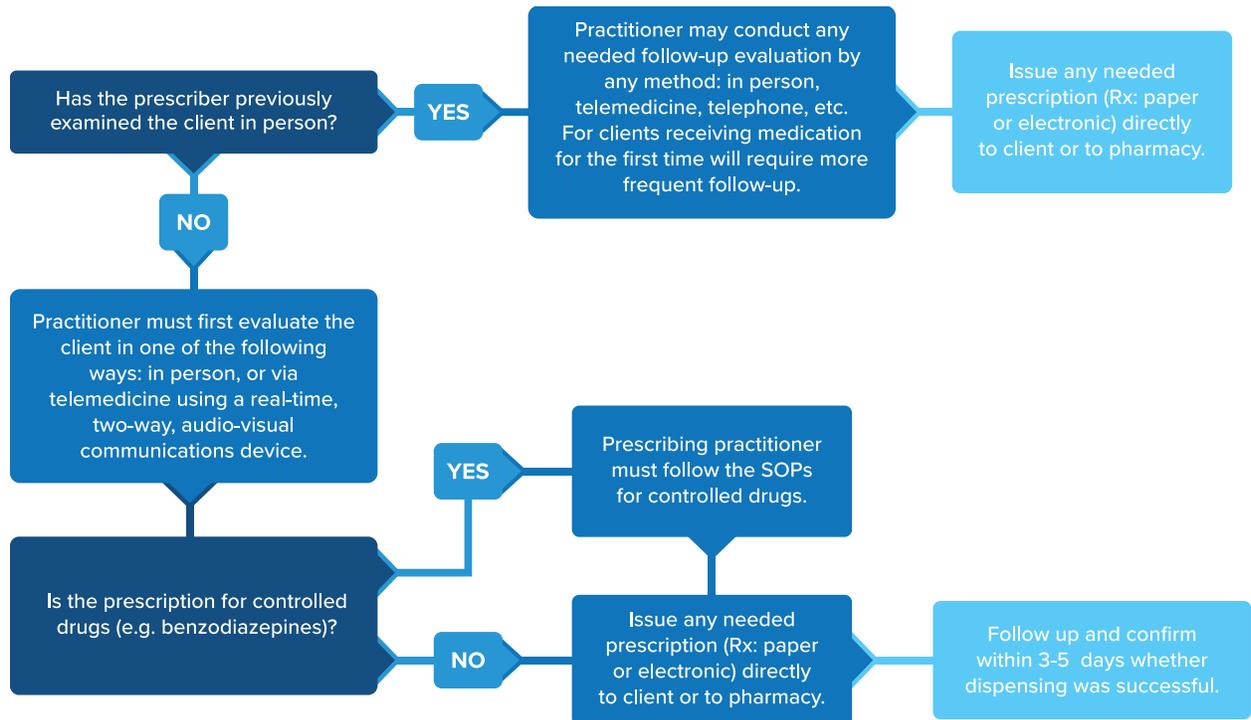
- Circulate the new/adapted SOPs to all service providers and conduct brief orientation, if needed.
- The prescriber should be aware of the availability of specific medications in the geographic location of the client and should inform about existing prescribing choices. Clients receiving treatment through remote MHPSS services should have an active relationship with a prescribing professional in their physical vicinity.
- Consider extended prescription duration (>1 month, but no more than 6 months) for MNS clients with stable conditions and based on their needs and context. (For more information, please see the [IASC Guidance on Operational Considerations for Multisectoral Mental Health and Psychosocial Support Programmes during the COVID-19 Pandemic, 2020](#).)
- 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 (see the box below for further guidance). 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.
- Optimal clinical management of clients can be achieved through a multidisciplinary treatment team. This should be discussed with all clients and consent should be sought. The service provider should arrange for regular communication with other professionals involved in care for the client. In settings where clinical staff are not immediately available, collaborative relationships with local community workers should be developed as these professionals may be invaluable in case of emergencies.

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.

Reference the chart below for the recommended steps on prescribing psychotropic medication to clients during remote service delivery.

How to Prescribe Psychotropic Medication to Clients During Remote Service Delivery



3.7 Understand Risk and Manage an Emergency

- Decisions on managing risk must be made in accordance with updated service mapping and any relevant national or organizational emergency protocols. If clarification is needed on these procedures, and for technical consultation, a supervisor should be consulted.
- When working with clients who are likely to be vulnerable because of their psychological state, protection-related environment, physical isolation, or being a member of a marginalized group, risk should be assessed early to promote their safety and consider their ability for effectively, confidentially receiving remote support.
- In accordance with standard organizational procedures and the confidentiality agreement signed upon intake, clients should be aware of the limits of confidentiality and that their information may be shared with other relevant parties if they are determined to be a risk to themselves or others. Client should be informed prior to breaking confidentiality by service provider.
- If the service provider identifies and/or a client expresses that they are in a situation that presents a risk to themselves or someone else, efforts must be undertaken to identify their whereabouts and conduct crisis intervention.
- Risk should be assessed using appropriate risk assessment and safety planning tools, develop a safety plan and encourage the client to seek support from the nearest available emergency mental health service provider identified in your service mapping.
- Upon determining the need for urgent care, to provide care in person and follow the mhGAP guidelines.

- If it has been identified that the client may be unable to access emergency services (i.e., due to movement restrictions put in place) this should be discussed for preparedness, including the establishment of a safety plan identifying how support can be sought from other services friends or family, in line with national and organizational protocols.
 - If possible, provide additional remote support for caregivers ([see dedicated section with additional information](#)).
 - Educate the client and caregiver on when to seek urgent care (mhGAP-HIG curriculum) and bring the client to a health facility.
- Once a client has stabilized following an emergency situation, they should still be considered high priority and provided with regular follow-up.
- If an emergency has occurred and the safety plan has been used, once the client's condition is stabilized, review the effectiveness of the safety plan and make adjustments as needed based on the experience.
 - Consult a specialist/supervisor and refer for further specialized care (e.g. refer to hospital).

3.8 Support Family Members and Caregivers

In certain situations, it may not be possible to provide remote services directly for clients, for example in emergency situations, if the client is a child, or presently does not have the cognitive ability to receive remote services, or if the client is a person with intellectual disability. In such situations, make a referral to the most appropriate external service provider and keep in close contact with the caregiver, provide practical tips and advice for managing the situation, managing their own stress, normalizing their feelings and provide counseling if necessary.

If possible, prior to beginning remote service delivery, consider developing a comprehensive treatment and follow-up plan, such as Wellness Recovery Action Plan (WRAP) ([See the Resources list at the end of this section for guidance on WRAP](#)) in collaboration with the client and caregiver, including specific considerations and action points for the caregiver to take in case of emergency or other situation where support is required but not suitable for the client directly.

Key considerations for implementing remote services

- Remote services should be available in multiple modalities, and both providers and clients know how to engage with services in all formats.
- Customize approach to each client's needs, situation (risks, access to private spaces and technology, etc.) and preferences.
- If possible, conduct an initial session with new clients in person to establish rapport and trust before transitioning to remote services.
- Confirm client identity at the beginning of every remote session.
- Call or send text reminders to clients in advance of remote appointments, to prevent missed appointments.
- Educate clients and families on how to engage with remote services, including using psychoeducation for families and caregivers to help them understand their role in supporting clients in receiving services remotely.
- Obtain client feedback on an ongoing basis and make adaptations to remote delivery as needed.
- Discuss and troubleshoot with supervisors the challenges encountered with remote service delivery, such as logistical problems and challenging client interactions.

Resources

- [IOM Internal Guideline for Remote MHPSS Working Modalities](#)
For guidance on adapting communication skills to remote modality, reference pages 8-13.
- [IFRC guideline on suicide and self-harm in relation to COVID-19](#)
For guidance on managing risk, refer to pages 25-29.
- [Operational Considerations for Multisectoral Mental Health and Psychosocial Support Programmes During the COVID-19 Pandemic](#)
Reference Chapter 2 (p. 15) for guidance on Medication Management.
- [WHO Quality Rights self-help recovery tool for mental health & well-being](#)
- [Copeland Center for Recovery and Wellness Guidance on WRAP](#)

Section 4 Cross-Cutting Components

4.1 Cross-Cutting Component: Ethical Considerations

All staff must adhere to the laws in place in their area of work, their organizational/institutional code of conduct and any quality standards, safeguarding policies, as well as their relevant professional code of ethics when providing services to clients regardless of whether they are provided face-to-face or remotely, from home or a service delivery point.

The rights and priorities of the client must remain paramount and considered at all times. The core concepts of informed consent and self-determination, confidentiality and privacy, recordkeeping and competence require additional attention. Specific recommendations on expectations for the provision of remote MHPSS are outlined in the [Confidentiality Agreement in Appendix E](#). All staff providing remote MHPSS services must read and sign the Confidentiality Agreement.

