Training of Trainers and Supervisors (ToTS) training programme
Welcome

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

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

- Name
- Profession
- Current posting
- Interest and experience in mental health.
In this first section we will discuss:

- The training agenda
- Background and learning objectives of the workshop
- Pre-test.
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<td><strong>Session 1</strong>&lt;br&gt;9:00–10:30</td>
<td>Welcome and introduction to Mental Health Gap Action Programme&lt;br&gt;Importance of integrating mental health into non-specialized health settings</td>
<td>Introduction to mhGAP ToHP training methodology and competencies</td>
<td>Training skills: Using mhGAP ToHP person’s story Video demonstrations</td>
<td>Participant facilitation exercise and feedback</td>
<td>Supervision: Theory and practice</td>
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<td><strong>Session 2</strong>&lt;br&gt;11:00–12:30</td>
<td>Implementation of mhGAP-IG&lt;br&gt;Familiarization with mhGAP-IG Version 2.0</td>
<td>Preparing and evaluating a training course (including training needs assessment – TNA)</td>
<td>Training skills: Role play</td>
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<td><strong>Session 3</strong>&lt;br&gt;13:15–15:00</td>
<td>Essential care and practice module</td>
<td>Training skills: Presentation skills</td>
<td>Competency-based assessments: structure and feedback</td>
<td>Participant facilitation exercise and feedback</td>
<td>Individual feedback and plan for running own course</td>
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<td><strong>Session 4</strong>&lt;br&gt;15:30–17:00</td>
<td>Essential care and practice (continued)</td>
<td>Training skills: Facilitating group discussions&lt;br&gt;Facilitator demonstrations</td>
<td>Participant facilitation exercise: Participants given time to prepare delivery of mhGAP ToHP training</td>
<td>Participant facilitation exercise and feedback</td>
<td>Individual feedback and plan for running own course (continued)&lt;br&gt;Finish and wrap up</td>
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Aims of mhGAP ToTS

What can you expect?

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

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

**REMEMBER**: You are learning **how to conduct** a training on mhGAP-IG and/or provide supervision.
1. Become familiar with mhGAP Intervention Guide (mhGAP-IG) and training manuals.

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

3. Develop and practise supervision skills.
Pre-test

Pre and Post-test MCQs

Test the participants’ knowledge of mhGAP-IG by doing the pre-post test MCQs
Mental Health Gap Action Programme (mhGAP)

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

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

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

https://www.youtube.com/watch?v=TqlafjsOaoM&feature=youtu.be%29
mhGAP-IG target audience

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

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

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

Specialized psychiatric knowledge and skills

MNS patients who come to clinics

MNS patients manageable by mhGAP trained personnel
An evidence-based, clinical guide for the assessment and management of mental, neurological and substance use disorders in non-specialized health settings
mhGAP-IG modules

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

Think about the health care systems in your local setting.

Answer these questions:

1. Is mental health care integrated into primary health care/non-specialized health care?
2. If not, why not?
Seven good reasons for integrating mental health into non-specialized health settings

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

**Phase I: Plan**
- Assemble an mhGAP operations team
- Conduct a situational analysis
- Develop an mhGAP operations plan and budget

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

**Phase III: Provide**
- Provide services at facility level
- Provide treatment and care in the community
- Support delivery of prevention and promotion programmes
Phase I: Plan

1.1 Assemble an mhGAP operations team
1.2 Conduct a situation analysis
1.3 Develop an mhGAP operations plan and budget
Phase I: Plan

- The manual includes adaptable implementation tools
Phase II: Prepare

2.1 Adapt components of the mhGAP package
2.2 Train health care providers and others in the health system
2.3 Prepare for clinical and administrative supervision
2.4 Strengthen care pathways
2.5 Improve access to psychotropic medicines
2.6 Improve access to psychological interventions
Phase II: Prepare

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

### Practical tips for adaptation of mhGAP package components

A workshop is an effective method for adaptation, because it provides an opportunity for the working group to discuss issues face-to-face and reach a consensus efficiently. Alternatively, feedback and translation may be received by email or videoconferencing, which may be more cost-effective.

Adaptation is continuous, and some may also be done during training and supervision. Detailed notes on adaptations and translations of mhGAP materials should be recorded.

Make only essential adaptations to the mhGAP-IG 2.0. Large changes that are contrary to the formal evidence-based mhGAP recommendations should be avoided.

Any local literature about MNS conditions and the services available in the country or district should be provided during the adaptation workshop, in addition to the results of the situation analysis.

Remember that the guide is not for specialists.

It is sometimes better to test particular interventions or modes of delivery. If necessary, changes can be made in a subsequent revision.

Ensure that adaptations are appropriate for the district of implementation, which may differ in a country. Invite the minister of health or other leaders to endorse the adapted materials.
Phase III: Provide

3.1  Provide services at facility level
3.2  Provide treatment and care in the community
3.3  Support delivery of prevention and promotion programmes
Nepal's mental health care package consists of three community interventions: detection of MNS conditions, home care, and counselling. Female community health volunteers, the least trained health workers in the health system in Nepal, are trained in case detection and referral with the community informant detection tool (43, 44) to increase initiation of care for people with MNS conditions. They also provide home care to people receiving services from mhGAP-trained health workers, in which they monitor adherence to prescribed medicines, assess care from family members, and provide psychoeducation to both patients and family members. These services increase help-seeking behaviour and adherence to treatment.

The programme faces two challenges. Although the community health volunteers are an integral part of the Government health care system, they are not on the payroll, so it is difficult to ask them to undertake additional tasks. Secondly, nonspecialist health care providers are already overburdened. In the absence of mental health specialists in a district, treatment of MNS by health workers is complemented by community interventions to increase access, adherence and the quality of care, by the development of mid-level mental health and psychosocial workers in the district health care system. Paraprofessional counsellors are mobilized to provide psychosocial support in both health facilities and the community, which has ensured that psychological treatment is an integral part of Nepal's mental health care package. The absence of a position for counsellors in the health care system, however, is a challenge for sustaining psychosocial services, and advocacy is needed for a long-term mental health strategy and programme that include allocation of a sufficient budget to sustain mental health services and development of personnel with the support of NGOs and local communities.

