LSE Department of International Development

DIGITAL MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT

CHALLENGES AND BEST PRACTICES

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Disclaimer

This report has been prepared for the International Federation of the Red Cross and Red Crescent (IFRC) and the Swiss Red Cross (SRC) by a consultancy team from The London School of Economics and Political Science (LSE). The views expressed are those of the authors and do not reflect those of the IFRC, the SRC, or the LSE.

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List of Acronyms / Glossary

GDPC	Global Disaster Preparedness Center *Reference centre to support innovation and learning in disaster preparedness, established by the American Red Cross and the International Federation of the Red Cross and Red Crescent.*
IASC	Inter-Agency Standing Committee *The highest-level coordination forum of the United Nations system for humanitarian action. It regroups 18 international organisations inside and outside the UN to develop policies, set priorities of action and mobilise resources for humanitarian action.*
ICRC	International Committee of the Red Cross *Independent humanitarian organisation mandated to protect people in armed conflict worldwide.*
IFRC	International Federation of Red Cross and Red Crescent Societies *Global Secretariat of the National Red Cross Red Crescent Societies*
IFRC PS Centre	International Federation of the Red Cross and Red Crescent Reference Centre for Psychosocial Support *Reference centre of the International Federation of the Red Cross and Red Crescent. mandated to support National Societies in promoting and enabling the psychosocial well-being of affected populations, staff, and volunteers.*
IRCRCM	International Red Cross Red Crescent Movement *The overarching international humanitarian movement which regroups the individual National Red Cross Red Crescent Societies, the International Federation of Red Cross and Red Crescent Societies and the International Committee of the Red Cross. It is made up of nearly 14 million volunteers and over 160,000 local branches in 192 countries.*
MHPSS	Mental Health and Psychosocial Support *According to the Inter-Agency Standing Committee, it is 'a composite term for any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder'.*

NS National Red Cross Red Crescent Society
Autonomous national organisation committed to the Fundamental Principles of the International Red Cross Red Crescent Movement. Each of the 192 National Societies consists of a network of local volunteers and staff who provide a wide variety of services.

PFA Psychological First Aid
A method designed for emergency intervention, providing short-term relief to people experiencing an acute mental health crisis.

RCT Randomised Controlled Trial
An experimental evaluation method based on the random attribution of a treatment and controlling of extraneous variables between the treatment and control groups to evaluate the efficacy of a treatment.

SOP Standard Operating Procedure

UNDP United Nations Development Program
United Nations agency dedicated to advancing development and eradicating poverty worldwide.

UNHCR United Nations High Commissioner for Refugees
United Nations Refugee Agency dedicated to protecting rights and lives of refugees, forcibly displaced and stateless people.

UNICEF United Nations International Children's Emergency Fund
United Nations agency dedicated to providing humanitarian aid and development assistance to children worldwide.

WHO World Health Organization
United Nations agency that connects key stakeholders in promoting health and fighting diseases.

Executive Summary

Addressing mental health and psychosocial wellbeing has become imperative worldwide, however, the treatment gap is only increasing. This is especially the case for low- and middle-income countries, societies affected by emergencies and conflicts, and vulnerable groups. This report aims at recommending ways in which digital technologies could help address this gap effectively. This report is structured around seven Chapters:

Chapter I introduces the purpose and research scope of this report before presenting the key concepts with which this report engages, and the methodology employed. Commissioned by the IFRC Reference Centre for Psychosocial Support and the Swiss Red Cross in partnership with the London School of Economics and Political Science (LSE), this study analyses how digital technologies can be leveraged for improving the provision of mental health and psychosocial support (MHPSS) services and the challenges faced by practitioners throughout this process. Importantly, the report aims at identifying solutions from the field and proposing practical recommendations to address these challenges. To achieve so, 32 interviews with key informants were conducted, complemented with in-depth desk-based research.

Chapter II presents the theoretical approach to digital MHPSS adopted in this report. After introducing the International Red Cross and Red Crescent Movement (IRCRCM) approach to MHPSS, the report proposes an analytical framework to assess digital MHPSS practices. The framework is composed of the five main elements – safety, effectiveness, scalability, sustainability, and participation (SESSP) – and is devised to guide the design, implementation, and evaluation of digital MHPSS interventions.

Chapter III considers how digital technologies can advance the provision of MHPSS services. The chapter analyses the current landscape of conventional MHPSS activities within the Movement. It is argued that digital technologies have the potential of overcoming some of the specific needs encountered by National Societies in the provision of conventional MHPSS services to date. This is because i) digital interventions can overcome the barrier of stigma thanks to anonymity; ii) digital interventions can be equally effective as in-person interventions, in certain circumstances; iii) digital interventions allow scaling up services access to previously inaccessible populations, and at minimal marginal costs; iv) digital technologies can improve the continuum of care if integrated into the wider care system and can improve local capacity-building; and v) digital interventions can make MHPSS provision more participatory. In short, digital MHPSS has the potential of bridging the growing treatment gap in MHPSS. Finally, this chapter also gives an overview of how digital MHPSS is used in the Movement so far.

Chapter IV presents the evidence collected through the interviews. The section progresses following the SESSP Analytical Framework, systematically matching common challenges faced by practitioners at each level to practical solutions emanating from field experience with digital MHPSS. Main themes include data security, quality of care, cultural appropriateness, resource limitations, accessibility of services, and inclusiveness.

Chapter V synthesises overarching solutions from the field and from practical recommendations that arose from the previous analysis of challenges and solutions. The identified recommendations are intended to advance the provisions of MHPSS services by pointing out how and when can digital technologies enhance this provision. The recommendations are:

1. To the Movement: Leverage digital tools to collect data on digital interventions for monitoring and evaluation. Leverage the data thus gathered to enhance planning.

2. To the Movement: Develop hybrid models of both digital and conventional MHPSS within single interventions and comprehensive programs to maximise efficiency and impact.

3. a) To the Movement: Adopt and adapt existing evidence-based interventions
   b) To the IFRC: Facilitate adoption by creating, updating, and disseminating a whitelist of evidence-based interventions; and a blacklist of unsafe interventions
   c) To the IFRC: Create an MHPSS Innovation centre to develop, maintain and update new interventions to be distributed at minimal marginal cost

4. To the Movement: Critically engage in partnerships to overcome resource gaps and optimise outcomes. Partnerships with private companies must comply with special safety standards to ensure the integrity of humanitarian principles.

5. To the Movement: Build synergies with local structures by organising efficient task transfers and referrals, and by building local capacities.