4.1.1 Informed consent

- Whether the client is new or has been receiving services and will transition to face-to-face care, a consent form to receive remote support should be provided and signed prior to commencing remote care. Clients should be informed of the decision to provide remote support and the reasoning should be explained, with space to ask questions. Where possible these discussions should be provided during a face-to-face prior to the measures being implemented. [See Informed Consent Form for Remote MHPSS in Appendix F](#).
- When presenting remote support as an option to provide ongoing care, the different modalities available must be discussed, including any related privacy issues.
- Clients must verbally agree to receiving remote support over an agreed modality. If the client agrees, then this agreement must be documented. Preferably an agreement should be documented on an informed consent form signed by the client ([see Appendix F](#)). Where this is not possible, the staff member must read aloud the content of the informed consent form and make a dated note of the verbal agreement using client codes rather than names and store this record of consent securely. If the client is a minor or has a caretaker due to a severe MNS disorder, the caretaker must provide the consent.
- Clients (and/or caretakers, where appropriate) must be informed that they have the right to withdraw their consent to treatment at any time.
- Respecting clients' rights includes discontinuing services if refused, or discontinuing the remote modality of services and resuming face-to-face services when possible. If a client doesn't feel comfortable receiving remote support and/or doesn't give their consent, make sure that they are aware on how they can contact the team to request services at a later time. Clients should have access to the phone number of their MH focal point, and any hotline set up for the project, or contacts of other services that the team is made aware of.
- For children or others who do not have capacity to provide consent, their caregiver must agree to giving consent on their behalf in line with the steps described above.

- If sessions are to be audio or video recorded with the client’s consent for the purposes of supervision, an informed consent form detailing this must be signed ([See the Supervision section for further details](#)).

Possible reasons of refusal of the remote model and how to address them

| Reasons | Suggestions to address them |
|--|---|
| Clients who believe that they can’t express themselves adequately in the remote mode | <ul style="list-style-type: none"> • Mention the benefits of remote service delivery • Address any misconceptions related to it |
| Individuals with sensory or physical disabilities | <ul style="list-style-type: none"> • Adapt the remote sessions according to client’s capacity, involving caretaker where applicable |
| Not having a secure or private space to communicate from | <ul style="list-style-type: none"> • Show understanding of this concern • Discuss with the client alternative options to communicate with service providers remotely |
| Clients who don’t prefer the remote model | <ul style="list-style-type: none"> • Explain the reasons behind providing remote support • Respect client wishes if they insist to refuse the remote model |
| Clients do not have the means to connect to remote services (no phone credits/internet data, no electricity to charge phone, etc.) | <ul style="list-style-type: none"> • Brainstorm alternatives with the client (e.g., can a phone be borrowed for the sessions? Are there safe spaces in the community with phones that the client access?) • Inform client about risks of using devices other than their own for remote sessions |

4.1.2 Ensuring Privacy

4.1.2.1 Staff Space

- Remote support must be provided from a private space. A private space is a confidential place where there is no risk of being overheard, and limited distractions. If necessary, inform others in the home/workplace that a confidential call is taking place to prevent any disruption.
- If a client cannot be contacted from a private space this must be discussed with a supervisor to identify any alternate solutions before proceeding.

4.1.2.2 Client Space

- A client must also have private place in which they can talk without fear of being overheard or interrupted by anyone who may be nearby, including neighbors, friends or family members.
- It is best to arrange a time to talk using a messaging service so that a client can be prepared and has time to find a private space. When they are contacted at the agreed time, they must be asked to confirm that they are in a private space and are comfortable to talk. Confidentiality must be assured during every contact.

4.1.2.3 What to Do if a Client Is Not Able to Talk Without Being Overheard?

Problem solve/brainstorm with the client:

- Is there another day or time when they would be able to talk privately?
- With respect to the movement restrictions in your particular context and measures to reduce physical contact, can your client find an alternative place where they can talk, e.g. garden?
- Is there another modality of remote support that you could use to check in, i.e. if they can't talk on the phone could a check-in be done via messaging or email?
- Can the client join the remote session from the nearest safe/private space in their area?

Consult the [IOM Internal Guideline for Remote MHPSS Working Modalities](#) (pages 6-8) for additional tips on setting up the physical and technological space for remote service delivery.

4.1.3 General Principles of Data Protection

- 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.
- Emails and messaging services:
 - 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.

4.1.4 Recordkeeping and storage

Details/notes of all interactions with clients should be completed on the same day of the consultation, and if possible, directly after the contact. This includes all remote interactions, no matter how brief the interaction or what method of remote interaction was used. For those who have appropriate systems already implemented and access to the necessary technologies, digitized recordkeeping is preferable with the necessary safety and data protection measures in place. For those who are interested in developing a new digitized recordkeeping system, this should be discussed with IT and technical unit.

4.1.5 If Working from Your Organization’s Facility/Office with Access to Client Files:

- Notes should be completed and added to the client file in accordance with standard organizational procedures.

4.1.6 If Working from Home/Outside Your Organization’s Facility/Office:

- No client files should be stored at home.
- Notes should be made in a notebook specifically designated for client notes.
- Notes should be kept in one notebook to prevent multiple pieces of information being created that can be easily misplaced.
- No identifying information about clients should be entered in notes that are kept outside of an organizational facility. Client codes should be used to identify clients.
- All notes should be locked away and stored safely. If remote support is being provided from home and there is not a safe place where notes can be locked away, this information must be shared with a supervisor, who should provide a lockable box.
- Client files should be updated using the notes when the MHPSS facility can be safely accessed again.

4.2 Cross-Cutting Component: Capacity Building

4.2.1 Training

All staff providing remote support to clients should receive training on the practical steps and procedures presented in these guidelines, adapted for the context in which they are working. Supervisors supervising service providers should also be trained to adapt their supervision to remote delivery. Training of staff prior to transitioning and throughout remote implementation should be prioritized, and procedures put in place to offer remote training where required. Training sessions and related materials should be developed in close collaboration with technical advisors and based on the needs of trainees.

4.2.1.1 Considerations for Training Related to Public Health and Other Emergencies

Providing clear, factual information on public health emergencies, such as COVID-19 or Ebola, or other disasters that may create uncertainty and fear, as well as providing advice on staying safe and employing positive coping strategies can significantly improve well-being. Staff and service providers should be trained to provide psychoeducation to clients and communities about relevant public health or other emergencies. MHPSS providers should develop an updated list of links and psychoeducational.

Experience from the field

One of the key findings from the 2021 International Medical Corps case study evaluating the transition to remote MHPSS programming during the COVID-19 pandemic was the need to provide more in-depth and specialized training for service providers as a way of alleviating some of the challenges encountered during remote implementation. A training curriculum in Remote MHPSS service provision could include the following modules:

- General principles of remote MHPSS service provision
- Setting up remote MHPSS services
- Preparing for remote MHPSS service provision
- Conducting remote MHPSS services
- Managing risk during remote MHPSS service delivery
- Setting up an MHPSS hotline/helpline

4.2.1.2 Best Practices for Conducting Remote Training

Undertaking training remotely presents a unique set of challenges related to level of engagement by participants, information retention, time management, etc. Adaptations and special considerations must be made when conducting remote training.

- Maintaining active participation and engagement over long periods can be difficult in remote training. If possible, consider spreading the training agenda over several days with a smaller number of hours allocated per training day.
 - Consider sending out reading materials before the training starts so that participants can come to the session with background knowledge.
 - Consider incorporating questions and answers (Q&A) from previous in-person or remote training into a document, to be provided to participants prior to the training, which may reduce the time required for Q&A during the session.
 - Make the necessary adjustments to the training agenda, including building in more frequent breaks and energizers.
- To account for poor internet connection, consider supplementing real-time training with offline learning participants can undertake on their own time by sharing additional reading and exercises via email or other available file sharing platforms (e.g., Dropbox, Google Drive, SharePoint, etc.), or by post/courier.
 - Consider recording remote training sessions and sharing recordings with participants who may have missed parts or entire sessions due to connectivity problems.
- Plan how interactions will take place during training; ad-hoc communications can be difficult to manage, especially with many trainees. For example, consider using the hands-raise icon and taking questions one at a time, or asking participants enter questions in the chat/messaging section to be answered at a specified and allocated time.
- To enhance engagement and participation:
 - Balance knowledge-based learning and practice. For example, assigning participants to prepare and deliver brief presentations on a specific topic can solidify acquired knowledge.

- Incorporate other participatory methods, such as role plays (and assign roles and provide instructions to participants ahead of time).
- Allow space for questions and feedback.
- Choose a communication platform that is easily accessible by all participants.
- Utilize interactive platforms where available (such as Teams and Zoom breakout rooms), and conduct the training using video capability, where possible.
- Send regular reminder invitations to all participants before the remote session to reduce absences.