Phase III: Provide

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

- Raise awareness
- Ensure coordination
- Monitor and evaluate

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

In small groups:

• Identify and discuss current levels of MNS service provision in your areas.

• Use the flip chart paper to draw/map future levels of service provision including:
  o Possible multidisciplinary teams
  o Which facilities can provide services and how
  o What community services can be offered
  o What can be done to prevent and promote mental health.
Familiarization
with mhGAP-IG Version 2.0
Familiarization activity
Essential care and practice module
Introduction to mhGAP ToHP training methodology
Aim of the mhGAP Training of health-care providers training manual

• Build participants’ clinical skills to be able to assess, manage and follow up individuals with priority MNS conditions.
• Train participants to use the mhGAP-IG Version 2.0 in their daily clinical practice.
• Improve participants’ knowledge and understanding of priority MNS conditions.
• Give participants the confidence to provide care to people with priority MNS conditions and receive support and clinical supervision in mhGAP-IG.
Think back to training sessions you have attended in the past.
What are the skills of a good trainer?
What made a training successful?
What made a training session less effective?
mhGAP ToHP approach to training

• The mhGAP ToHP training applies:
  o adult learning principles
  o an experiential learning cycle
  o competency-based learning
  o effective use of feedback.
I hear and I forget, I see and I remember, I do and I understand.

Confucius
Adult learning principles

• Adults learn best when they can use their own life experience.

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

1. Doing/having an experience
2. Reviewing/reflecting on the experience
3. Concluding/learning from the experience
4. Planning/trying out what you have learned

The cycle is a continuous process that encourages reflection and learning from experiences.
• The mhGAP training manuals include a series of competency checklists to be used throughout the training and in supervision.
• Competency checklists describe essential steps needed to perform different clinical skills.
• The checklists represent a framework to evaluate the trainee’s skills development.
Effective use of feedback

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

• To give effective feedback create a comfortable environment where participants are open to receiving feedback.
Activity 4: Feedback activity

Draw a house
Providing feedback

**Do**

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

**Do not**

- Focus on the person
- Use judgmental language
- Immediately list all the things that need improvement.
Preparing and evaluating an mhGAP ToHP training course
Preparing for an mhGAP ToHP training

Before the training starts:

• Conduct a brief training needs assessment (TNA).
• Adapt the material to fit the local context.
• Decide on the length and delivery method for the training.
• Prepare yourself.
A TNA is a systematic process which identifies the gap between the participants’ current skills and knowledge and the desired skills and knowledge.

The TNA should be brief and ensure that:

- The facilitator understands the participants’ training needs.
- The facilitator understands expectations regarding how participants should apply the training.
# Training needs assessment

**Location of training:**

**Contact person:**

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<thead>
<tr>
<th>Please identify which of the following sources were used to complete this form:</th>
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<tbody>
<tr>
<td>[ ] WHO/UN sources of information</td>
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<tr>
<td>[ ] National sources of information</td>
</tr>
<tr>
<td>[ ] Other published literature</td>
</tr>
<tr>
<td>[ ] Review of adverse events</td>
</tr>
<tr>
<td>[ ] Audit reviews</td>
</tr>
<tr>
<td>[ ] Review of hospital admissions data</td>
</tr>
<tr>
<td>[ ] Discussion with management</td>
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<tr>
<td>[ ] Discussion with staff</td>
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<tr>
<td>[ ] Discussion with patients</td>
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<tr>
<td>[ ] Other:</td>
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**Target population**

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

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

**Local Resources**

Which medications are available in this area?

- [ ] Acamprosate
- [ ] Amitriptyline*
- [ ] Benzhexol
- [ ] Biperiden*
- [ ] Buprenorphine
- [ ] Carbamazepine*
- [ ] Chlorpromazine*
- [ ] Cholinesterase inhibitors
- [ ] Clonidine
- [ ] Diazepam*
- [ ] Disulfiram
- [ ] Fluoxetine*
- [ ] Fluphenazine*
- [ ] Haloperidol*
- [ ] Lithium*
- [ ] Lofexidine
- [ ] Methadone*
- [ ] Methylphenidate
- [ ] Midazolam*
- [ ] Morphine*
- [ ] Naloxone*
- [ ] Naltrexone
- [ ] Oxazepam
- [ ] Phenobarbital*
- [ ] Phenytoin*
- [ ] Risperidone*
- [ ] Sodium Valproate*
- [ ] Thiamine*

WHO Essential Medicines List 2017

**What are local prescribing regulations?**

**What brief psychological treatments are available?**

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

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

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

• Although the structure of the training and supervision materials should stay the same, the content can be adapted to fit the local sociocultural context.
Purpose of mhGAP ToHP training manual adaptation

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

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

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

Use this ToTS training time to:

• Adapt the mhGAP ToHP training manual—make it culturally appropriate and relevant
• Adapt the supervision models to make them fit the local setting.
Decide the length of mhGAP ToHP training

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

- Deliver training in all nine modules on consecutive days
  - or
- Deliver the training in three parts, e.g. over three weekends
  - or
- Choose not to deliver all nine modules but only chose ECP and the most relevant priority MNS condition.
Which MNS conditions would you prioritize?
Preparing yourself

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

• Show respect for the participants’ individuality and experience – know the participants’ names and make sure they know yours.

• Establish guidelines/ground rules for the training – e.g. one person speaking at a time, listening to each other, no telephones etc.

• Establish guidelines for giving feedback.