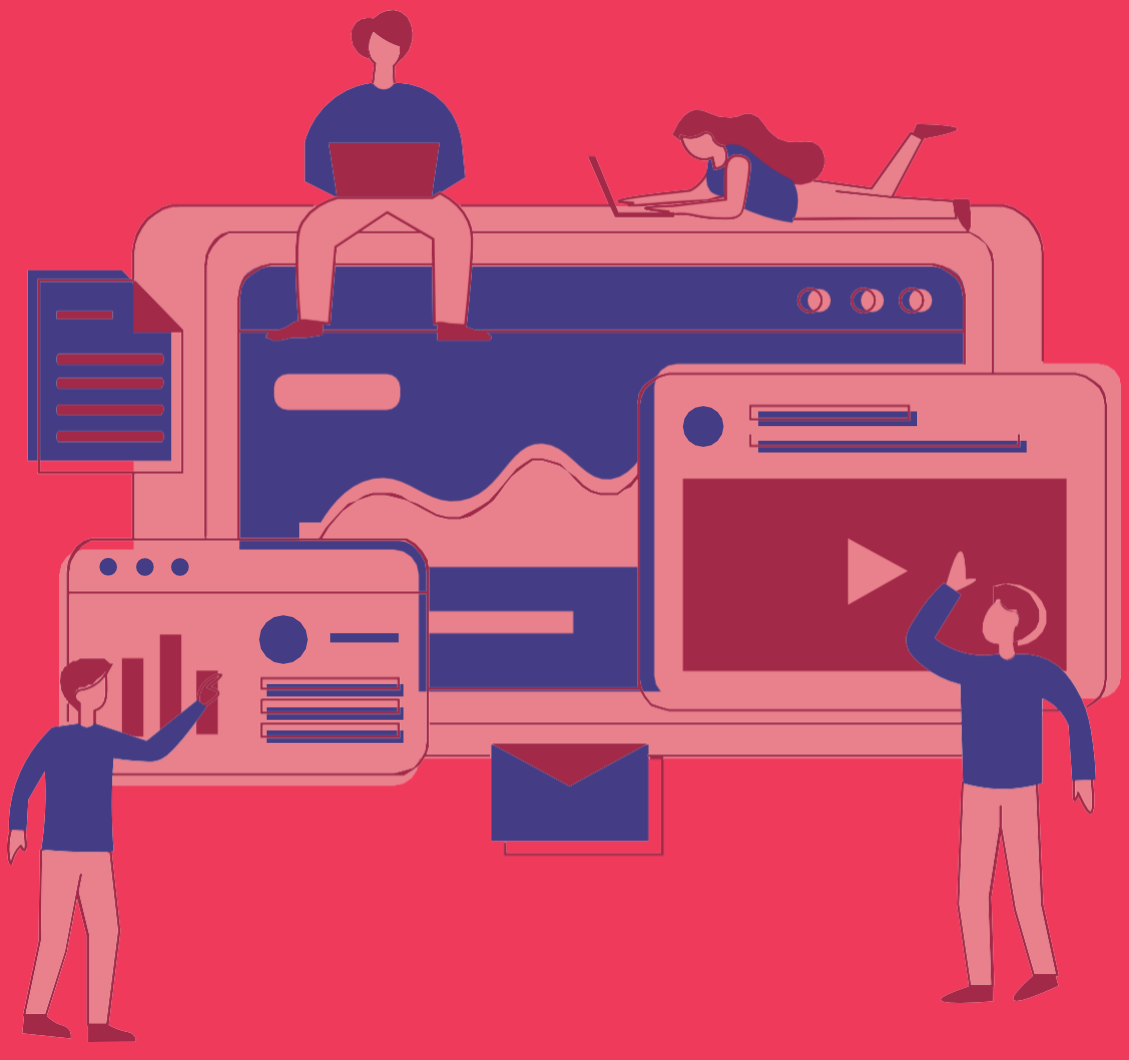
6. To the IFRC: Develop digital training modules, Standard Operating Procedures, and supervision for practitioners to improve quality of care and to safeguard practitioners' wellbeing.

Chapter VI highlights three critical considerations that should be accounted for when providing digital MHSPP services.

1. First, there is a bias in the literature on the effectiveness of digital MHPSS interventions, as most of the research has been conducted in Western and high-resource contexts. Hence the evidence base of digital MHPSS interventions should be critically considered.
2. Second, the inequitable access to digital MHPSS should be considered. The capacity to digitalize MHPSS services differs between the Global North and the Global South. In addition, other factors such as gender, also affect individuals' access to digital MHPSS services.
3. Finally, digital MHPSS interventions are just one aspect in the advancement of individual and social wellbeing. Without an enabling environment for holistic wellbeing, the impact of digital MHPSS services is limited.

Chapter VII concludes by identifying areas of further research and calling upon the wider MHPSS community to create a durable platform for knowledge sharing and innovation in digital MHPSS.

I. INTRODUCTION



I. Introduction

1. Background and Purpose of this document

Nearly one-third of the global population suffers from a common mental disorder at one point in their lifetime (primarily mood, anxiety, and substance use disorders).[1] The ongoing COVID-19 pandemic has further deteriorated global mental wellbeing,[2] and disrupted critical mental health services worldwide.[3]

Treating and preventing mental health problems is an urgent concern for global health. Apart from stress and mental illness being a risk factor for many diseases, globally more than 700,000 lives are lost to suicide every year.[4] Mental health problems also hamper productivity, with the approximate global cost of 6 trillion USD by 2030.[5] Most importantly, however, mental wellbeing is a human right and a cornerstone of human flourishing.[6]

However, the world faces a pervasive provision gap in mental health and psychosocial support (MHPSS), underpinned by a chronic shortage of mental health staff. The global median number of mental health workers stands at 13 per 100,000 inhabitants and only 1.4 and 3.8 in lower- and lower-middle-income countries, respectively.[7] The IRCRCM as one of the most important providers of humanitarian MHPSS faces additional challenges as it is routinely engaged in circumstances where provision and support work are marred by access difficulties, like natural disasters or armed conflict. These challenges create an urgent need for innovative solutions that provide adequate care to affected populations and alleviate the burden off service providers. Digital technologies have emerged as a promising approach to overcoming this provision gap by bridging physical distances and serving larger populations at lower cost.

To advance the provision of MHPSS, the IRCRCM adopted a resolution in 2017 aiming at strengthening the Movement's collective response to mental health and psychosocial needs. In 2019, the Movement's 'Policy on Addressing Mental Health and Psychosocial Needs' was published, reiterating the Movement's approach to MHPSS, and establishing eight policy statements,[8] together with a Roadmap for 2020-2023 for achieving set targets. Given the potential of digital interventions in improving MHPSS

[1] Steel et al., "The Global Prevalence Of Common Mental Disorders: A Systematic Review And Meta-Analysis 1980–2013."
[2] Santomauro et al., "Global Prevalence And Burden Of Depressive And Anxiety Disorders In 204 Countries And Territories In 2020 Due To The COVID-19 Pandemic"
[3] WHO, "The Impact Of COVID-19 On Mental, Neurological And Substance Use Services."
[4] WHO, "Suicide."
[5] The Lancet Global Health, "Mental Health Matters."
[6] Patel and Saxena, "Transforming Lives, Enhancing Communities — Innovations In Global Mental Health."; Patel et al., "The Lancet Commission On Global Mental Health And Sustainable Development."
[7] WHO, *Mental Health Atlas 2020*.
[8] The Working Group of the International Red Cross and Red Crescent Movement Project on Addressing Mental Health and Psychosocial Consequences of Armed Conflicts, Natural Disasters and Other Emergencies, *International Red Cross And Red Crescent Movement Policy On Addressing Mental Health And Psychosocial Needs*.

delivery, the Roadmap encourages the design, evaluation, and documentation of digital MHPSS delivery to facilitate the achievement of the Movement's MHPSS goals by the end of 2023.[9]
The present report aims to contribute to this task by answering four research questions:

1. What digital MHPSS interventions exist inside and outside the Movement?
2. What are the common challenges faced by actors inside and outside of the Movement in their implementation of digital MHPSS?
3. What are viable solutions and best practices in overcoming these challenges?
4. What should relevant stakeholders do to effectively leverage digital innovations for MHPSS within the Movement?

This report aims to present an analysis of what practices exist today and practical solutions for addressing the challenges seen in the field. The report proceeds as follows: First, conceptual and methodological issues will be clarified. Second, the report reviews the IRCRCM's MHPSS approach and devises an analytical framework on digital MHPSS. Based on a needs assessment of current MHPSS within the Movement, the report highlights the potential value added by digitalising MHPSS interventions. Third, the report presents the findings from desk-based research and key informant interviews, presenting an overview of existing digital MHPSS, summarising common challenges and highlighting viable solutions. Finally, a set of six recommendations will be derived, before engaging in a critical reflection of the analysis.

2. Key Concepts

2.1 Mental Health

According to the World Health Organisation (WHO), health encompasses wellbeing in physical, mental and social aspects, where mental health is a 'state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community'.[10]

2.2 Psychosocial Support

In explaining the causes of mental health conditions, social factors are just as important as individual factors, if not more. As suggested in the Bronfenbrenner Ecological Systems Theory,[11] individual development is affected by the surrounding context, from microsystems such as family and school to macrosystems such as societal norms. If well-aligned, these social systems can be a crucial source of psychological resilience.[12]

[9] *International Red Cross And Red Crescent Movement Commitments On Addressing Mental Health And Psychosocial Needs: A Roadmap For Implementation 2020 – 2023*.
[10] "Mental Health: Strengthening Our Response."
[11] Bronfenbrenner, *The ecology of human development: Experiments by nature and design*.
[12] International Committee of The Red Cross, *Guidelines On Mental Health And Psychosocial Support*.