4.2.2 Supervision

Effective supervision is essential to enhancing and maintaining clinical staff competencies, increasing fidelity to evidence-based treatment models, and reducing unnecessary interventions (e.g., MHPSS staff making referrals to multiple services when contraindicated or failing to disengage services when goals are achieved), and thereby reducing waitlist times and healthcare costs. All staff, whether working from home or at an organizational facility/office should continue to receive regular supervision in line with their organization’s quality standards and standard operating procedures.

- During the initial stages of implementing a remote support system staff will need additional support. Managers and supervisors should check in regularly and conduct supervision at least once a week. Inquire about staff well-being on an ongoing basis and look out for signs of stress and burnout ([Refer to Cross-Cutting Component: Staff Well-being and Self-Care](#)).
- If providing remote support to clients, it is helpful to receive supervision by the same method of communication that is used with clients, to gain direct experience of the strengths and limitations of the chosen way of working. Also consider practicing delivering sessions remotely and applying the existing guidance and good practices.
- Supervisees should discuss and troubleshoot with supervisors the challenges encountered with remote service delivery, such as logistical problems and challenging client interactions.
- In the absence of on-site supervision, audio/video recording of the supervisees’ sessions with clients can be helpful in reviewing and providing feedback on the supervisees’ skills as long as the client is comfortable and provides consent. A signed consent form should be on file for every session that is recorded.

4.2.2.1 Methods of Supervision

Supervision can take place through ad-hoc and more structured methods. For example, supervisors and supervisee may agree to hold regular (i.e., weekly) individual or peer supervision sessions over video conferencing or phone or meet on a need basis. The structure and frequency of supervision sessions need to be adapted to supervisees’ needs. Supervisors may utilize a sample version of supervision protocols available in [Appendix G](#), which include:

Knowledge and Skills Building

1. Case Presentations (telephone calls and video conference calls) [See Protocol 1](#).
2. Offering bite-size information through WhatsApp and SMS text messages. [See Protocol 2](#).

Improving Attitude/Motivation

- Supervisor support (through SMS text messages and WhatsApp messages). [See Protocol 3.](#)
- Peer support (through SMS and MMS messaging groups WhatsApp). [See Protocol 4.](#)
- Reflective discussion (telephone calls or video conference calls) [See Protocol 5.](#)

4.2.2.2 Supervision Plans

Once the supervisor has chosen the relevant protocol(s) they should create a supervision plan. The plan needs to be shared with the supervisee(s) to ensure the content accurately reflects the needs and goals of the supervisee(s). The plan needs to include the preferred supervision methods, protocols, duration and frequency of supervision and (where possible) the dates of supervision for the first 6 months. Supervisors should ensure that feedback from the supervisee(s) is included in the plan to keep the supervisee(s) engaged and motivated to gain as much as possible from supervision. Any standardized forms to be used during supervision can be shared with the supervisee (s) at this initial meeting to familiarize themselves with the documents.

The supervisor in agreement with program management teams needs to decide how supervision will be monitored and evaluated. This could include looking for opportunities to bring in an outside expert to evaluate the skills of the supervisee(s) by conducting at least one face-to-face, observational supervision sessions during the first 6 months to evaluate the progress of the supervisee (s) and/or evaluate the progress of the supervisor/supervisee relationship. Alternatively, supervisor and supervisee(s) may agree to meet every 6 months to re-evaluate the goals and aims of supervision, reflect on their professional relationship, review and adapt the remote supervision methods and protocols to match the changing needs of the supervisee(s).

4.2.2.3 Remote Case Conferences

When MHPSS services are provided for individuals by a number of different providers or as part of a multidisciplinary team, it is recommended to conduct regular case conferences, to ensure that service providers address clients' needs as a team and all aspects of required care are discussed and agreed, and the clients' condition and care plan are monitored and adapted by the team as necessary. Case conferences also indirectly provide a useful form of capacity building for staff, who have the ability to learn from each other.

It is recommended, for these reasons, to ensure continuation of case conferencing through remote means, if in-person meetings are not possible. Supervisors should ensure to establish and maintain a means of and framework for remote case conferencing, utilizing suitable and confidential platforms that enable multiple service providers to participate. If case conferencing is already taking place in-person, consider trying to keep to same schedule or routine as the team or group of service providers normally use, and ensure to request feedback from participants on the method of remote case conferencing in order to gain valuable information to improve its functionality.

Resources

- [Mental Health and Psychosocial Support in Ebola Virus Disease Outbreaks: A Guide for Public Health Program Planners \(IASC\)](#)
- [Remote Psychological First Aid During COVID-19 \(IFRC\)](#)
- [IASC Guidance and Operational Considerations for Multisectoral Mental Health and Psychosocial Support Programs during the Covid-19 Pandemic](#)
- [IASC Basic Psychosocial Skills: A Guide for COVID-19 Responders](#)
- [Mental Health and Psychosocial Support Network \(MHPSS.net\) MHPSS COVID-19 Toolkit](#)
- [Integrated Model of Supervision for Mental Health and Psychosocial Support Handbook \(IFRC\)](#)
- [Remote PM+ Training of Helpers: Training & Lessons Learned Report \(IFRC\)](#)

4.3 Cross-Cutting Component: Monitoring and Evaluation

Monitoring and evaluation (M&E) is necessary to assess whether the remote MHPSS program is achieving its desired results, provide measures of the quality of the services provided remotely, and document lessons for consideration in future remote programming. Indicators already included in the common monitoring and evaluation framework should be disaggregated by remote vs. non-remote type.

Reference [International Medical Corps COVID-19 MEAL Guidelines](#)¹ for an example of M&E methods can be adapted to remote implementation during public health emergencies and ensuring infection, protection and control protocols are in place for these activities.

4.3.1 Documentation of Remote MHPSS Sessions:

Clients' information can be recorded using hardcopies or digitized recordkeeping tools, putting in place necessary data protection measures noted earlier in the guidelines. Recordkeeping tools need to be adapted for use in remote modalities, with the following considerations in mind:

1. Specify if the session is conducted in person or remotely.
2. If remote, specify the communication type (e.g., video conferencing, audio call, etc.).
3. Include information on client's preference for the model of service: in person, remote or combined.
4. If the session is planned in advance or conducted as an emergency call.
5. Mention the needed assessment and management interventions that could not be conducted remotely.
6. Note logistical challenges and good practices.

¹ For non-International Medical Corps staff, the Guidelines can be made available upon request via meal@internationalmedicalcorps.org

4.3.2 Using Satisfaction Surveys

Satisfaction surveys can be used to evaluate clients' and caregivers' levels of satisfaction with the remote MHPSS services and solicit feedback for further improvements. The survey may assess efficacy of remote services (including perceived improvement in functioning, well-being and symptomology); client preferences, including if alternative modalities need to be implemented; challenges or barriers as well as positive developments encountered during remote services. Try to mitigate for bias by making the satisfaction reporting as anonymous as possible, such as using postal service or online link to anonymous feedback mechanism, while protecting the identity and confidentiality of respondents. [A sample satisfaction survey is included in Appendix H.](#)

4.4 Cross-Cutting Component: Staff Well-being and Self-Care

The well-being of staff is of utmost importance always—and especially so during emergencies and global crises. All organizations have a responsibility to provide the best working environment for their staff this includes the prioritization of the health and well-being of all staff.

Staff and service providers who work in emergency settings are at an elevated risk of developing burnout, which often result from chronic workplace stress that has not been successfully managed and may manifest in the following symptoms:²

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

Working remotely and in isolation can exacerbate stress. Setting clear boundaries and practicing self-care can reduce staff and service providers' risk of developing burnout and increase the ability to maintain a healthy work/life balance.

It is the responsibility of the organization to prioritize health and mental well-being of their staff. Below are some crucial steps the organization must take to do this:

- Update staff welfare policies to include promoting staff well-being during remote service provision.
- Ensure that staff are given the technologies and tools needed to implement remote services such as phones, laptops, tablets, chargers, enough phone and internet credit to ensure they incur no out of pocket expenses.
- HR and Senior Management teams should ensure that staff are only working within their contracted hours.
- HR and senior management teams should ensure that staff do not feel isolated and are involved in regular team discussions, social events and opportunities. They should be regularly reminded that they are part of a team and an organization and not feel as if they have to struggle alone.

² World Health Organization, ICD 11, <https://www.who.int/news/item/28-05-2019-burn-out-an-occupational-phenomenon-international-classification-of-diseases>

- HR and senior management should implement policies that show staff how to take sufficient and regular breaks from their screens in order to stretch, move and take fresh air through their working day.