• Use non-judgmental language.
Ways to create a comfortable learning environment

• Promote an atmosphere that feels comfortable to share ideas and experience – acknowledge that it takes courage to act and share in front of strangers and peers but we are all in the same boat and this training is an opportunity to practise and learn new skills.

• Acknowledge the participants’ existing skills and experience – encourage them to give their own experience as examples.

• Be encouraging and positive as participants practise new skills.

• Use charm and, where appropriate, humour, to put participants at ease.
Establishing Ground Rules
Evaluation

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

• Think of as many training methods as you can
Training methods

• Lectures
• Real life stories/examples
• PowerPoint Presentations
• Small group discussions
• Large group discussions
• Role plays
• Facilitator Demonstrations
• Simulations
• Brainstorming
• Video demonstrations
• Quizzes

• Case studies
• Assignments
• Reading texts
• Storytelling
• Student demonstrations
• Reflection
• Games
• Group projects
• Written tasks
• Self study
Presentation skills
Practical session

• Everyone has three minutes each to deliver their presentation

• At the end of the presentation everyone will receive some brief feedback.
Training skills:
Presentation skills

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

How effective is a lecture alone?
Suggestions for an effective presentation

• Communicate in a language that is easy to understand (avoid jargon)
• Maintain eye contact with participants (if culturally appropriate)
• Project vocally so that those in the back of the room can hear clearly
• Be interactive; Use real life stories and examples

• Display enthusiasm for the topic and its importance
• Move around the room
• Use participants’ names as often as possible
• Display a positive sense of humour
• Provide positive feedback
• Be an effective role model (if you are training in communication skills then use effective communication skills).
Components of a presentation

• Clear introduction
• Clear goals: Trainees and trainers know what the trainees will learn and why
• Training content is logical and facilitates learning
• Learner participation: Space for questions and discussions, debates and reflections
• Inclusion: Trainees’ ideas, experiences and knowledge are included in the presentation
• Summarize: Review what was taught, why and how it fits into the overall learning goal.
Group discussions
Some discussions during mhGAP ToHP training will be conducted in small groups under the supervision of facilitators (e.g. discuss psychosocial interventions for depression).

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

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

• When a group of individuals comes together for a training it is the responsibility of the facilitator to manage the interaction between group members.

• Characteristics of an effective group:
  o The group understand its goal (overall and immediate)
  o There is good communication between group members
  o The members share leadership responsibilities
  o The group can make decisions considering everyone’s view point.
Tips on creating small groups

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

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

- Group discussion facilitation activity
Facilitator demonstration
Demonstration is a interaction between trainers to illustrate possible scenarios.

Demonstration by the master trainer and co-facilitator.

Participant discussion after the demonstration:

- How did the second role play differ from the first?
- What was it like to experience those two interactions as an observer?
- How might it be to experience those types of interaction as a patient/client?
- How can this demonstration be helpful to you as a provider/facilitator?
mhGAP-IG person’s story
Training skills: Person’s story

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

The technique involves a mixture of story and reflection to stimulate discussions on people’s understandings of priority MNS conditions.
• In each module there are different story options for each priority MNS condition – either a script that is read out or a video. You can also use a taped narration. Choose the option that is most relevant to the cultural context you are in and/or adapt the story when necessary.

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

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

• Familiarize yourself and practise using the person’s story technique
Video demonstrations
Video demonstrations are used as an example of a clinical interaction (either assessment, management intervention and/or follow-up session) between a health-care provider and an individual (with or without their family member/carer).

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

Video demonstrations:

• State clearly the objective of the demonstration.

• Follow instructions in the facilitator's guide, especially when facilitating the discussion and eliciting opinions from participants.

• If a video is not available for a module that should have one (such as not available for the training language or a power outage), act out the entire correct script with a co-facilitator.
Practical session

• Practise using a video demonstration from mhGAP ToHP training manual material
Role plays
Training skills: Role plays

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

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

- Choose a role play from any of the priority MNS conditions.
Competency-based learning assessments: Structure and Feedback
Competency-based education and assessment

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

• Activity

• Reflection
Introduction to competency-based education and assessment
Introduction

• Competency-based health education has been around for 20 years.

• Uses outcomes to inform curricula and assessment processes.

• Each competency tells us what a person should

• New to the training of mhGAP-IG Version 2.0.
Without competencies

- Content (i.e. mhGAP-IG Version 1.0)
- Curriculum
- Assessment
- ??? Competencies
Competency-based education

- Competencies
- Content (mhGAP-IG Version 2.0)
- Curriculum
- Assessment
Key features of competencies in the mhGAP ToHP training

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

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

3. Competencies are dynamic and dependent on context.
Key features of competencies in the mhGAP ToHP training

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

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

3. Competencies are dynamic and dependent on context.
Competencies are considered in terms of knowledge, skills and attitudes.
How competencies inform teaching and assessment

- **Knowledge**
  - Didactic/discussion
  - Multiple-choice questions

- **Skills**
  - Practical sessions
  - Role plays

- **Attitudes**
  - Discussion/reflection
  - Supervisor assessment
Key features of competencies in the mhGAP ToHP training

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

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

3. Competencies are dynamic and dependent on context.
Competencies are the building blocks of teaching and practice

• Competencies can both be built on and broken down.
• Competencies should build on each other to ensure the person is ready to practice.
• They can also be broken down into the specific criteria needed for each competency.
Drive a car
Drive a car

Park the car

- Know the parking regulations
- Knows size of car
- Change gears
- Maneuver car into space
- Apply brakes
- Turn car off
- Buy a ticket
- Do not park somewhere that blocks others
Know the driving rules
Know how a car works
Park the car
Drive on a freeway
Drive in the city
Drive safely
Know the parking regulations
Knows size of car
Change gears
Maneuver car into space
Apply brakes
Turn car off
Buy a ticket
Do not park somewhere that blocks others
Overarching competency