2.3 Mental Health and Psychosocial Support (MHPSS)

According to the Inter-Agency Standing Committee, MHPSS is a 'composite term […]to describe any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder'.[13] MHPSS encompasses multi-layered responses that can address mental health needs in the short- and long term. MHPSS interventions are situated along a continuum ranging from general to focused intervention, from community-focused to individual-focused.[14]

2.4 Digital MHPSS

Digital mental health (or 'e-mental health') describes 'the use of information and communication technology (ICT) – in particular the many technologies related to the Internet – to support and improve mental health conditions and mental health care.'[15] Accordingly, digital MHPSS refers to MHPSS interventions that are supported by ICTs.

3. Methodology

To address the research questions, we employ a two-part mixed methods approach. At its core, we conducted 32 key informant interviews from which we derived information on 37 digital MHPSS interventions. This analysis is complemented by desk-based research.

3.1 Desk-Based Research

To establish a theoretical foundation for our research, we conducted desk-based research on the effectiveness of digital and conventional MHPSS and reviewed existing guidelines on MHPSS and digital technologies in humanitarian settings, drawing on scientific publications and grey literature of various humanitarian organisations. This research highlights key issues and debates around (digital) MHPSS, pinpoints challenges and current developments, and informs the Analytical Framework against which we evaluate our findings. Moreover, web-based research allows us to identify existing digital MHPSS interventions inside and outside the movement.

3.2 Key informant interviews

The core part of our data collection rests on the realisation of 32 semi-structured key informant interviews with mental health experts and field practitioners from inside (20) and outside the Movement (12) (cf. Annex 1 for the full list of interviewees) who reported their experiences in implementing 37 digital MHPSS interventions (cf. Annex 2). Semi-structured interviews are the best-suited data collection method for our study because they allow a deeper understanding of digital MHPSS in a purposive manner while giving interviewees ample freedom to express what they deem important.[16]

[13] Inter-Agency Standing Committee, *IASC Guidelines On Mental Health And Psychosocial Support In Emergency Settings*.
[14] Lee et al., "Identifying Research Priorities For Psychosocial Support Programs In Humanitarian Settings."
[15] Riper et al., "Theme Issue On E-Mental Health: A Growing Field In Internet Research."
[16] Hamilton and Corbett-Whittier, *Using Case Study In Education Research.*

Key informants were initially identified using purposive sampling, in close consultation with the clients. This method is appropriate because it allows us to identify informants who were most likely to provide relevant insights.[17] The selection was made based on the following criteria: professional experience with digital MHPSS; balance between researchers and practitioners; geographical balance; balance between internal and external informants. We complemented this initial sample via a snowball sampling method, eliciting the knowledge of our interviewees to identify more knowledgeable experts on the topic. Moreover, one participant observation in an internal workshop by the Movement's Global Disaster Preparedness Centre was conducted.

3.3 Limitations

First, privileging in-depth informant interviews instead of surveys reduces the breadth of the data. Second, our sampling method did not allow for a representative sample of interviewees, leading to an under-representation of lower-income regions that reflects structural disadvantages in digitalising MHPSS. Third, though the team is international in make-up, we are deeply aware of our biases in analysing social and mental health issues from across different contexts.

4. Ethics and Anonymity

Our empirical methodology was approved by the LSE Ethics Committee. We elicited the informed consent of all interviewees via signed consent forms and included direct quotes only upon explicit authorisation.

[17] Tongco, "Purposive Sampling As A Tool For Informant Selection."

Figure 1: Overview of interviews conducted[18]

[18] Authors' own production.

II.
THE APPROACH:
DIGITAL MHPSS

II. The Approach: Digital MHPSS

1. The IRCRCM Approach to MHPSS

The IRCRCM's MHPSS model consists of a four-layered intervention pyramid (Figure 2). As interventions move up the pyramid from basic psychosocial support to specialised mental health care, their focus moves from promotion of mental wellbeing to prevention of mental health conditions, to treating distress and mental health conditions. The higher up the pyramid, the more focused and specialised care becomes, and the higher levels of competencies and training are required. This continuum of care should be situated in a protective environment where rights and dignity of service users are respected. This report adopts this approach throughout its considerations on digital MHPSS.[19]

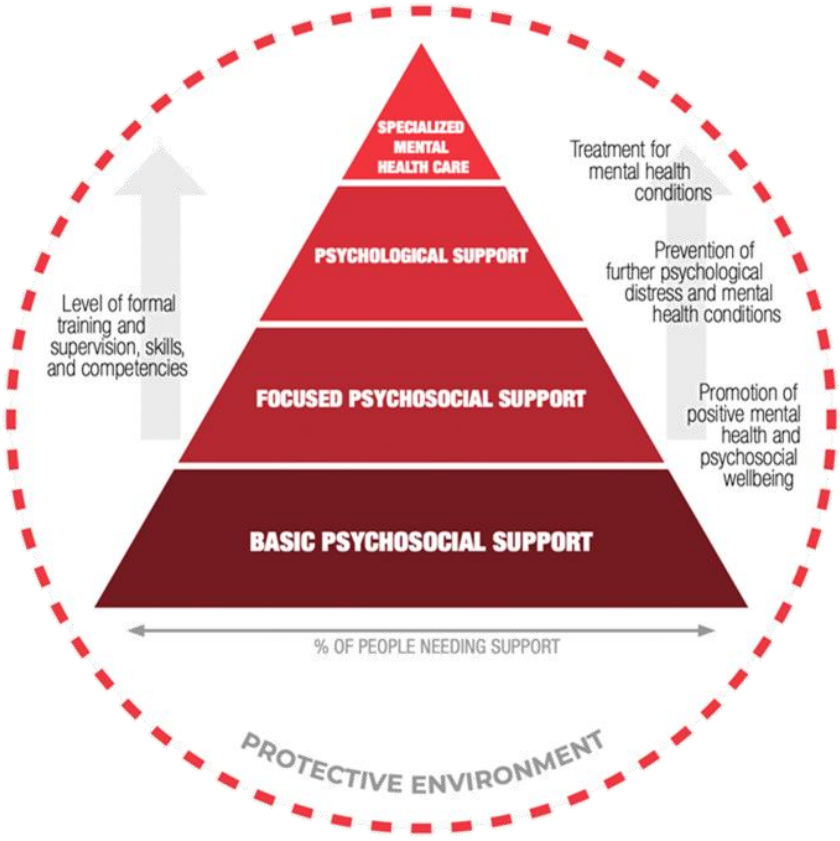


Figure 2: The IRCRCM Mental Health and Psychosocial Support Framework[20]

[19] Psychosocial Centre International Federation of Red Cross and Red Crescent Societies, "The MHPSS Framework."
[20] Adapted from Psychosocial Centre International Federation of Red Cross and Red Crescent Societies, "The MHPSS Framework."

2. Analytical Framework for Digital MHPSS Interventions: SESSP

To assess practices of digital MHPSS and guide corresponding recommendations, this report establishes an original analytical framework encompassing five key dimensions: **Safety, Effectiveness, Scalability, Sustainability,** and **Participation**. Each dimension consists of several facets which highlight key determinants of the success of digital interventions (Figure 3 and Table 1).

This set of guiding principles is developed based on the 'Guidelines on Mental Health and Psychosocial Support' by the ICRC,[21] as well as the 'Common Monitoring and Evaluation Framework for Field test version Mental Health and Psychosocial Support in Emergency Settings' developed by Inter-Agency Standing Committee (IASC),[22] the 'Monitoring and Evaluation Framework for Psychosocial Support Interventions' in the Movement,[23] and the 'Mental Health And Psychosocial Technical Note',[24] in addition to practical concerns and needs of the IRCRCM. This analytical framework is not meant to be exhaustive, but to serve as a guide to highlight core principles in evaluating and recommending digital MHPSS.