Below are some tips that staff can use on how to protect and maintain psychosocial well-being while providing remote MHPSS services:

- Schedule the remote sessions only in working hours.
- Set expectations with clients during the initial session of when you will be available and when clients can call. Hold to this boundary if they call outside of hours.
- Wherever available, use the business accounts of applications, such as WhatsApp, which help reinforce professional boundaries and provide automated reply options outside of business hours, letting the person know when they can expect to receive a response.
- Make sure clients know where to go or whom to contact if they need urgent assistance or care. Consider providing clients with referrals for such instances during the initial session.
- Plan ahead and prepare how you will let a client know you cannot talk if they call outside of working hours. Convey empathy, respect and warmth.
- Stay consistent with appointment times.
- Ensure your caseload is manageable, both in terms of the number of clients as well as intensity of any complex cases.
- Seek support from your supervisor when managing cases. Discuss any challenges or difficulties that affect your performance at work.
- Maintain a healthy lifestyle such as sleeping enough hours daily and eating enough and healthy food and including physical activity.
- Maintain a daily routine that includes enjoyable or stress-relieving activities.
- Maintain social contact with family and friends.
- If you can't manage your work-related stress alone, ask for support from a staff care focal person or your supervisor.

Sample messages* to set boundaries with clients contacting after hours

2021 International Medical Corps case study evaluating transition to remote MHPSS programming during the COVID-19 found that clients perceived remote services as 24/7 availability by service providers and often called them after hours or during leave. Messages prepared in advance can help service providers tactfully manage such situations:

- "I can tell you are struggling. I want to talk to you, but I am not available right now. If you need to talk to a provider urgently you can contact the organization I mentioned that provides urgent care [alternatively, if applicable: contact the crisis line]. Would you like me to share the number?"
- I'm sorry, I can't talk outside of business hours. Can we set up a time to meet tomorrow to address your needs?

**Tailor these messages to cultural norms and contextual realities.*

See [WHO Doing What Matters in Times of Stress](#) for additional guidance on how to maintain your psychosocial well-being.

Appendices

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Appendix A: Assessment Tool for Transitioning to Remote MHPSS Programming and Service Provision

This tool can support those designing and conducting an assessment for transitioning MHPSS programming and service provision to remote or hybrid modalities in humanitarian contexts. This may be necessary for reasons such as epidemics, poor security, lack of access to in-person services for certain groups. The tool is intended to be used as a template, which can be adapted to different contexts and areas of MHPSS programming.

It is recommended that MHPSS programs conduct risk assessments and contingency plans as a regular part of program design, and use this assessment tool to gather updated information at such a time as when it is recognized that some form of transition to remote programming and/or service provision will be required in the near future.

Information from an assessment is needed to make evidence-based decisions about remote MHPSS program planning, such as:

1. **Barriers and opportunities** to providing or accessing face-to-face MHPSS services or capacity-building efforts.
2. **Existing national guidelines and efforts** support or prevent remote MHPSS service delivery.
3. **Knowledge, attitudes, perceptions and needs** of clients, community members and service providers in regards to remote MHPSS programming and level of comfort working with remote technologies
4. **Actors currently working on mental health** at the national, regional and community level that need to be engaged in transition to remote MHPSS programming.
5. **Capacity building needs** of staff, service providers and partners may have to facilitate effective transition to remote MHPSS programming.
6. **Available and needed resources** at the organizational, community and national level to support the transition.

Below, please see templates to be selected based on the assessment type (country, community, organizational/program, mapping).

Template I: Country-Level Analysis

Purpose

To summarize information relevant to the agency/service provider, clients/beneficiaries and other stakeholders transitioning to remote MHPSS programming, already available before or during the onset of the need to transition. Quick assessment of existing policies and regulations, efforts and systems that may support or prohibit remote MHPSS programming.

Method

Desk research

Sources of Information

Desk reviews can include, but are not limited to:

1. Statements released by governing agencies/ministries, UN agencies
2. Assessments and reports by humanitarian and development agencies, governments or UN agencies
3. Guidance, tools, statements and reports released by humanitarian coordination actors, such as IASC, UN, MHPSS TWGs, Humanitarian Coordination Clusters
4. Scientific and grey literature

Sample Outline

- Introduction
- Rationale for the need to transition to remote programming and/or service provision
- Description of methodology used
- Contextual factors
- Description of the situation/context, including the primary cause and its impact on society, commerce, industry, travel, availability of services.
- Law and policy pertaining to the reason for transitioning to remote service provision, humanitarian/development agencies' ability to program, laws and regulations pertaining specifically to the provision of telemedicine or remote service provision, human resources, logistics. Recent or expected changes to law and/or policy.
- Readiness and openness of government stakeholders to support remote MHPSS programming.
- Technological infrastructure and access, including mobile network and internet coverage, accessibility (e.g., cost, existing government bans on certain platforms, etc.), preferred and widely-used platforms, security and privacy (e.g., surveillance concerns).
- Contextual information related to remote MHPSS programming and service provision, including:
 - Evidence-based guidance
 - Documented lessons learned from relevant previous experience (internal and external reports)
 - Analysis
 - Identified knowledge gaps
 - Expected/perceived challenges and opportunities
 - Recommendations

Template II: Community-Level Analysis

Purpose

To understand the needs and concerns of community members and leaders, clients and service providers as well as barriers to access to remote MHPSS services. Analysis will include whether clients and their family members have the means to confidentially connect to services remotely; existing resources that can be leveraged (e.g., crisis or helplines to connect clients to services, private and safe community spaces for taking calls, etc.); community members' level of openness to engaging with remote MHPSS services and so on.

Methods

Key Informant Interviews (KIIs) and Focus Group Discussions (FGDs).

Sources of Information

Community members and leaders, MHPSS clients/beneficiaries, service providers.

Sample Questions

Service Provider

- What current provisions/resources are in place for remote MHPSS services? What services? Where? How are they provided remotely?
- What could be done to improve the MHPSS framework/system to support the transition to/improvement of remote MHPSS services?
- Do clients/community members have the ability to access remote MHPSS services? What can be done to improve this? Are there any groups or individuals for which it may be more difficult? (Probe: survivors of gender-based violence, older adults, children, people with intellectual or physical disabilities, those with hearing impediments, etc.)
- Do service providers have the ability to provide remote services? What can be done to improve this?
- What other challenges do you foresee in the provision and receipt of remote MHPSS services?
- What are the capacity needs of service providers to be able to effectively continue the provision of MHPSS services remotely?
- Are there any people who may not be able to benefit from remote MHPSS services? Who and Why? Will there be alternative in-person services or support available, such as inpatient care?

Community members and leaders:

- How do you think the current context is effecting/will affect people in your community?
- What do you think will be the impact on people mental health and well-being?
- What support and services should be available for people during this period? How should/could they be provided in the safest possible way?
- How do you think people will ask for or try to reach support and services if they need them? How can it be made easier and more accessible? What challenges do you encounter/foresee?
- Do you believe the provision of remote MHPSS services could result in an increase of uptake of such services? Why or why not?
- Are there any marginalized groups that may need special attention or support?

Clients/MHPSS Beneficiaries:

- Is the current situation causing any changes in your mental health or well-being or treatment?
- Do you need any additional support to address these changes? What? How can this be done?
- How do you think a transition to remote MHPSS service delivery will affect the support and services you currently receive? Do you see any challenges or opportunities in using this modality?
- Will you be able to engage with MHPSS services via phone, videocall? Why/why not?
- Do you have any reservations or fears in terms of receiving services remotely for a period of time? Can you tell me what they are, and what would help to alleviate them? (Probe: access to a confidential and safe space; privacy and ability take services without interruptions, etc.)
- Do you have any advice for how we can ensure that remote MHPSS services are accessible, safe and acceptable for you?

Template III: Organizational and Program-Level Analysis

Purpose

Assessment of strengths and limitations in staff and service provider knowledge and capacity to implement remote programming. What resources, tools and training do they need to do their job effectively? Does the program budget accommodate acquiring additional resources to support the transition?

Methods

Key informant interview, Focus Group Discussion and/or staff workshop.

Sources of Information

MHPSS Management and Program staff, MHPSS Service Providers, Agency Management, Operations management and staff

Sample Questions

- What administrative, operational and managerial activities and tasks (including logistical, human resource and finance) require adaptation for remote programming and service delivery?
- What MHPSS services and activities require mitigation for transition to remote delivery?
- Do the training and supervision practices require changes for remote delivery? What additional training do staff require for transitioning to remote programming and delivery of remote MHPSS services?
 - What remote MHPSS training materials and tools are available that can be adapted and used for capacity building of staff and service providers (*Can also be identified through desk review*).
- What staff care practices are in place (if any) and how can they be adapted to be relevant and useful for remote programming? What additional staff-care practices are required?
- How can documentation and M&E practices and systems be adapted for remote programming, ensuring safety, confidentiality and privacy of all sensitive data?