Drive a car

- Know the driving rules
- Know how a car works
- Park the car
- Drive on a motorway
- Drive in the city
- Drive safely
- Know where to parking regulations
- Know size of car
- Change gears
- Manoeuvre can into space
- Apply brakes
- Turn car off
- Buy a ticket
- Do not park somewhere that blocks others
Core competencies

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

- Know where to parking regulations
- Know size of car
- Change gears
- Manoeuver can into space
- Apply brakes
- Turn car off
- Buy a ticket
- Do not park somewhere that blocks others
Key features of competencies in the mhGAP ToHP training

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

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

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

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

→ This needs to be considered when developing assessment.
What are the competencies for the mhGAP ToHP training?
<table>
<thead>
<tr>
<th>Domain</th>
<th>Competency</th>
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<tbody>
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How will we assess the competencies?
Assessment in the mhGAP ToHP training

Specific considerations:
- Pass/fail not appropriate
- Developmental levels not appropriate
- Limited time and other resources
- Focus on feedback and ongoing improvement
Types of assessment

Knowledge
- Didactic/discussion
- Multiple choice questions

Skills
- Practical sessions
- Role plays

Attitudes
- Discussion/reflection
- Supervisor assessment
Multiple-choice questions

• Written examinations are a good way to test knowledge

• Well-written MCQs can differentiate between stronger and weaker learners

• Standardized, easy, cost and time-effective
DEP multiple choice questions

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

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

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

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

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

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

• Can be used for both practising and assessing skills.

• Properties similar to an observed structured clinical examination (OSCE), which can be a reliable method of examination.

• Uses criteria-based assessment to provide feedback on skills.
PSY role plays

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

Role play 1: Assessment

Purpose: To assess a person for possible psychosis.

Duration: 30 minutes or less.

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

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

Extended version (only read this if instructed by facilitator)

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

Option 2: After about eight minutes of the interview, you clutch your chest and start complaining of chest pain. You remain calm, but it feels as though you are being crushed. Only if the health-care provider asks, you let them know that your father died of a heart attack at 47 years old, you have smoked all your life, and you have never been checked for any other health problems before so you do not know about any other conditions. You get this pain occasionally when you are walking up hills.
Role play 1: Assessment

**Purpose:** To assess a person for possible psychosis.

**Duration:** 30 minutes or less.

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

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

---

**Extended version (only read this if instructed by facilitator)**

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

You may need to revise your assessment based on the new information or focus on additional aspects.
Role play 1: Assessment

Purpose: To assess a person for possible psychosis.

Duration: 30 minutes or less.

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

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

Please assess the following competencies:

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

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

Extended version (only read this if instructed by facilitator)

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

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

### (Only use competencies which apply to task)

<table>
<thead>
<tr>
<th>Need/Work</th>
<th>Advanced</th>
<th>N/A</th>
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</table>

1. **Promote respect and dignity**
   - Treat all persons with MNS conditions with respect and dignity in a culturally appropriate manner.
   - Promote inclusion and collaborative care of people with MNS conditions and their families.
   - Protect the confidentiality and consent of people with MNS conditions.

2. **Know common presentations**
   - Know common presentations of priority MNS conditions.
   - Know other symptoms that may present as part of priority MNS conditions.

3. **Know assessment principles**
   - Name steps of history-taking for an MNS assessment and key features of each presenting complaint.
   - Past MNS history, general health history, family history of MNS conditions, psychosocial history.
   - Name assessment principles for MNS conditions: physical examination, mental status examination, differential diagnosis, basic laboratory tests, identify the MNS condition.
   - Name two or three key points under each of the assessment principles for MNS conditions.

4. **Know management principles**
   - Understand importance of integrating care for priority MNS conditions into primary practice.
   - Name management principles of priority MNS conditions, i.e. develop treatment plan in collaboration with primary care, psychosocial interventions, pharmaceutical interventions when indicated, refer to specialist, appropriate management for follow-up, work together with carers and families, foster strong links with other services, modify treatment plans for special populations.
   - Name one or two key points under each of the management principles for priority MNS conditions.

5. **Use effective communication skills**
   - Create an environment that facilitates open communication in priority MNS conditions.
   - Involve the person, and their carer when appropriate, in all aspects of assessment and management of priority MNS conditions.
   - Actively listen to the person with an MNS condition.
   - Be friendly, respectful and non-judgemental at all times in interactions with a person with an MNS condition.
   - Use good verbal communication skills in interactions with a person with an MNS condition.
   - Respond with sensitivity when people with MNS condition describe difficult experiences.

6. **Perform assessment**
   - Perform an MNS assessment using history-taking, including presenting complaint, past MNS history, general health history, family history of MNS conditions, and psychosocial history.
   - Consider and exclude other conditions to priority MNS conditions.
   - Consider other concordant conditions, both MNS and physical conditions.

7. **Assess and manage physical conditions**
   - Understand importance of assessing physical health in assessment for priority MNS conditions.
   - Take a detailed history of physical health, including asking about physical risk factors, in priority MNS conditions.
   - Perform a physical examination and investigations for priority MNS conditions, as appropriate and available.
   - Manage physical health conditions and risk factors or refer to specialist if needed in people with MNS conditions.

### Competency assessment

(Only use competencies which apply to task)

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8. **Assess and manage physical conditions**
   - Assess and manage physical conditions.

9. **Provide psychosocial interventions**
   - Perform a follow-up assessment for priority MNS conditions.
   - Perform a follow-up assessment for priority MNS conditions, determining management in relation to the priority MNS condition.
   - Manage crisis presentations and deviations from treatment plan in priority MNS conditions.

10. **Deliver pharmaceutical interventions as needed and appropriate**
    - Identify if there is a need for medication in priority MNS conditions.
    - Work collaboratively with persons with priority MNS condition to educate them about risks and benefits of treatment, potential side-effects, duration of treatment, and importance of adherence.