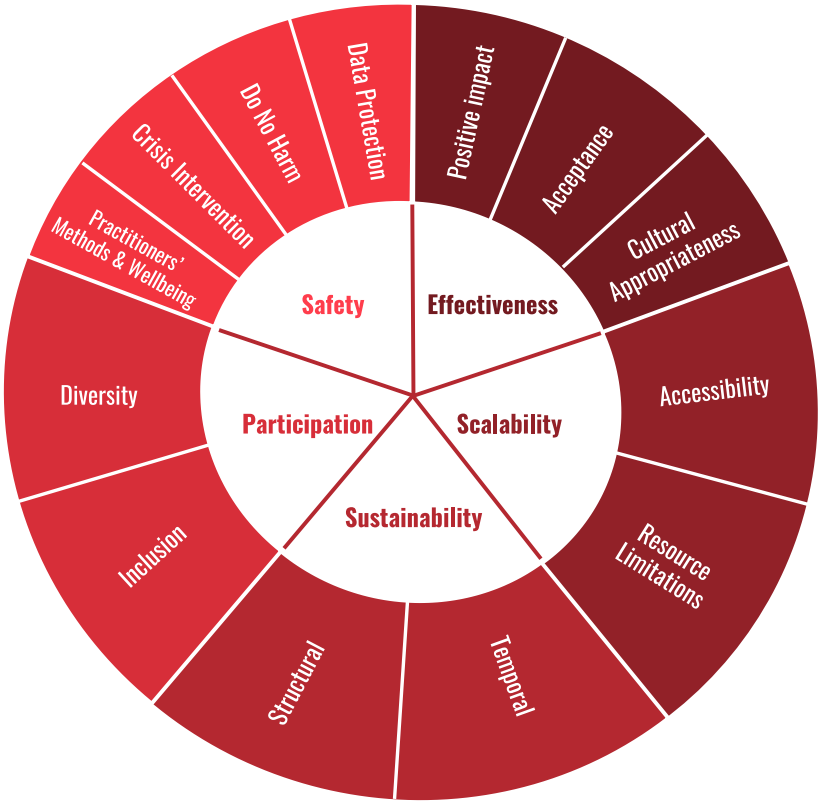


Figure 3: SESSP – Analytical Framework for Assessing Digital MHPSS Best Practices[25]

[21] The 5 principles are: (1) Upholding humanity, impartiality, and non-discrimination, (2) Ensuring community participation and cultural awareness, (3) Complying with medical and health care ethics, (4) Delivering quality of care in line with internationally accepted standards, (5) Ensuring a continuum of care, International Committee of The Red Cross, *Guidelines On Mental Health And Psychosocial Support*.

[22] IASC Reference Group on Mental Health and Psychosocial Support in Emergency Settings, *Mental Health And Psychosocial Support In Emergency Settings - Monitoring And Evaluation With Means Of Verification: Version 2.0*.

[23] Psychosocial Centre International Federation of Red Cross and Red Crescent Societies, *IFRC Monitoring And Evaluation Framework For Psychosocial Support Interventions*.

[24] UNICEF, *Mental Health And Psychosocial Technical Note*.

[25] Authors' own production.

Dimension	Facet	Indicative questions
Safety	Data Protection	• Is data securely protected with anonymity? • Is data used and accessed by designated parties for appropriate use?
	Do No Harm	• Does the intervention have adverse impacts on users? • How are possible adverse impacts/ unsafe use of users monitored? • Are the staff properly trained by professionals, following a standard operating protocol that outlines ethical principles in implementing and using the intervention?
	Crisis Intervention	• Are there crises intervention protocols and systems that promptly address emergencies (such as acute distress, suicidality) that users face in digital MHPSS tools?
	Practitioners' methods and wellbeing	• Are the practitioners' methods impeded by the digital in some ways? • Is the practitioners' wellbeing being taken care of considering the risks they are exposed to as they adopt digital MHPSS tools addressed?
Effectiveness	Positive effect on MHPSS	• Are primary/ secondary outcomes (symptom reduction, prevention, improve quality of life) achieved (as measured and evaluated by reliable and validated tests)? • Do outcomes last in the long run?
	Acceptance of the intervention by the target population	• Is the intervention well-received by the target population? • Does it respond to specific challenges/needs of the target population?
	Cultural Appropriateness	• How well does the intervention adapt to local contexts? • Is it relevant (culturally, socially) for the target population?
Scalability	Accessibility	• How far can the intervention reach a population with different characteristics (such as literacy level, demographics)?
	Resource Limitations	• Does it require a high level of technical capability/ financial and human capital? • Does it require staff with a high level of specialisation?
Sustainability	Temporal sustainability	• Could long-term funding be secured? • How sustainable is the partnership for the intervention? • How sustainable are the human resources in implementing the intervention?
	Structural sustainability	• Is the intervention embedded into the wider healthcare system and work in synergy with existing infrastructure (e.g., governmental and professional bodies)
Participation	Diversity	• Are differences and intersectionalities within user groups respected reflected in and considered in the design and implementation processes?
	Inclusion	• Are user groups meaningfully involved in the design, implementation, and evaluation? • Are users' feedback captured by evaluation mechanisms and addressed?

Table 1: SESSP – Analytical Framework for Assessing MHPSS Best Practices

III.
FROM CONVENTIONAL TO DIGITAL MHPSS

III. From Conventional to Digital MHPSS

This chapter gives an overview of current conventional MHPSS interventions within the Movement to identify needs to be addressed. It then explores the potential of digital MHPSS in overcoming these needs. Finally, it presents an overview of how digital MHPSS is used in the Movement so far.

1. Current Landscape of conventional MHPSS within the IRCRCM

1.1 Scope of Activities

In October 2021, the Movement published the report 'Mental Health Matters: Progress Report on Mental Health and Psychosocial Support Activities', based on a survey of 163 National Red Cross Red Crescent Societies (hereinafter NS).[26] The report compares the Movement's (conventional) MHPSS activities from 2021 with those conducted in 2019. From the analysis of the survey data, we can derive current challenges and needs related to MHPSS in the Movement.

According to the survey, approximately 94% of all NS provide some MHPSS services, while 83% have included an MHPSS focus within their strategy.

Psychosocial interventions are generally more common than mental health interventions. 59% of NS conduct stress management activities, 54% conduct self-care, 51% psychoeducation and 46% conduct anti-stigma interventions, among a large variety of activities. Psychological First Aid skills are strongly diffused among staff and volunteers across all regions. Mental health interventions are less common and focus on lower-bound psychological support (63%), group therapy and support groups (35%), and training in basic psychological support (48%). However, 70% of NS offer referrals to more specialised mental health services (e.g., psychiatrists and psychologists).

Psychological First Aid

Psychological First Aid (PFA) is designed as an immediate response to crises, stabilising and assessing needs of people affected.[27] It has been widely endorsed and integrated into MHPSS response structures for disasters.[28] PFA aims at facilitating long-term recovery by helping service users feel safe, connected, accessing support (social, physical, emotional) and feeling capable of helping themselves.[29] The key action principles of PFA are Look, Listen and Link.[30] Studies have cautioned that while PFA allowed greater accessibility of basic MHPSS, it was also used to substitute higher-level or other MHPSS in some instances.[31]

For more information: 'A Guide to Psychological First Aid for Red Cross and Red Crescent Societies' by Psychosocial Centre, IFRC

[26] IRCRCM, "Mental Health Matters: Progress Report on Mental Health and Psychosocial Support Activities".
[27] American Psychological Association. "Understanding Psychological First Aid".
[28] Shultz and Forbes, "Psychological First Aid."
[29] WHO. *Psychological First Aid: Guide For Field Workers*.
[30] Psychosocial Centre IFRC, *A Guide to Psychological First Aid for Red Cross and Red Crescent Societies.*
[31] Snider, *Psychological First Aid: Five Year Retrospective (2011-2016).*