- What actors and stakeholders should be coordinated with to ensure that the transition is effective, services are not duplicated, gaps in service provision are identified and mitigated?
- What resources are in place, available or needed for transitioning to remote MHPSS programming and service delivery (including human resource, financial, technical)?
- Will tools being used to assess/measure the treatment effectiveness be applicable in a remote setting? What adaptations may need to be made?

Template IV: Mapping

Purpose

To understand what MHPSS services are available to clients and caregivers and to determine what services will transition to remote modality. 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.

Method

4Ws Mapping

Sources of Information

MHPSS TWG, Health and Protection Clusters, Relevant Ministries, All MHPSS and other relevant service providers, UN Agencies. For more information and advice on conducting 4Ws/service mapping, consult [WHO/UNHCR Assessing mental health and psychosocial needs and resources Toolkit for humanitarian settings](#) Tool 1, Page 30.

Sample (and Simplified) Remote MHPSS Service Mapping/4Ws Tool

Note: 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.

| Agency/ Provider | Available in-person services | Where the service can be accessed | Focal Point & contact details | Available remote services | How the service can be accessed | Who utilizes these services | Focal point & contact details | Services that will not continue or temporarily close (if any) | Notes on discontinuing services |
|------------------|------------------------------|-----------------------------------|-------------------------------|---------------------------|---------------------------------|-----------------------------|-------------------------------|---|---------------------------------|
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For context where a recent 4ws mapping has already been completed, consider how the MHPSS coordination group can adapt the existing mapping for any updates.

Appendix B: Contingency Planning for Remote MHPSS Programming and Service Provision

List current administrative and programming activities (including logistical, human resource and finance) that require mitigation for remote delivery:

| Activity | Risk/Challenge* | Probability** (high, medium, low) | Mitigation Measure(s)*** | Staff Responsible**** | Comments/Notes |
|----------|-----------------|--------------------------------------|--------------------------|-----------------------|----------------|
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*Factors/events that may necessitate transition to remote delivery of the activity

**How likely is the risk/challenge to occur? Probability can help prioritize the planning process

***Actions to be taken to minimize/prevent disruptions resulting from risk/challenge

****Primary responsible person for implementing mitigation measure(s) for the activity

List the current MHPSS service and activities that require mitigation for remote delivery:

| Service/Activity | Risk/Challenge | Probability (high, medium, low) | Mitigation Measure(s) | Staff Responsible | Comments/Notes |
|------------------|----------------|------------------------------------|-----------------------|-------------------|----------------|
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List the current managerial activities that require mitigation for remote modality:

| Activity | Risk/Challenge | Probability (high, medium, low) | Mitigation Measure(s) | Staff Responsible | Comments/Notes |
|----------|----------------|---------------------------------|-----------------------|-------------------|----------------|
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List the current training and supervision practices and activities that require mitigation for remote modality:

| Activity | Risk/Challenge | Probability (high, medium, low) | Mitigation Measure(s) | Staff Responsible | Comments/Notes |
|----------|----------------|---------------------------------|-----------------------|-------------------|----------------|
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List the current staff care activities that require mitigation for remote modality:

| Activity | Risk/Challenge | Probability (high, medium, low) | Mitigation Measure(s) | Staff Responsible | Comments/Notes |
|----------|----------------|---------------------------------|-----------------------|-------------------|----------------|
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List the Monitoring, Evaluation, Accountability, Learning and documentation practices that require mitigation for remote modality:

| Practice/ Document | Risk/Challenge | Probability (high, medium, low) | Mitigation Measure(s) | Staff Responsible | Comments/Notes |
|--------------------|----------------|---------------------------------|-----------------------|-------------------|----------------|
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List the coordination tasks and practices that require mitigation for remote modality:

| Task | Risk/Challenge | Probability (high, medium, low) | Mitigation Measure(s) | Staff Responsible | Comments/Notes |
|------|----------------|---------------------------------|-----------------------|-------------------|----------------|
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List the resource mobilization tasks that require mitigation for remote modality:

| Task | Risk/Challenge | Probability (high, medium, low) | Mitigation Measure(s) | Staff Responsible | Comments/Notes |
|------|----------------|---------------------------------|-----------------------|-------------------|----------------|
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Additional guidance

For additional and inter-sectoral contingency planning guidance, refer to [International Federation of Red Cross and Red Crescent Societies Contingency Planning Guide, 2012](#)

If it is not possible to continue provision of certain MHPSS services, please mitigate using [IMC \(2016\) Guidance Note: Disengagement/Exit strategies for the Discontinuation or Handover of Programming | Mental Health Innovation Network \(mhinnovation.net\)](#)

Appendix C: Key Considerations for Providing Remote Individual Support for Children

Infants, children and adolescents have unique physical, mental, behavioral, developmental, communication, therapeutic and social needs that must be addressed and met in all aspects of support.

Initial contact should always occur with at least one of the caregivers' present. However, remember "who" your client is—e.g., the child / adolescent—and do not just focus on the caregiver / family member. Ensure that you are actively involving and talking directly to the child / adolescent throughout the support you provide. During this initial session it is important to consider the child's age, developmental level and ability to follow directions and cooperate with caregivers. This information helps you to quickly understand what psychosocial interventions may be supportive, and whether you can proceed with individual sessions or with the same caregiver joining sessions.

If the individual is legally classified as a child, parent/caregiver's informed consent and child's verbal assent will be needed. Explain the concept of confidentiality to the child and the caregiver. Remember that children have the right to expect privacy confidentiality and the promotion of their human rights and every stage of assessment, treatment and follow up.

Practice cyber security and ensure that any details or sensitive information about the child/adolescent is stored in a secure way.

Clarify to both caregiver and child/adolescent under what circumstances caregivers or other adults would be given information.

Adolescents may be dependent upon their caregivers to access care (i.e. head of household has the only mobile phone). Therefore, providers should establish a therapeutic alliance with the caregiver as well as the adolescent. The technology may pose a challenge to alliance-building. Providers may include an introduction to and explanation of the technology in user-friendly terms and ensure that both adolescents and parents feel that their perspectives are understood.

For adolescents, plan to see them separately from the caregiver if possible in your second session. Try to arrange and agree a time and date for the second session when the adolescent can have access to the technology (i.e. mobile, tablet, etc.) by themselves. Confirm this verbally during first session with both caregiver and adolescent. Reconfirm with both caregiver and adolescent one day before next session.

At the beginning of the session remind the adolescent about confidentiality and their rights.

In some cases, a child / adolescent may act out even in the presence of a caregiver, for example a very hyperactive preschooler, oppositional child, or uncooperative adolescent may attack the equipment, be aggressive to the caregiver, hide, not speak or try to leave. Parents of children seeking mental health care may themselves have a mental disorder and may be compromised in their ability to supervise the youth during the remote sessions. Thus, the

provider should conduct a similar assessment of the ability of the accompanying adult to contain the youth and/or for the adult him/herself to safely participate in sessions and follow treatment recommendations.

If you will be working with children / adolescents it will be important to familiarize yourself with the three main child / adolescent mental and behavioral disorders (mhGAP-IG), and if not familiar please discuss with your MHPSS supervisor to ensure you are oriented fully before commencing any work.

Recognize Red Flags Indicating Further Intervention or Referral Are Needed:

- The child/ adolescent may not feel free to be candid about his/her environment or circumstance with a potentially offending caregiver nearby.
- The child/adolescent may be living in a chaotic environment so during any remote interactions if you use a video call and you can see any red flags that may indicate a child protection problem then please discuss them with your supervisor immediately.
- If you are on a telephone call and hear anything in the background or have any brief interactions that raise child protection concerns, then discuss them with your supervisor immediately.
- The technology itself may be intimidating to child/ adolescent, particularly if they have never met the provider before. Some children with developmental or psychotic disorders may not tolerate not seeing or being physically present with the provider offering them support. Work quickly and closely with your MHPSS focal point to look for safe, appropriate and timely alternative approaches.

Important Components of Your Remote Support Will Need to Be:

- Caregiver involvement in the treatment (especially for children and adolescents)
- Teaching skills and practicing skills at home (between session “homework assignments”)
- Measures of progress (e.g., rating scales, improvements on homework assignments) that are tracked over time. Remember if you are using video calls you can hold these rating scales to the camera so the caregiver can understand or even see the scales if they are visual representations and this may help the caregiver engage with the treatment.

Additional Considerations

Practicing at a distance creates a unique relationship with the client that requires attention to and adherence to professional ethical principles, including special considerations with children and families. For example, maintaining professional language in all communication, including SMS messages to adolescent and caregiver, even if they use more informal language.

Ensuring that child / adolescent understand how they can access “out of hours” services if needed, and what times / days of the week you would be available to take any additional “calls” that fall outside of your agreed next session.