11. **Plan and perform follow-up**
    - Understand importance of follow-up for priority MNS conditions.
    - Know when and how to plan for follow-up for priority MNS conditions.

12. **Refer to specialists and link with outside agencies**
    - Know when to refer to a specialist at any stage of assessment or management of a priority MNS condition, as appropriate and available.

### OVERALL

**Areas of strength:**

**Areas for improvement:**
Supervisor assessment

• Uses a longer period of observation to assess attitude.

• Whilst providing feedback on attitude, can also give feedback on knowledge and skills.

• The same assessment form can be used for role plays, final feedback and workplace-based assessment.

• Be honest with feedback and give as much detail as possible.
### Competency assessment

**Only use competencies which apply to task.**

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8. **Assess and manage emergency presentations**
   - Recognize emergency presentations of priority MNS conditions.
   - Perform emergency assessment of priority MNS conditions, including risk assessment.
   - Manage emergency presentation of priority MNS conditions using non-pharmacological interventions.
   - Manage emergency presentation of priority MNS conditions using pharmacological interventions, as appropriate and available.

9. **Provide psychosocial interventions**
   - Perform psychosocial education, including the priority MNS condition and treatment available.
   - Address current psychosocial stressors to reduce stress and strengthen social support, as appropriate for the priority MNS condition.
   - Promote functioning in daily activities, as appropriate to the priority MNS conditions.
   - Involve carer and others in psychosocial intervention for priority MNS conditions, as appropriate.
   - Recognize role of other psychological treatments in priority MNS conditions, and either provide or refer on, as appropriate, i.e. brief psychological treatments for depression, specific advice regarding child and adolescent mental and behavioral disorders; interventions to improve cognitive functioning in dementia; motivational interviewing in disorders of substance use; relaxation training in other significant mental health complaints.

10. **Deliver pharmacological interventions as needed and appropriate**
    - Identify if there is a need for medication in priority MNS conditions.
    - Work collaboratively with person with priority MNS conditions to educate them about risks and benefits of treatment, potential side effects, duration of treatment, and importance of adherence.
    - Select and prescribe medication for priority MNS conditions (if has prescribing rights), as appropriate and available.
    - Consider needs of special populations when prescribing for priority MNS conditions.
    - Follow up medications for priority MNS conditions, including monitoring for side effects and adherence, considering special populations, and knowing when medications can be safely reduced and/or stopped.

11. **Plan and perform follow up**
    - Understand importance of follow up for priority MNS conditions.
    - Know when and how to plan for follow up for priority MNS conditions.
    - Perform a follow up assessment for priority MNS conditions, determining management dependent on progress of priority MNS condition.
    - Manage crisis presentations and deviations from treatment plan in priority MNS conditions.

12. **Refer to specialist and link with outside agencies**
    - Know where to refer to specialist at any stage of assessment or management of a priority MNS condition, as appropriate and available.
    - Link with other services and outside agencies for priority MNS conditions, as appropriate and available.

### OVERALL

**Areas of strength:**

**Areas for improvement:**

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</table>

**OVERALL**

**Areas of strength:**

**Areas for Improvement:**
<table>
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<tr>
<th>Competency assessment (Only use competencies which apply to task)</th>
<th>Needs work</th>
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<td>Understand importance of integrating care for priority MNS conditions into primary practice</td>
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(Only use competencies which apply to task)

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2. Know common presentations

- Know common presentations of priority MNS conditions
- Know other symptoms that may present as part of priority MNS conditions

3. Know assessment principles

- Name steps of history-taking for an MNS assessment and key features of each: presenting complaint, past MNS history, general health history, family history of MNS conditions, psychosocial history
- Name assessment principles for MNS conditions: physical examination, mental status examination, differential diagnosis, basic laboratory tests, identify the MNS condition
- Name two or three key points under each of the assessment principles for MNS conditions

4. Know management principles

- Name management principles of priority MNS conditions, i.e. develop treatment plan in collaboration, psychosocial interventions, pharmacological interventions when indicated, refer to specialist, appropriate plan for follow-up, work together with carer and families, foster strong links with other services, modify treatment plans for special populations
- Name one or two key points under each of the management principles of priority MNS conditions

5. Use effective communication skills

- Create an environment that facilitates open communication in priority MNS conditions
- Actively listen to the person with an MNS condition
- Be friendly, respectful and non-judgemental at all times in interactions with a person with an MNS condition
- Use good verbal communication skills in interactions with a person with an MNS condition
- Respond with sensitivity when people with MNS condition disclose difficult experiences

6. Perform assessment

- Perform an MNS assessment using history-taking, including presenting complaint, past MNS history, general health history, family history of MNS conditions and psychosocial history
- Consider and exclude other conditions to priority MNS conditions
- Perform collateral assessment (i.e. carer, school), as appropriate, in priority MNS conditions
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7. Assess and manage physical conditions

- Understand importance of assessing physical health in assessment for priority MNS conditions
- Take a detailed history of physical health, including asking about physical risk factors, in priority MNS conditions
- Perform a physical examination and investigations for priority MNS conditions, as appropriate and available
- Manage physical health conditions and risk factors or refer to specialist if needed in people with MNS conditions

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### OVERALL

**Areas of strength:**

**Areas for Improvement:**
Activity
Role plays...with a twist

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

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

• How was it to assess without the competencies?
• How was it to assess with the competencies?
• How was it to provide direct feedback?
• Other reflections?
• Competencies comprise of **knowledge, skills and attitude**

• They are **building blocks** of teaching and practice

• They are **dynamic** and dependent on **context**

• **Assessment** of competencies involves discussing strengths and areas for improvement
Participant Training Exercise
Supervision:
Theory and technique
What is supervision?

In pairs, discuss:

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

(five minutes)

Share your thoughts with the group.

(10 minutes)
What is supervision?

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

• A place to discuss challenging clinical cases as well as administrative and programmatic issues, problem solve, find solutions and set realistic goals.
What is supervision?