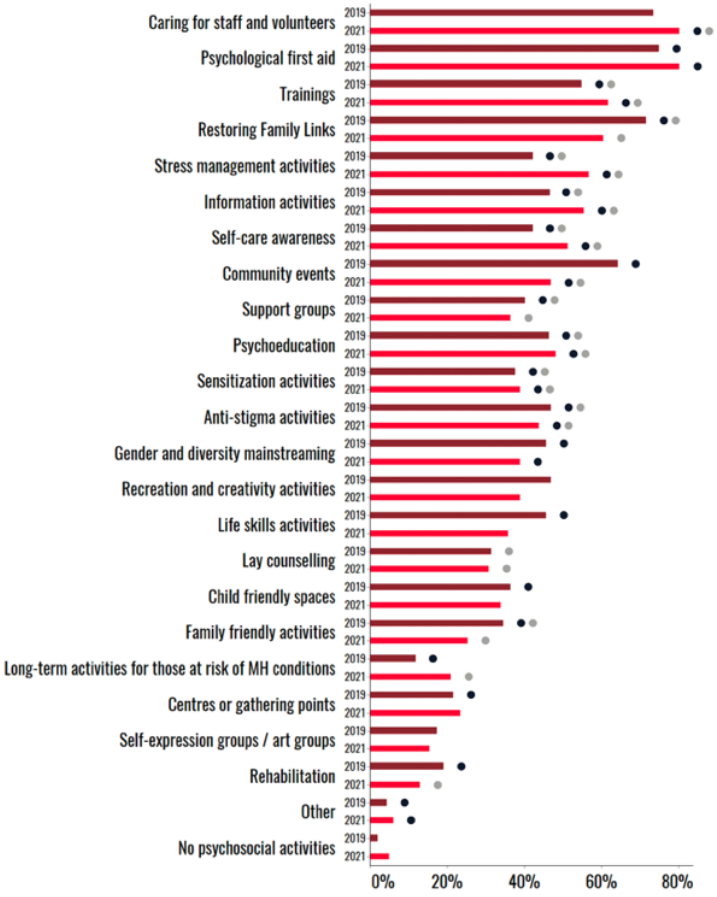


Figure 4: Provision of psychosocial support activities[32]

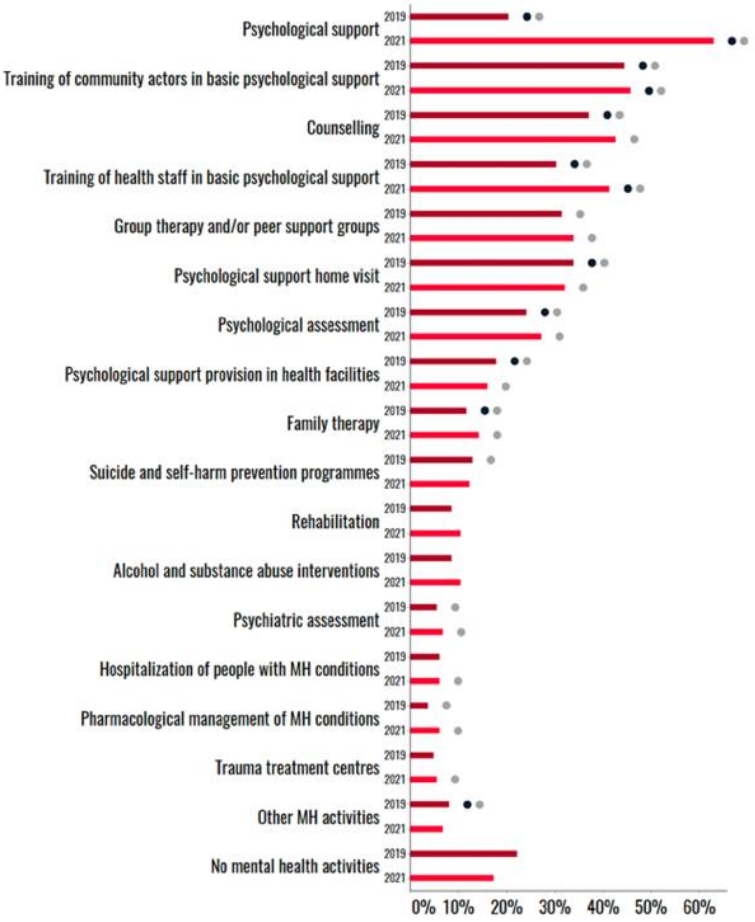


Figure 5: Provision of mental health activities[33]

1.2 Needs and Challenges

The following figures display the most prominent challenges among the NS when implementing MHPSS programmes:

1.2.1. Data Collection and Evaluation

Evaluation of activities is limited in breadth and depth, due to a lack of funds, tools, and staff expertise. Only 10% are involved in MHPSS research and less than 50% of NS report having an information system in place that ensures confidentiality and protection of personal data. The lack of systematic data collection impedes the development of the field, especially since the evidence is thinner for lower-level psychosocial interventions compared to specialised mental health care.

[32] IRCRCM, "Mental Health Matters: Progress Report on Mental Health and Psychosocial Support Activities", 11.
[33] Ibid, 14.

1.2.2 Financial needs

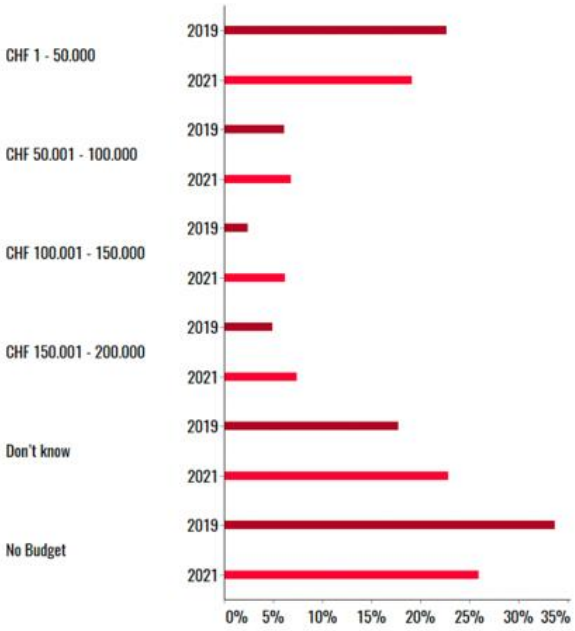


Figure 6: MHPSS Budgets[35]

Financial limitations present the biggest challenge to implementing MHPSS, cited by 75% of NS.

Across regions, 25% of NS report having no budget for MHPSS.[34]

Of those who are aware of the budget (22% don't know), 19% have less than 50k CHF; 7% have 50-100k, 6% have 100-150k and 7% have 150-200k.

1.2.3 Lack of human resources

Lack of human resources and expertise is a crucial challenge to 42% of NS. Approximately one-third of NS have less than five MHPSS staff members, two thirds have between less than twenty. But there is significant heterogeneity: 12% of NS have more than 100 staff members. Staff limitations are partially balanced by the fact that 37% of NS can mobilise more than 100 volunteers involved in MHPSS. However, the great majority of MHPSS staff and volunteers do not have specialised qualifications.

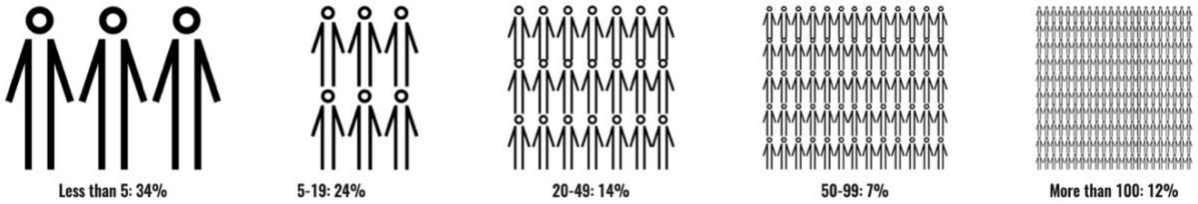


Figure 7: Staff involved in MHPSS activities [36]

Figure 8: Volunteers involved in MHPSS activities

[34] According to the publication, this "may be due to the fact that many activities are delivered as an integrated approach and therefore the budget is not captured specifically under MHPSS but is included in other sectors."
[35] IRCRCM, "Mental Health Matters: Progress Report on Mental Health and Psychosocial Support Activities", 24
[36] IRCRCM, "Mental Health Matters: Progress Report on Mental Health and Psychosocial Support Activities", 20.