Create a clear and easy-to-follow risk management plan in case of emergencies so the caregiver child/adolescent knows what to do in times of crises.

Appendix D: Checklist: Preparing for Remote MHPSS Service Delivery

Planning

- Ensure client has consented to receive remote support
 - Ensure adapted consent form has been shared/read to client
 - Ensure there is documentation that consent was obtained
 - If consent was obtained in writing, with client's signature
 - If consent was obtained verbally, documented by MHPSS staff (date/time)
- Ensure there is an agreed upon date and time for the call, and who will initiate call
- Ensure there is an agreed upon method (e.g. voice call, video call)
- Ensure MHPSS staff and client have discussed the need for each to be in a private space during the time of the call, to ensure confidentiality

Contacting

- Ensure the call is being initiated at the agreed upon date/time, by the designated person who will initiate call
- Confirm the identity of the client on the call
- Confirm that the client is in a confidential space for the call
- If the client states there is no confidentiality, problem solve/brainstorm to identify an alternative space, time, or date for a call
- Conduct the session using as many of the same principles of care as possible
- When ending the call, confirm the date/time for the next session

Documenting

- Complete detailed notes of the session on the same day of the consultation, and if possible, directly after the contact, in a notebook specifically designated for client notes
- Ensure client's unique identification code is used, avoiding the name or other identifying information about the client, to protect confidentiality
- Client notes and other documentation should be stored in a safe location (e.g., locked cabinets and/or password-protected online database)

Appendix E: Confidentiality Agreement for Remote MHPSS

The purpose of this form is to document consent from the MHPSS staff to keep all information of the client confidential as MHPSS service delivery is adapted to remote support during the COVID 19 pandemic, whereby MHPSS staff will continue to provide services to clients either going to the field directly from home while the office is closed or providing services through phone.

Confidential Information. While working from home, the MHPSS staff should take detailed notes for the client file, and must keep all information confidential, securely stored and must keep it under lock and key. MHPSS staff should strictly maintain the confidentiality of all clients' details and information should only be shared on a need-to-know basis to only authorized staff (e.g. interdisciplinary team; supervisor). All efforts should be made to use the client's unique identification number, and to avoid the use of the client's name in such discussions or email exchanges.

Confidential client information should never be discussed in the presence of third parties, including colleagues, friends, family members, etc. Any files and/or documents containing confidential information should never be shared or released to third parties, unless there are already agreed upon terms³ for high-risk clients.

Confidential information includes, but is not limited to, the following:

- Identifying information about the client, including name, address or phone number;
- Information relating to the client's family;
- Information regarding the client's case;
- Information about the discussion during the session; or
- Any other information that would identify the client or potentially place the client and/or family members at risk.

Once service provision transitions back to face-to-face service delivery, MHPSS staff will systematically update individual client files accordingly, and subsequently return all written/printed notes to his/her supervisor for safe disposal (shredding where possible).

Terms. By signing this Confidentiality Agreement, you agree to the highest ethical standards and to abide by the following provisions:

1. All communications between MHPSS staff and clients are confidential and recording the session in any form is not permitted to either party.
2. The MHPSS staff shall not disclose confidential information to anyone without the client's express consent to release such information.
3. I understand that as a MHPSS staff, I have a duty to keep client information confidential throughout my term as a staff as well as after my employment status ends.
4. I understand that my failure to abide by the terms of this Confidentiality Agreement may result in a written warning, or possibly, the termination of my job as a staff at the organization.

³ E.g. Some UNHCR-run camp settings have directives for summary information to be shared on suicidal cases

I, _____ (MHPSS staff name),
have read the Confidentiality Agreement and understand its terms and my responsibilities as
_____ (organization's name) MHPSS staff member.

Signature of MHPSS Staff: _____ Date: _____

Signature of Supervisor: _____ Date: _____

Appendix F: Informed Consent Form for Remote MHPSS

I consent to engaging in remote MHPSS services being delivered by International Medical Corps' MHPSS staff. I understand that remote MHPSS may include assessment, treatment planning, case management, as well as psychosocial, psychological, or psychiatric support.

Remote MHPSS will occur either through interactive audio or video applications through mobile phones, or via telephone calls. All remote MHPSS services will be delivered one-to-one, unless the client is a child under the age of 16 years old, or requires additional support for hearing impairments or if in a state of psychiatric crisis.

I understand I have the following rights with respect to remote MHPSS:

- I understand that the information released by me during the course of my sessions is generally confidential. There are mandatory exceptions to confidentiality, including but not limited to reporting child and vulnerable adult abuse, expressed imminent harm to oneself or others.
- I understand that there are risks and consequences of MHPSS services being delivered remotely, including but not limited to, the possibility, despite reasonable efforts on the part of International Medical Corps that: the transmission of my personal information could be disrupted or distorted by technical failures; the possibility that the clinical information obtained may not be as rich, and that clinical interventions and recommendations will take this into account to mitigate risks.
- I understand that given the limitations of remote MHPSS service provision, I may be referred to alternative services if appropriate and available.
- I also understand that there are potential risks and benefits associated with any form of MHPSS intervention, and that despite my efforts and efforts of my MHPSS service provider, my condition may not improve, or may have the potential to get worse.
- I understand that the use of WhatsApp audio/video systems are not 100% secure and may have issues with Wi-Fi connectivity. All attempts to keep information confidential while using these systems will be made but a guarantee of 100% confidentiality cannot be made with inherent issues with these communication systems. Consenting to this show an awareness of these issues and a decision by this client to use these systems for remote MHPSS services.
- All of my questions regarding the above matters have been answered to my approval.
- By consenting to the contents of this document, I agree that certain situations including emergencies and crises are inappropriate for audio/video based mental health services. If I am in crisis or in an emergency, I should seek urgent help from an emergency responder. I understand that an emergency situation may include thoughts about hurting or harming myself or others, having uncontrolled psychotic symptoms, if I am in a life threatening or emergency situation, and/or if I am abusing drugs or alcohol and am not safe.
- I have discussed and agreed upon the following with my service provider:
 - Modality(ies) of remote contact to be used.
 - Time, date and duration of contact.

- If reminders are necessary and how they should be given, for example by text message, email or phone call.
- Who should initiate the contact.
- What to do if I do not call/respond to a call at an agreed time.
- What to do if there is a network failure and a call is cut off/not able to be made.
- What to do if there is uncertainty of the identity of the individual who responds using my device/platform account.
- I have the right to withhold or remove consent at any time without affecting my right to future care or treatment.
- I have (been) read this document in entirety, and fully understand the benefits and risks. I have had the opportunity to ask any questions I have, and have received satisfactory answers.
- I voluntarily consent to participate in remote MHPSS _____ consultation(s)
Client ID
- I consent to the collection and use of information from these consultations, as set out above

_____ Date: _____

Designate if consent is provided by a caregiver of the client, if client is a child or in a psychiatric crisis

Appendix G: Protocols for Remote Supervision

Protocol 1: Case Presentations

Purpose

To build knowledge about common and complex presentations of people with mental, neurological and substance use (MNS) conditions or concerns. Enable supervisees to demonstrate how they translate their knowledge of assessing and managing people with MNS conditions into clinical practice.

Duration

1 to 1:30 mins hour per presentation

Delivered

Individually or as a group

Method

Telephone, video conferencing

- It is the responsibility of the supervisor to choose a supervisee to present a case during the supervision session.
- Supervisor informs the supervisee by text message/phone call of their responsibility to write and present a case at least 3 days before the planned supervision session.
- Supervisee will choose a person from his/her case load.
- Use standardized questions and forms to help the supervisee write up and present the case.
- Presentations can last between 10-20 minutes.
- On the agreed date of the supervision session the supervisor telephones/connects with the supervisee(s) through phone or video conference technology.
- Supervisor begins the session by reminding the supervisee(s) of the aims of the session and hands over to the supervisee to deliver her/his presentation.
- During the presentation, the supervisor (and other supervisees if part of group supervision) make notes on the presentation with any questions/comments and any anomalies with regards demonstrated clinical knowledge and skills.
- Once the supervisee has completed the presentation the supervisor starts the conversation by asking the other supervisees (if relevant) or explaining any questions/comments noted during the presentation.
- The supervisee is given an opportunity to respond to those questions/comments.
- The supervisor manages the discussions and ensures that the supervisee(s) learn from the discussion and can take some practical steps and instructions to improve their clinical competency. Do not exceed 30 minutes for this section.

- In the final 15 minutes of the session the supervisor summarizes the main discussion points. Focusing on the way knowledge about MNS conditions has been applied to practice and the practical steps identified to ensure it is in the future.

Strengths

Case presentations use relatively straightforward technology to build supervisees knowledge about the common presentation of mental, neurological and substance use conditions in primary healthcare settings. They encourage the supervisee to reflect on her/his practice, identify her/his strengths and weakness and create a practical plan of how to improve performance.