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

- One-off training without supervision is unlikely to change practice.
- Supervision should be seen as an essential, non-negotiable and ongoing component of mhGAP-IG implementation.
Goals of supervision

Post-training supervision has the following goals:

• **Clinical:** Ensures fidelity with mhGAP-IG and upskills supervisees.

• **Administrative:** Ensures documentation, record-keeping and processes are all adequate. Starts to identify future trainers to ensure sustainability.

• **Personal growth and support:** Ensures self-care and motivation are maintained, reduces stress and burnout.
Aim of support and supervision

Competence to Excellence
How do we achieve these goals?

• **Direct observation**: Supervisee is observed in vivo as they perform assessment/treatment/follow-up.

• **Indirect observation**: Supervisee is observed at a later time via audio or video-recording as they perform assessment/treatment/follow-up.

• **Case presentation/discussions**: Supervisee brings key aspects of cases/workload for presentation and discussion.
Supervision styles

• Every supervisor will have their own style, but they will need to adapt to their supervisee’s needs:
  
  o **Authoritative:** A more directive style. Useful for explicit advice or direction, challenging inappropriate behaviour or repeatedly poor clinical management.

  o **Facilitative:** More supportive and cathartic. Useful for self-reflection, validation and support.
## Supervision techniques

<table>
<thead>
<tr>
<th>Supervision techniques</th>
<th>Coaching</th>
<th>Guidance</th>
<th>Problem-solving</th>
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<tr>
<td>Collaboration</td>
<td>Handouts</td>
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<td>Instruction</td>
<td>Reflection</td>
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<td>Listening</td>
<td>Rehearsal of skills/role plays</td>
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<td>Modeling</td>
<td>Reinforcement</td>
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<td>Explanation</td>
<td>Monitoring + evaluation</td>
<td>Self-disclosure (limited)</td>
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<td>Feedback</td>
<td>Observation</td>
<td>Specific skills training</td>
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<td>Formulating</td>
<td>Question + answer sessions</td>
<td>Summarizing</td>
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<td>Goal-setting</td>
<td>Praise</td>
<td>Support</td>
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### Features of poor supervision

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

Master trainer demonstration
## Features of good supervision

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

In pairs:

• One person plays the role of supervisor
• One person plays the role of supervisee.
Activity: Role plays

As a group:

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

(10 minutes)
Supervisor skill set

• Supervisors should be any of the following:
  o A specialist in MNS disorders (psychiatrist, neurologist, psychiatric nurse)
  o A general health-care provider trained and practised in mhGAP-IG
  o A locally recognized/employed supervisor with skills in mhGAP-IG.

• When choosing supervisors, consider that the best supervisors are normally enthusiastic, dynamic, interested and competent clinicians.
• Supervisors can face a number of challenges in performing good supervision. Consider things you can do to support them:
  o Incentives or remuneration
  o Reducing other tasks or clinical time
  o Supervisor training or refresher course, or access to their own supervision
  o Ensure supervisees are punctual, prepared, and ready to participate
  o ???
Take-home messages

• Supervision is an essential component of the mhGAP ToHP training and implementation.

• Supervision can address clinical, administrative and personal growth and support issues.

• Good supervisors are usually interested, enthusiastic, competent clinicians, who use multiple techniques and adjust their style to suit the supervisee.

• Good supervisors need support.
Supervision – practical
Activity: Barriers to supervision

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

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

(10 minutes)
Barriers to supervision

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

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

**System**
- Lack of time allocated to supervision
- Lack of space available for supervision
- Lack of recognition of importance of supervision
- Clinical and academic matters take priority
For the mhGAP ToHP training, four different models of supervision have been suggested, although multiple modalities can be used if needed.

Each supervision modality can be done as a pair or a group.

Planning and preparing for a supervision, particularly putting aside regular time, allows for the best chance of success.

Consider what training, incentives and support can be offered to supervisees and supervisors to help facilitate regular supervision.
Models of supervision for mhGAP-IG Version 2.0

**Apprenticeship Model**
Supervisee does a ‘placement’ with supervisor for a set period of time (normally weeks to months).
Supervisee initially observes supervisor consultations, and is encouraged to interpret clinical information and ask questions.
Supervisor then performs direct clinical observation of supervisee performing clinical review, and also provides discussion and de-brief, and feedback.

**On-site Supervision**
Supervisor performs regular, scheduled, on-site visits to the supervisee/s.
Supervisor performs clinical observations of supervisee, reviews patient documentation, holds de-briefing sessions, evaluates clinic implementation of mhGAP-IG, addresses clinical challenges.

**Case conference Supervision**
Supervisor meets regularly with supervisee/s.
Supervisor usually does not perform direct clinical observation, but uses other supervision interventions, including indirect observation (listening to recordings), case discussion, instruction or teaching, feedback, goal-setting, reflection etc.
Can be performed as face-to-face (preferred) or remote.

**Peer Supervision**
A possible solution when no supervisor is available.
Supervisees form small groups (ideally >3 people), determine structure and function, and appoint or rotate a ‘leader’ who will ensure the group stays on task.
Can be performed as face-to-face (preferred) or remote.

Greater resources, likely to be more effective

Fewer resources required, less evidence about efficacy
Apprenticeship model

- Supervisee/s does a placement with supervisor for set period of time (weeks to months).

- Supervisee/s initially observe/s supervisor consultations, whilst interpreting clinical information and asking questions.

- Supervisee/s later start/s performing clinical reviews under direct observation, followed by discussion, debrief and feedback.
## Apprenticeship model

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

- One-on-one: ✔
- Small group: ✔
Case study

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

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

• Supervisor performs regular, scheduled, visits to the supervisee/s’ workplace.

• Supervisor performs direct observation of supervisee, reviews documentation, holds debriefing sessions, evaluates service implementation of mhGAP-IG.