1.2.4 Lack of partnerships

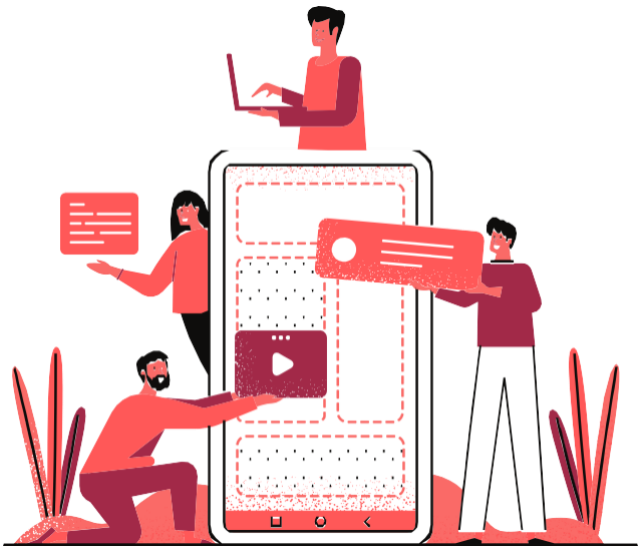
Strategies to overcome funding and skills gaps through partnerships are limited by a perceived lack of coordination with other NGOs and governmental organisations involved in MHPSS by NS (38%). There are few collaborations overall; most occur within the Movement, or with national governments. There are only very few partnerships with universities, private businesses, or UN agencies in the field of MHPSS. This stands in contrast to the perceived need for more partnerships in MHPSS, felt by 97% of survey responders. The most prominent need to be addressed through partnerships is that of technical support (78%). Partnerships are hampered by the above-cited limitations in finance and staff, but also logistical difficulties and organisational incompatibilities.

1.2.5 Insufficient access

Organisations face a dual problem of stigmatisation (35%) and limited access to affected individuals (22%), strongly inhibiting their work.

1.3 Conclusion

Overall, it must be noted that the Movement is substantially increasing its MHPSS efforts. However, lack of funding and staff inhibit progress for the implementation of the 2020-2023 MHPSS Roadmap. Prominent shortcomings also include lack of specialised staff, programme evaluation, partnerships, and access to the affected population.



2. The Potential of Digital MHPSS

Considering the structural needs of the Movement identified above, digital delivery formats promise to enhance MHPSS services. In 2019, there were 5.2 billion unique mobile subscribers, 4.1 billion internet users, 3.8 billion active social media users and 204 billion apps downloaded.[37] As the digital infrastructure continues to expand, the Movement could build on existing technologies as well as recent innovations – catalysed by the COVID-19 pandemic – to diversify and increase its MHPSS efforts. This section surveys the existing literature to understand where the main benefits of digital MHPSS lie for each of the SESSP principles.

2.1 Safety

Digital interventions can help **overcome stigma** thus reducing barriers to seeking psychological and psychosocial help. Digital tools can be used with full anonymity, allowing individuals to share their experiences without fear of stigmatisation. This is especially important for those who face **'double stigma'**[38] such as ethnic minorities, women, the LGBTQ+ population or refugees.

FADFADA[39]

Fadfada is a psychosocial support platform launched in August 2020 by UNDP Syria, in collaboration with the WHO. To use it, individuals only need to fill a short form in which they are asked to describe the issue they are facing. The platform ensures complete anonymity, and the only personal information that is required is a phone number or an alternative means of contact. In addition, users can indicate the time at which they want to be contacted.

The intervention involves 26 specialists - ranging from psychiatrists, sociologists, psychologists, social workers, and family counsellors- who are assigned to the user after careful assessment of the required help. Cases are prioritised in accordance with the nature and severity of the case. Specialists follow up on the case and conduct around 6 sessions on the phone (the concrete number of sessions depends on the needs of the user).

The platform can be accessed from all over the country, including inaccessible areas such as Raqqa. Moreover, through the emphasis on anonymity – in a context of high stigmatisation of mental health needs – it has been possible to create an accessible safe space for users affected by double stigma such as the Syrian LGBTQ+ population and women.

So far, the platform has already provided help to more than 8,000 cases.

[37] Budd et al., "Digital Technologies In The Public-Health Response To COVID-19."
[38] Gary, "Stigma: Barrier To Mental Health Care Among Ethnic Minorities."
[39] Interviewee 4.

2.2 Effectiveness

Although there is still a need for further research, **scientific studies demonstrate strong and significant effects of digital interventions in specific areas.** These include remote psychotherapy against depression,[40] substance use disorder,[41] and anxiety,[42] among others.[43]

Furthermore, there is increasing evidence on the effectiveness of automated (self-guided) interventions that address common mental health problems. Self-guided digital interventions, such as **mobile applications based on cognitive-behavioural therapy (CBT)** have been clinically proven to reduce severity in cases of depression, anxiety, insomnia, general stress, and worry.[44]

The effectiveness of remote MHPSS interventions depends greatly on the acceptance of the programme by the service users. Reassuringly, scientific studies find broad **acceptability of evidence-based digital interventions for mild to moderate mental health problems.**[45]

Guided v. Self-guided interventions

Guided digital interventions: can range from audio/video counselling - in which in-person counselling is replicated through digital technologies - to apps and websites that include some kind of interaction with a specialist (e.g., weekly calls/chats). The distinguishing factor behind this intervention is that a counsellor/specialist can be approached by the user when needed, either remotely or in-person.

Self-guided digital interventions: many apps and websites offer services which are largely automated, with the user either self-guiding the intervention or sent automated remainders and notifications related to their therapeutical needs. In this case, the user does not have access to a specialist. Some interventions also combine self-guidance elements with support from practitioners.

[40] Lungu et al., "Blended Care-Cognitive Behavioral Therapy For Depression And Anxiety In Real-World Settings: Pragmatic Retrospective Study".
[41] Lin et al., "Telemedicine-Delivered Treatment Interventions For Substance Use Disorders: A Systematic Review".
[42] Berryhill et al., "Videoconferencing Psychological Therapy And Anxiety: A Systematic Review".
[43] Hubley et al., "Review Of Key Telepsychiatry Outcomes", 269.
[44] Attridge, "Internet-Based Cognitive-Behavioral Therapy For Employees With Anxiety, Depression, Social Phobia, Or Insomnia: Clinical And Work Outcomes"; Venkatesan et al., "Digital Cognitive Behavior Therapy Intervention For Depression And Anxiety: Retrospective Study".
[45] Schneider et al., "Acceptability Of Online Self-Help To People With Depression: Users' Views Of Moodgym Versus Informational Websites".

2.3 Scalability

In contexts in which resources are scarce, access is limited, and gaps in service provision are high, digital MHPSS interventions are efficient alternatives to face-to-face interventions. One of the main advantages of self-guided and remotely guided digital MHPSS interventions is their ability to reach larger parts of the population with fewer human resources. Thus, digital services promise to **bridge the growing treatment gap in MHPSS.**[46] This is especially important for low and middle-income countries, where the resources are less abundant.[47]

Digital MHPSS has the potential to **improve access and reduce costs** for geographically remote or conflict-affected areas, [48] as well as for populations facing other barriers to access, such as transportation costs, lack of free time, lack of childcare, or stigma.[49] Hence, digital MHPSS has the potential **to lower economic and social costs** associated with accessing MHPSS services. Moreover, digital MHPSS allows for **flexible engagement on-demand and just-in-time,** delivered at individual pace.[50]

In addition, digital MHPSS can reduce the provider's operating costs. Even though designing, implementing, and evaluating digital MHPSS interventions might require a large initial investment, self-guided tools, in particular, allow service provision at **near-zero marginal cost per additional user.**[51]

Furthermore, digital tools allow for the development of remotely assisted forms of MHPSS that can be **delivered by non-specialists.** For instance, Self-Help-Plus, developed by the WHO to increase stress management capabilities can be conducted by 'briefly trained lay facilitators'.[52] Similarly, digital MHPSS allows for the scaled-up diffusion of skills such as PFA, which can be delivered by virtually everyone. By increasing the capacities of communities and individuals to self-care and peer support in bottom-layer MHPSS, community resilience is strongly increased, while simultaneously **enhancing task transfer** as more specialist capacities are freed up for top-tier MHPSS interventions[53].

In short, digital technologies can maximise the accessibility of MHPSS services at often similar levels of effectiveness, thus bridging the pervasive treatment gap in MHPSS.

[46] Lal, "E-Mental Health: Promising Advancements In Policy, Research, And Practice", 57.

[47] Carter et al., "The Emergence Of Digital Mental Health In Low-Income And Middle-Income Countries: A Review Of Recent Advances And Implications For The Treatment And Prevention Of Mental Disorders".