Weaknesses

Case presentations require the supervisees to recall the details of a specific case and the actions they took as such it may not be an accurate representation/demonstration of their knowledge or how they have applied their knowledge in practice.

Technology considerations

The strength of the telephone/internet/data connection can be a factor in carrying out case presentations via telephones and video conferencing platforms. Weak telephone/internet and data connections can mean that the discussions are regularly interrupted or lost, which can be frustrating for the participants and lead to confused communication.

Protocol 2: Offering Bite Size information through SMS/WhatsApp

Purpose

To provide new knowledge and build on existing knowledge of common and complex presentations of people with MNS conditions.

Duration

1-2 messages every week

Method

Phone, Smartphone

Delivery method

Individual or as a group

It is the responsibility of the supervisor to identify relevant pieces of evidence-based information that will build on the knowledge of the supervisee(s) to deliver quality care to people with mental, neurological and substance use disorders.

- These could take the form of texting small chunks of information that reinforce the information learnt in training.
- Posing questions that encourage the supervisee(s) to seek new information that can be discussed at a later time.
- Posing reflective questions that encourage the supervisee(s) to think about how they apply their knowledge to clinical practice.

- Using WhatsApp and SMS messaging to pose quiz questions to the supervisee(s).
- Send links to relevant evidence-based articles about caring for people with mental, neurological and substance use conditions.
- Send links to TED Talks, YouTube videos such as the WHO and IMC mhGAP-IG training videos that could be watched on a smartphone.
- Supervisee(s) must commit to reading and/or watching the educational resources within set times.
- If the supervisee(s) work close to one another they can organize times to meet and discuss these resources together.
- Supervisor and supervisee(s) can decide to use telephones or video conferencing to discuss the educational material.
- During these discussions, the supervisor should encourage and support the supervisee to reflect on ways that they can translate that knowledge into their own clinical practice.
- Supervisor can choose to set 'homework' tasks to the supervisee(s) so, they can practice applying that new knowledge in practice.
- It is the supervisor's responsibility to ensure that the supervisee(s) are trained and understand how to use the technology and e-learning platforms.

Strengths

Educational resources shared through WhatsApp or SMS messages can build on or reinforce knowledge gained through initial training programs. They can also ensure that the supervisee(s) knowledge is kept up to date and in line with evidence-based practice. Regular WhatsApp messages and SMS messages can keep supervisee(s) motivated and interested in learning. Sending information to groups of supervisees can enhance learning by opening supervisee (s) to each other's opinions and experiences.

Weaknesses

It can be hard to convey complicated information over messaging services. Therefore, any information sent will need to be followed up with a telephone conversation.

Technology considerations

It can be hard to read a large amount of information on small screens therefore this is best facilitated with a smartphone. Accessing and downloading information from the internet requires a strong internet connect and/or data connection.

Protocol 3: Supervisor Support

Purpose

Decide a regular time where the supervisor can have a telephone call with the supervisee. The supervisee is encouraged to share any challenges and concerns they have with delivering services and caring for people living with MNS conditions.

Duration

As needed for 1 hour per phone call.

Delivery

Individually

Method

Telephone

- The supervisee is encouraged to reflect before the telephone call on the current challenges s/he is facing and to start identifying the sort of support s/he requires from the supervisor.
- Supervisor and supervisee agree upon a time and telephone each other.
- The supervisee starts the conversation by explaining any professional challenges or problems s/he is facing in delivering their work.
- The supervisor listens to the supervisee and asks any questions s/he may have to ensure to have the best grasp possible of the situation.
- The supervisor then takes the lead in supporting the supervisee(s) to solve problems and develop a goal orientated plan of action.
- The supervisor and supervisee agree to another conversation the following week where they can discuss how the supervisee felt implementing those solutions and if the challenges have changed or if they need to find new solutions.

Strengths

Supervisor support telephone calls give the supervisee a sense of confidence as they learn they are not alone and have a support system when needed.

Weaknesses

It can be difficult for the supervisor to manage the contact as the supervisee may wish to contact the supervisor out of working hours (in the case of emergencies) or when it is not convenient. The supervisor must set clear boundaries about the contact.

Technology considerations

If supervisee(s) work in remote areas telephone signals may be weak and thus it can be difficult for the supervisor and supervisee to connect.

Protocol 4: Peer Support

Purpose

Create SMS or MMS peer group discussions and forums that enable the peers to exchange ideas, frustrations, support (problem solving and emotional) and information relevant to their professional work

Duration

Ongoing and ad-hoc

Delivery

Group

Method

WhatsApp, SMS messages

- Supervisor gathers all the telephone numbers and/or WhatsApp numbers for their supervisees.
- Supervisor sets up a group chat and is responsible for managing and overseeing the content discussed in the group
- The supervisor welcomes the supervisees to the group with an initial ‘welcome message’, which highlights the purpose for the group and explains why it has been set up (for example to provide a safe forum for supervisees to share information, support each other, problem solve together (especially if faced with a complex or emergency case), share tips/problems with logistics, etc.). Supervisor can set time limits on when to use the group—e.g., you can post messages/questions between the hours of 9 a.m. to 5 p.m., Monday to Friday (to ensure that the group remains professional and is not taken over by discussions about social activities and/or disturb people in the middle of the night).
- Within those parameters the supervisees are free to use the group as they need.
- The supervisor can guide group discussions by posing questions and or giving discussion topics or motivational statements, depending on the needs of the supervisees decided in the introductory meeting.
- If a supervisee requires individual assistance (for example with requiring more private emotional support, or support with a complex case) it is the responsibility of the supervisor to contact that person individually.
- If supervisees flag up logistical problems with service delivery in this group, then it is the responsibility of the supervisor to work with the program management team to address those problems and find ways to resolve them.

Strengths

These forums can enable peers to support and encourage each other. Problem solving discussions can show the supervisor the kinds of problems that the supervisees face and through reading and watching the discussions the supervisor can learn and understand the sort of motivation/attitudes that the supervisees have towards the work. The supervisor can also identify any gaps in knowledge and skills which they can address in more knowledge/skills-based supervision.

Weaknesses

Using social media platforms such as WhatsApp can mean that the discussion is hijacked by more social activities rather than remaining professional. Some members of the group may remain quiet, and discussions may be dominated by a few.

Technological considerations

Supervisees need to be reminded to respect confidentiality at all times and not share intimate details through SMS or MMS.

Protocol 5: Reflective Discussion

Purpose

Encourage the supervisee to reflect on their strengths and weaknesses, identify areas they want to prioritize and work on, examine their attitudes and beliefs, and improve their clinical care.

Duration

40 minutes

Delivery

Individually

Method

Telephone, video conference

- It is the responsibility of the supervisor to organize a time for the reflective discussion and remind the supervisee at least 3 days before.
- Supervisor sends the reflective discussion form and/or informs the supervisee of the standardized headings they can use to encourage self-reflection.
- It is the responsibility of the supervisee to spend some time before the session answering the questions in the reflective discussion form and thinking about their own practice.
- Supervisor and supervisee(s) telephone and/or sign on to video conference platform at the same time.
- The supervisor starts the sessions by reminding the supervisee about the aims of the session (for example this is an opportunity for the supervisee to think about her/his own practice, identify where s/he is proud of the work delivered and where s/he feels s/he needs some more support).
- The supervisee then begins the session by briefly explaining the areas s/he has reflected upon (from the standardized forms) and why.
- The supervisor can help the supervisee reflect further if required by asking “why” and seeking further explanations and clarifications and specific examples.
- By the end of the discussion the supervisee will have created a list of specific skills/tasks that the supervisee agrees to try into their practice.
- Supervisor needs to arrange another discussion time to follow up on the supervisee(s) progress and discuss how the supervisee felt implementing the new skills/tasks.

Strengths

Reflective discussions help the supervisees build self-awareness, this is particularly important when delivering clinical care as it helps the supervisees understand their role within their clinical interactions, what they do well and what their weaknesses are, what they need help in and where they need to gain more knowledge or practice skills.

Weaknesses

Self-reflection is not easy, and many supervisees may feel too overwhelmed or busy to engage in the discussions. Reflective discussions require the supervisees to think about their own practice, therefore the accuracy of their reflections is subjective. The supervisor is not able to observe the person in clinical practice to support or refute these reflections. It can be time-consuming for the supervisor as the session needs to be delivered individually.

Technology considerations

If supervisee(s) work in remote areas telephone signals may be weak and thus may be difficult for the supervisor and supervisee to connect.