• Supervisor addresses clinical and administrative challenges and provides general support.
# On-site supervision

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
<th>Formats available</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Effective</td>
<td>• More resource-intensive than other methods</td>
<td>✔</td>
</tr>
<tr>
<td>• Direct observation</td>
<td>• Supervisor will need to be released from usual duties to attend workplace</td>
<td>✔</td>
</tr>
<tr>
<td>• Immediate feedback</td>
<td>• Supervisee/s will need to be released from usual duties for several hours</td>
<td></td>
</tr>
<tr>
<td>• Early detection of non-normative practice</td>
<td>• Requires patient consent</td>
<td></td>
</tr>
<tr>
<td>• Ability to assess service implementation of mhGAP-IG</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>One-on-one</th>
<th>Small group</th>
<th>Large group</th>
<th>Distance</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔</td>
<td>✔</td>
<td></td>
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</tbody>
</table>
On-site supervision

Case study

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

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

- Supervisor meets regularly with supervisee/s.

- Does not involve direct observation, but instead utilizes indirect observation (audio or video-recordings) or case discussion.

- Also involves debrief, feedback and other supervision techniques.
## Case conference supervision

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
<th>Formats available</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Likely to be effective</td>
<td>• No opportunities for direct supervision</td>
<td>✔️</td>
</tr>
<tr>
<td>• Less resource-intensive</td>
<td>• Personal reporting of cases can be inaccurate</td>
<td>✔️</td>
</tr>
<tr>
<td>• Flexible, efficient, can be done out of hours and workplace</td>
<td>• Less opportunity to detect non-normative practice</td>
<td>✔️</td>
</tr>
<tr>
<td>• Can be done distance and by larger groups</td>
<td></td>
<td>✔️</td>
</tr>
<tr>
<td>• Can be used in emergency situations</td>
<td></td>
<td>✔️</td>
</tr>
<tr>
<td></td>
<td></td>
<td>✔️</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>One-on-one</th>
<th>Small group</th>
<th>Large group</th>
<th>Distance</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
</tbody>
</table>
Case study

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

Following the training, the health-care providers received monthly case conference supervision. The primary care doctors reported increased competence in diagnosing and managing common mental disorders, and in identifying and managing risk of suicide. Overall, the intervention in Nepal was felt to be a success.
• Supervisees form groups (ideally three to six) and provide support and advice to each other on practice, using indirect observation or case discussion. Also provides administrative and personal support.

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

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

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
<th>Formats available</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Low resource</td>
<td>• Less evidence for effectiveness</td>
<td>✔</td>
</tr>
<tr>
<td>• Acceptable to supervisees</td>
<td>• No opportunity for direct supervision</td>
<td>✔</td>
</tr>
<tr>
<td>• Likely to offer good personal support, motivation and encouragement</td>
<td>• Personal reporting of cases can be inaccurate</td>
<td>✔</td>
</tr>
<tr>
<td>• Suitable for distance and larger groups</td>
<td>• Less opportunity to detect non-normative practice, and risk of spread within group</td>
<td>✔</td>
</tr>
</tbody>
</table>

- One-on-one
- Small group
- Large group
- Distance
Case study

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

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

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

- **Who?**
- **What?**
- **When?**
- **Where?**
- **How?**
Preparing for supervision – who?

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

Who will be the supervisees?
• The smaller the group the better supervision is likely to be.
• Consider practicalities such as availability and location when choosing people in your group.
Preparing for supervision – what?

What type of supervision group will you have?

• Choose from:
  o Apprenticeship model
  o On-site supervision
  o Case conference supervision
  o Peer supervision

• Determining what type of group you will have is dependent on resources and settings.

• Where resources permit, supervision that allows for direct observation should be encouraged. However, in low-resource settings, providing supervision through case conference or peer supervision is still better than no supervision at all.

• You can utilize multiple supervision models, or progress from a more intensive to a less intensive model.
Preparing for supervision – when?

When will supervision occur?

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

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

How will supervision take place?

• Supervision session structure and agenda should be predetermined and adhered to.

• Use multiple interventions in supervision, including direct observation, instruction, demonstration, role play, discussion and reflection. If there is no capacity to perform direct observation, consider indirect observation through videoed or taped sessions.

How will the group function?

• Develop contracts and agreements for how each group's supervision will run. This includes considering criteria for membership, how feedback will be given, and the session structure.

• For peer supervision groups, a leader should be determined to ensure that the structure is maintained.

• Consider how fidelity to mhGAP-IG will be maintained, and how progress and success will be monitored.

• Proformas have been designed to help perform supervision
<table>
<thead>
<tr>
<th>Case details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>History</strong></td>
</tr>
</tbody>
</table>

| Current situation/problem |

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

| Points you want to discuss |

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

| Next steps |
### Supervision report and feedback

<table>
<thead>
<tr>
<th>Facility:</th>
<th>Supervisee name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
<td>Supervisor name:</td>
</tr>
</tbody>
</table>

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

#### Areas for improvement

#### Administrative/programmatic feedback
Strengths (e.g. processes, supplies, staffing)

#### Areas for improvement
<table>
<thead>
<tr>
<th>Personal reflection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility:</td>
</tr>
<tr>
<td>Date:</td>
</tr>
</tbody>
</table>

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

**Personal strengths**

**Areas for development**

**Administrative or other challenges**

**Future plans (to be filled in with supervisor)**
### Competency assessment

**Only use competencies which apply to task**

<table>
<thead>
<tr>
<th>Needs</th>
<th>Work</th>
<th>Achieved</th>
<th>N/A</th>
</tr>
</thead>
</table>

1. **Promote respect and dignity**
   - Treat all with MNS conditions with respect and dignity in a culturally appropriate manner
   - Promote inclusive and collaborative care of people with MNS conditions and their carers
   - Protect the confidentiality and consent of people with MNS conditions