[48] Lal and Adair, "E-Mental Health: A Rapid Review Of The Literature", 26.

[49] Ibid.

[50] Ibid.

[51] Aebersold, "E-Mental-Health für traumatisierte Geflüchtete. Bericht zum Schritt I: Literatur- und Marktanalyse von erprobten und bewährten Materialien und Ansätzen".

[52] Brown et al., "Self Help Plus: Study Protocol For A Cluster-Randomised Controlled Trial Of Guided Self-Help With South Sudanese Refugee Women In Uganda", See Annex 2 for further details on Self Help Plus.

[53] Aebersold, "E-Mental-Health für traumatisierte Geflüchtete. Bericht zum Schritt I: Literatur- und Marktanalyse von erprobten und bewährten Materialien und Ansätzen", 19.

2.4 Sustainability

Once the technology is put in place, digital interventions often are more financially sustainable, since they have lower variable costs, e.g., for wages.[54] Moreover, digital tools can improve treatment at early stages, **preventing** the development and aggravation of symptoms that require more expensive treatment.[55]

When digital services are integrated into the wider healthcare system, they can improve the **continuity of care** by offering flexibly available services on-demand, either as stand-alone or awaiting face-to-face treatment and in-between sessions. This is especially important considering the high rates of disengagement associated with mental health services.[56]

Finally, digital tools can enhance capacity building to achieved sustained **community resilience**. First, it is possible to scale-up online training of local lay-implementers of psychosocial interventions. Mobile apps or video call technology bridge the geographical distance between participants and trainers, thus reducing the cost and increasing the accessibility of the workshops[57]. Second, the Internet and social media allow increasing awareness and mainstreaming mental wellbeing support to counteract stigmatisation.[58] This might strongly improve mental health outcomes for entire communities in the long run.[59]

2.5 Participation

Digital technologies offer the opportunity to create broad-scale interventions that allow **representation and community participation.** To many, digital interventions are a means to democratise humanitarian action.[60] Social media for example allows people to easily connect to each other in a disaster to provide psychosocial support. Digital technologies can be leveraged to **integrate the target group** in project design (e.g., online focus groups), implementation (capacity-building), monitoring, and evaluation (online user feedback).

[54] Christensen, Griffiths and Evans, *E-Mental Health In Australia: Implications Of The Internet And Related Technologies For Policy*, 4.
[55] Ibid.
[56] O'Brien, Fahmy and Singh, "Disengagement From Mental Health Services."
[57] Interviewee 21.
[58] Christensen, Griffiths and Evans, *E-Mental Health In Australia: Implications Of The Internet And Related Technologies For Policy*, 4.
[59] Ibid.
[60] Meier, *Digital Humanitarians*.

Strengths and potential benefits of digital MHPSS interventions

Safety

- Stigmatisation can be avoided thanks to anonymity

Effectiveness

- Scientific evidence proves effectiveness of both guided and unguided digital interventions. Further research is needed.

Scalability

- Improve access for geographically remote populations and populations with other barrier to access
- Flexibility for the user
- Reduce the provider's operating costs

Sustainability

- Reduce burden on mental health specialists as they can be delivered by trained non-specialists
- Improve prevention
- Improve continuity of care (through its integration into the wider health care system)
- Enhance capacity building

Participation

- Improve service user engagement in design, implementation, and evaluation.
- Democratisation of MHPSS services

3. Current landscape of Digital MHPSS Interventions

Based on 32 interviews with researchers and practitioners, we gathered detailed information on 24 digital MHPSS interventions from within the Movement, in addition to 13 interventions from outside the Movement, which might be adaptable by the Movement.

In the upper bounds of the pyramid, the most common use of technology is video calls to conduct remote personal counselling and, in some cases, psychiatric treatment. But there is also a growing body of mobile apps for psychological counselling using CBT-based approaches, which have a strong evidence base (for example, Step-by-Step, SAHA, Sui, Stay fine – see Annex 2).

In general, digital technologies are currently more often employed for psychosocial support, in more diverse forms and with higher levels of automation (self-guidance). For a detailed overview of the reviewed interventions, refer to Annex 2.

Step-by-Step[63]

WHO in collaboration with multiple partners, including the National Mental Health Programme (NMHP) at the Ministry of Public Health (MoPH) in Lebanon, Freie Universität Berlin, and University of Zurich developed an internet-based guided self-help intervention for adults with depression called Step-by-Step.

It is currently being used in research trials and at scale in Lebanon as both an app and a web-based intervention which guides users through several training modules in psychoeducation, behavioural activation, stress management and increasing social support, using an illustrated narrative approach. Step-by-Step was designed as a scalable treatment for depression in populations affected by adversity. It has been tested in randomised controlled trials with populations in Lebanon, including Syrian refugees, as well as Syrian refugees in Germany, Sweden, and Egypt under the European Union funded STRENGTHS project.

It can be delivered with or without guidance. In the guided version, users access support from trained helpers (e.g., university graduates) who answer questions and review activities, at an individual time investment of 15 – 20 minutes per week. In the contact-on-demand approach there is an in-built messenger to reach e-volunteers.

The intervention was found to be effective in reducing depressive symptoms and positively received in two fully powered RCTs in Lebanon, with more trials underway as part of the STREGNTHS trial. WHO is developing an open source platform for running the intervention and plans to release this and all content under Creative Commons for Step-by-Step for adaptation and use in 2022. The app has been translated and adapted for other user groups such as Albanian migrants in Switzerland and Germany, university students in China and overseas Filipino workers.

For more information, contact psych_interventions@who.int or visit: http://strengths-project.eu/en/strengths-home/

[61] Harper Shehadeh et al., "Step-By-Step, An E-Mental Health Intervention For Depression: A Mixed Methods Pilot Study From Lebanon."
[62] van 't Hof et al., "Evaluating The Effectiveness Of An E-Mental Health Intervention For People Living In Lebanon: Protocol For Two Randomized Controlled Trials."
[63] Interviewee 2.