Protocol 6: Live Observed Sessions

Purpose

Observe and build the clinical skills of supervisee particularly in learning how the supervisees are using what they have learned and how they apply this in practice

Duration

1 hour

Delivery method

Individual

Method

Video conference platform such Skype or WhatsApp on smartphone, table, laptop or computer

- It is the responsibility of the supervisee to identify and have an open discussion with a beneficiary and explain the reasons for wanting to live stream the assessment or management intervention. The supervisee must not live stream the session without consent from the beneficiary. The supervisee can explain that the client is not the focus of the session, and their face does not need to be included in the live streaming only their voice, the focus of the live streaming is the supervisee.
- If they are given consent, then it is the responsibility of the supervisee to set a time and communicate that time to the supervisor
- At that time the supervisee and supervisor sign onto Skype or WhatsApp and set up their line of communication.
- It is the responsibility of the supervisee to set up the smartphone/tablet/computer in a way that ensures the confidentiality of the client and enables the supervisor to hear and/or watch the interaction.
- The supervisor remains silent throughout the session and simply observes the supervisee and client.
- At the end of the session the supervisor and supervisee should take at least 30 minutes to discuss the session.

- The supervisor should start the conversation by allowing the supervisee to reflect on the session, think about the strengths or the interaction (what went well) and think about where the supervisee felt like they were struggling.
- The supervisor should then share their reflections on the session and facilitate a discussion about areas where the supervisee may need more help.
- By the end of the conversation the supervisor and supervisee should have a plan about what is required to build on those areas of weakness.

Strengths

This method enables the supervisor to observe and see with their own eyes how the supervisee is applying their training in practice. It also shows the supervisor the problems and constraints that the supervisee may be facing—it enables them to walk in the shoes of the supervisee.

Weaknesses

Confidentiality of the client must be prioritized. It can be difficult to encourage clients to agree to be live streamed.

Technology considerations

Live streaming requires a strong internet connection.

Protocol 7: Recorded Role Plays

Purpose

Observe and build the clinical skills of the supervisee by watching how they translate their training into their practice.

Duration

1 hour

Delivery method

Individual

Method

Video conference platform like Skype or WhatsApp on smartphone, table, laptop or computer

- It is the responsibility of the supervisor to identify supervisees who can meet and record a role play. One of the supervisees plays the role of the healthcare provider and the other plays the role of the client. They pair record themselves conducting a routine assessment/management intervention (they can use real life scenarios to inform the role play)
- It is the responsibility of the supervisees to send that recording to the supervisor at least 3 days before the supervision session.
- It is the responsibility of the supervisor to ensure that the supervisees know how to use the technology and share the recordings through email, WhatsApp, Skype.
- It is the responsibility of the supervisor to review the role play and make notes on the skills used by the healthcare provider in the session. Based on the audio/video recording the

supervisor should assess the competency of the supervisee and highlight areas where they think they may need more support. The supervisor should use their expertise to decide if they want to use the session for any further teaching based on the audio/video. Or if they want to use the recorded session as a way to promote reflective thinking amongst the supervisee(s).

- The supervisor and supervisees meet online via telephone/or video conference technology at the agreed upon time.
- The supervisor starts the session by playing the recorded role play (or if it is too long) the most relevant parts of the role play. They then give the pair who recorded the role play an opportunity to reflect on what they felt went well and where they felt they needed more support.
- The supervisor then directs the subsequent discussion to focus on skills development (which could include communication skills, assessment skills, management skills etc.)
- It is the responsibility of the supervisor to ensure that the feedback remains constructive.
- The supervisor can set the supervisee(s) practical tasks to improve their clinical skills and ask that they also record themselves using these new skills.

Strengths

This method enables the supervisor to view the skills of the supervisee without having to consider the consent of an actual client. Although the inspiration for the role play may come from a client all information will be anonymous therefore respecting confidentiality at all times.

Weaknesses

As the supervisees will be pretending and working with another healthcare provider the interaction might not be as realistic as if they were with an actual client.

Technology considerations

The recordings must be shared with the supervisee through a secure web sharing site to ensure confidentiality.

Appendix H: Client Satisfaction Scale: Remote MHPSS Services

| | |
|--|--|
| Date: | |
| Receiving remote MHPSS services since: | |
| Service provider(s) seen remotely: | |
| Remote service(s) received: | |

Client Questionnaire

Please circle the number below which reflects how accurately the following statements describe the activities, values, policies and practices of this program.

| Please circle how well you think we are doing in the following areas: | Great 5 | Good 4 | OK 3 | Fair 2 | Poor 1 |
|---|------------|-----------|---------|-----------|-----------|
| Ease of getting care | | | | | |
| Ease of access | 5 | 4 | 3 | 2 | 1 |
| Service hours | 5 | 4 | 3 | 2 | 1 |
| Convenience of remote modality | 5 | 4 | 3 | 2 | 1 |
| Staff | | | | | |
| Listen to me | 5 | 4 | 3 | 2 | 1 |
| Treat me with respect | 5 | 4 | 3 | 2 | 1 |
| Take enough time with me | 5 | 4 | 3 | 2 | 1 |
| Explain what I want to know | 5 | 4 | 3 | 2 | 1 |
| Provide useful services | 5 | 4 | 3 | 2 | 1 |
| Help me with referrals/receiving services from other organizations or providers | 5 | 4 | 3 | 2 | 1 |
| Help me improve functioning in my daily life | 5 | 4 | 3 | 2 | 1 |
| Help me in achieving my goals | 5 | 4 | 3 | 2 | 1 |
| Explain the instructions for prescribed medication (if relevant) | 5 | 4 | 3 | 2 | 1 |
| Confidentiality | | | | | |
| Keep my personal information private | 5 | 4 | 3 | 2 | 1 |

| | Very satisfied 5 | Satisfied 4 | Somewhat satisfied 3 | Not satisfied 2 | Very unsatisfied 1 |
|--|---------------------|----------------|-------------------------|--------------------|-----------------------|
|--|---------------------|----------------|-------------------------|--------------------|-----------------------|

Overall Satisfaction

| | | | | | |
|--|---|---|---|---|---|
| How satisfied are you overall with the remote MHPSS services received? | 5 | 4 | 3 | 2 | 1 |
|--|---|---|---|---|---|

Please include any other feedback you may have which may help us to improve how we provide remote MHPSS Services.

Appendix I: A Consolidated List of All Resources Provided in the Guidelines

Assessment

- [IASC Assessment Guide](#) (Refer to Section 4, Ethics and Principles for Using Mental Health and Psychosocial Support Assessment Tools)
- [WHO/UNHCR Assessing mental health and psychosocial needs and resources Toolkit for humanitarian settings](#) (For more information and advice on conducting 4Ws/service mapping, consult Tool 1, Page 30)
- [Remote Data Collection During the Time of COVID-19: Lessons from Rwanda](#)

Contingency planning

- [IFRC Contingency Planning Guide](#)
- [Operational Considerations for Multisectoral Mental Health and Psychosocial Support Programmes During the COVID-19 Pandemic](#) (Refer to Sections 2.3 Considerations when Preparing Service Adaptations for COVID-19 Scenarios; and 2.6 Considerations for Remote Working in MHPSS)
- If it is not possible to continue provision of certain MHPSS services, please mitigate using [IMC \(2016\) Guidance Note: Disengagement/Exit strategies for the Discontinuation or Handover of Programming | Mental Health Innovation Network \(mhinnovation.net\)](#)

Remote communication skills

- [IOM Internal Guideline for Remote MHPSS Working Modalities](#)
(For tips on adjusting communication skills to remote delivery consult, pages 8-13)

Resources related to recent public health emergencies

- [Mental Health and Psychosocial Support Network \(MHPSS.net\) MHPSS COVID-19 Toolkit](#)
- [Mental Health and Psychosocial Support in Ebola Virus Disease Outbreaks: A Guide for Public Health Programme Planners](#) (WHO)
- [Remote Psychological First Aid During COVID-19](#) (IFRC)
- [IASC Guidance on Operational Considerations for Multisectoral Mental Health and Psychosocial Support Programmes during the COVID-19 Pandemic](#)
- [IASC Basic Psychosocial Skills - A guide for COVID-19 Responders](#)

Self-care and psychosocial well-being

- [WHO Doing What Matters in Times of Stress](#)

Suicide, self-harm and other emergencies in remote service delivery

- [IFRC guideline on suicide and self-harm in relation to COVID-19](#)
(For guidance on managing risk, refer to pages 25-29)
- [Suicide \(SUI\) module of the mhGAP-HIG](#)
- [Epilepsy/Seizures \(EPY\) Module of mhGAP-HIG](#)

Training and supervision

- [IFRC guide on Supportive Supervision during COVID-19](#)
(For special consideration for remote supervision refer to page 10)
- [IFRC guidance on Online Facilitation in Mental Health and Psychosocial Support](#) (for guidance on facilitating remote training to enhance the learning outcomes for participants combining technical skill with social-emotional learning)