2. **Know common presentations**
   - Know common presentations of priority MNS conditions
   - Know other symptoms that may present as part of priority MNS conditions

3. **Assessment principles**
   - Name steps of history-taking for an MNS assessment and key features of each: presenting complaint, past MNS history, general health history, family history of MNS conditions, psychosocial history
   - Name assessment principles for MNS conditions: physical examination, mental status examination, differential diagnosis, basic laboratory tests, identify the MNS condition
   - Name two or three key points under each of the assessment principles for MNS conditions

4. **Know management principles**
   - Understand importance of integrating care for priority MNS conditions into primary practice
   - Name management principles of priority MNS conditions, i.e. develop treatment plan in collaboration: psychological interventions, pharmacological interventions when indicated, refer to specialist, appropriate plan for follow-up, work together with carer and families, foster strong links with other services, modify treatment plans for special populations
   - Name one or two key points under each of the management principles of priority MNS conditions

5. **Use effective communication skills**
   - Create an environment that facilitates open communication in priority MNS conditions
   - Involve the person, and their carer when appropriate, in all aspects of assessment and management of priority MNS conditions
   - Actively listen to the person with an MNS condition
   - Is friendly, respectful and non-judgemental at all times in interactions with a person with an MNS condition
   - Use good verbal communication skills in interactions with a person with an MNS condition
   - Respond with sensitivity when people with MNS condition disclose difficult experiences

6. **Perform assessment**
   - Perform an MNS assessment using history-taking, including: presenting complaint, past MNS history, general health history, family history of MNS conditions and psychosocial history
   - Consider and exclude other conditions to priority MNS conditions
   - Perform collateral assessment (i.e. carer/school), as appropriate in priority MNS conditions
   - Consider other concurrent conditions, both MNS and physical conditions

7. **Assess and manage physical conditions**
   - Understand importance of assessing physical health in assessment for priority MNS conditions
   - Take a detailed history of physical health, including asking about physical risk factors in priority MNS conditions
   - Perform a physical examination and investigations for priority MNS conditions, as appropriate and available
   - Manage physical health conditions and risk factors or refer to specialist if needed in people with MNS conditions

8. **Assess and manage emergency presentations**
   - Recognize emergency presentations of priority MNS conditions
   - Perform emergency assessment of priority MNS conditions, including risk-assessment
   - Manage emergency presentation of priority MNS conditions using non-pharmacological interventions
   - Manage emergency presentation of priority MNS conditions using pharmacological interventions, as appropriate and available

9. **Provide psychosocial interventions**
   - Perform psychoeducation, including about the priority MNS condition and treatment available
   - Address current psychosocial stressors to reduce stress and strengthen social supports, as appropriate for the priority MNS condition
   - Promote functioning in daily activities, as appropriate to the priority MNS conditions
   - Involve carer and others in psychosocial intervention for priority MNS conditions, as appropriate
   - Recognize role of other psychological treatments in priority MNS conditions, and either provide or refer on, as appropriate, (i.e. brief psychological treatments for depression; specific advice regarding child and adolescent mental and behavioural disorders; interventions to improve cognitive functioning in dementia; motivational interviewing in disorders of substance use; relaxation training in other significant mental health complaints)

10. **Deliver pharmacological interventions as needed and appropriate**
    - Identify if there is a need for medication in priority MNS conditions
    - Work collaboratively with person with priority MNS condition to educate them about risks and benefits of treatment, potential side-effects, duration of treatment, and importance of adherence
    - Select and prescribe medication for priority MNS conditions (if has prescribing rights), as appropriate and available
    - Consider needs of special populations when prescribing for priority MNS conditions
    - Follow-up medications for priority MNS conditions, including monitoring for side-effects and adherence, considering special populations, and knowing when medications can be safely reduced and/or stopped

11. **Plan and perform follow-up**
    - Understand importance of follow-up for priority MNS conditions
    - Know when and how to plan for follow-up for priority MNS conditions
    - Perform a follow-up assessment for priority MNS conditions, determining management dependent on progress of priority MNS condition
    - Manage crisis presentations and deviations from treatment plan in priority MNS conditions

12. **Refer to specialist and link with outside agencies**
    - Know when to refer to a specialist at any stage of assessment or management of a priority MNS condition, as appropriate and available
    - Link with other services and outside agencies for priority MNS conditions, as appropriate and available

### OVERALL

**Areas of strength:**

**Areas for improvement:**
## Which forms when?

<table>
<thead>
<tr>
<th></th>
<th>Apprenticeship model</th>
<th>On-site supervision</th>
<th>Case conference supervision</th>
<th>Peer supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Difficult case report form</strong></td>
<td></td>
<td>✔</td>
<td></td>
<td>✔</td>
</tr>
<tr>
<td><strong>Supervision report and feedback form</strong></td>
<td>✔</td>
<td>✔</td>
<td>(supervisors may wish to use this form to give feedback)</td>
<td></td>
</tr>
<tr>
<td><strong>Personal reflection form</strong></td>
<td>✔ (every three to six months)</td>
<td>✔ (every three to six months)</td>
<td>✔ (every three to six months)</td>
<td>✔ (every three to six months, can be done for own reflection)</td>
</tr>
<tr>
<td><strong>Competency assessment form</strong></td>
<td>✔</td>
<td>✔</td>
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</tbody>
</table>
Evaluation of supervision

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

• Individual supervision groups are encouraged to periodically invite an outside supervisor to observe their group and provide feedback.
Activity: Supervision in your area

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

• Who?
• What?
• When?
• Where?
• How?
(15 minutes)

Present your findings to the group and provide your rationale.
(30 minutes for everyone; three to five minutes/group)
Take-home messages

• Supervision is an essential component of mhGAP ToHP training and implementation.

• There are models of supervision to suit every service and context.

• As a trainer, consider how you can support local supervision.

• You now have a plan for supervision in your area – use it!