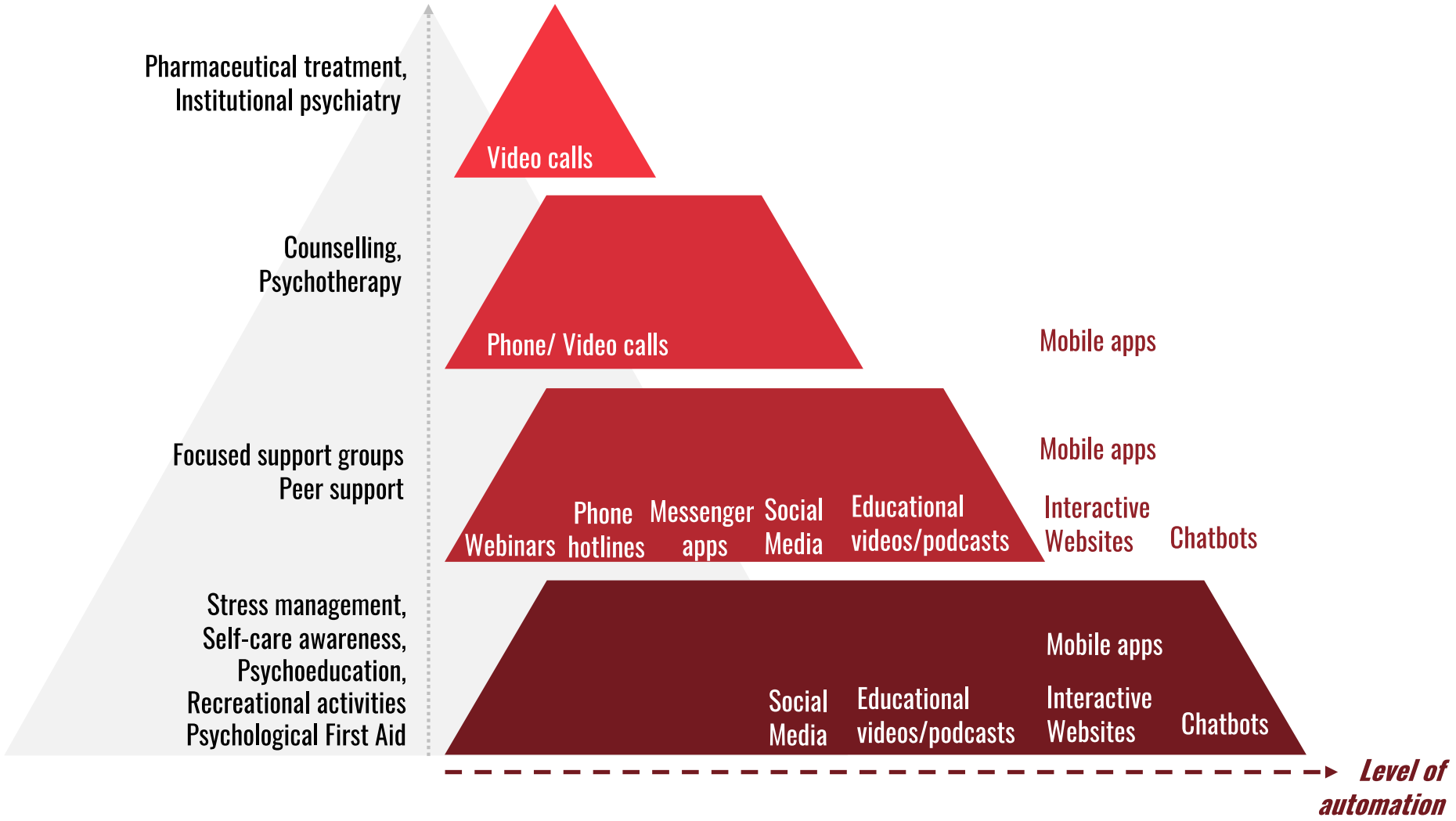


Figure 9: Classification of current interventions according to pyramid level[64]

[64] Authors' own production

IV.

DIGITAL MHPSS: CHALLENGES AND SOLUTIONS

IV. Digital MHPSS: Challenges & Solutions

1. Safety

1.1 Data Protection

Challenge 1: **Anonymity, Vulnerability and Data storage**

Data protection and anonymity are of utmost importance, especially for vulnerable users. The information provided, for example, during online consultations entails highly **confidential** elements on personal life issues. Given the persistent stigma around mental health, this could severely harm service users if divulged to third parties.

Anonymity in digital interventions expands the access of MHPSS to populations who are particularly at **risk of stigma**. For example, LGBTQI+ populations in Syria that find it hard to seek face-to-face counselling, reach out for help thanks to the Fadfada Project developed by UNDP (an online psychosocial support platform providing confidential support through virtual media).[65] Vulnerable populations facing administrative penalties, such as undocumented migrants in the Netherlands, who face deportation if their situation is revealed, use a WhatsApp helpline to seek help.[66] These examples illustrate that breaches of anonymity can entail both psychological and physical safety risks.

Digital MHPSS interventions could be potential targets of **data theft and hacking**. Many NS do not have adequately **secured data storage facilities**. Remote services provision poses additional risks to data security. Where data security cannot be guaranteed, the potential harm to service users can be immense, as detailed above. Therefore, for example, the PEARL database deployed in Africa to store the medical files of patients was required by the ICRC MHPSS Regional Specialist to be hosted on a Geneva server.[67] However, as the breaches of ICRC servers illustrate, even higher protection capacities are needed to guarantee the safety of digital MHPSS interventions.

<u>Solutions and Best Practices</u>

Digital solutions need to guarantee minimal **data accessibility by design**. For example, the Step-by-Step web-based version tailors authorisation only to those who need it and for specific purposes only.[68]

Moreover, services that ensure **end-to-end data encryption** should be favoured for online consultations, such as the Signal messenger app. Enhanced data protection can also be achieved by decentralised data storage on end-user devices or through blockchains, as compared to centralised servers.[69] However, security risks remain.

[65] Interviewee 4.
[66] Interviewee 5.
[67] Interviewee 14.
[68] Interviewee 1.
[69] Margheri et al., "Decentralised Provenance For Healthcare Data."; Ramachandran et al., "Towards Complete Decentralised Verification Of Data With Confidentiality: Different Ways To Connect Solid Pods And Blockchain."

Challenge 2: Commercialisation of data.

To overcome technical challenges and finance gaps, NS might be inclined to partner with private businesses. However, this may in turn amplify safety concerns. Many companies who are actively engaged in digital humanitarian action like Facebook or Google, for example, rely on the **commercialisation of data** of the service users. Therefore, special precautions are warranted when cooperating with private companies.

<u>Solutions and Best Practices</u>

One way to overcome this concern is pioneered by the Danish Red Cross. In their cooperation with the private start-up 'Boblberg' to provide psychosocial support for people suffering loneliness, the Danish Red Cross employs a legally **innovative partnership** agreement that guarantees **co-ownership of the personal data** gathered thus impeding its commercialisation.[70]

Boblberg[71]

Boblberg is a digital citizen-to-citizen platform to fight chronic loneliness developed by the Danish Red Cross in partnership with a private technology company.

The platform is available as a mobile app or website and functions as a simple message board where users can create a "bubble" (message) to make new friends, pursue hobbies, or share common experiences of life problems.

With over 400,000 users in Denmark, the intervention reached more than 7% of all Danes over the age of 15 and as many as 21% of all young people between the age of 15 and 24. In contrast to other social networks, there are no permanent profiles, safeguarding the anonymity of users to prevent negative effects of stigmatisation.

While the platform's code is owned by the partner organisation 'Boblberg', who also takes care of the day-to-day operations, the Danish Red Cross has employed an innovative partnership agreement securing the co-ownership of all user data generated to ensure non-commercialisation of data. The project is financed by charging the municipalities it operates in a fixed amount, which is sufficient to cover the operating, but entails significant costs for convincing and (re-) negotiating with the municipalities to extend the partnership.

For more information visit: https://boblberg.dk.

[70] Interviewee 8.
[71] Ibid.

1.2 Do No Harm

Challenge 1: **Unintended harm of interventions.**

Digital MHPSS interventions may cause unintended harm to users when **misused**, or when digital MHPSS is employed in contexts where MHPSS is highly stigmatised. For example, the Mexican Red Cross offers crisis support to young people by using a specific hashtag on social media. This may, however, expose the service users to stigmatisation or abuse by publicly identifying their vulnerability.[72]

Moreover, digital interventions need to be **updated** to remain safe. Otherwise, some features might become dysfunctional. Moreover, outdated information and could mislead users and lead to unintended harm in many possible ways.

<u>Solutions and Best Practices</u>

Organisations should only use **evidence-based interventions** to ensure safety.[73] Therefore, while organisations may want to develop a new digital MHPSS intervention tailored to their specific needs, such initiatives could be modelled based on **existing RCT-tested interventions** if they do not have the means to conduct an evaluation.

Protocols for all newly developed interventions should include **mandatory evaluation**, especially for specialised mental health care services, targeting more vulnerable users. For example, the digital version of the START Now project will be tested through an RCT to evaluate its safety for users before being scaled up and further disseminated.[74]

Challenge 2: **Dissemination of non-evidence-based digital interventions**

Since many digital MHPSS technologies are still new and applied in a plethora of different contexts, the **evidence of many interventions is incomplete**. Evaluations tend to be complex and expensive, draining already scarce resources. Therefore, many interventions remain unassessed or are evaluated superficially. Private sector interventions, in particular, are incentivised to prioritise profit over safety.[75] However, interventions that are not evaluated and not evidence-based can pose severe harm to service users seeking help and should not be disseminated.

<u>Solutions and Best Practices</u>

To avoid the dissemination of non-evidence-based interventions, a '**whitelist**' of rigorously evaluated interventions could be compiled and constantly updated, while considering factors of contextual and cultural adaptation. Conversely, non-evaluated interventions or such that have proven ineffective should be **blacklisted**. Funding organisations and donors should have access to such lists to make informed and safe choices for future service users.

[72] Interviewee 22.
[73] Interviewee 29.
[74] Ibid.
[75] Interviewee 20.

1.3 Crisis intervention

Challenge: **Limitations in case of acute crisis**

Digital MHPSS interventions may fall short in delivering effective crisis care. While digital interventions allow for more flexible and immediate access to care, they also enable more abrupt break-off of contact, reducing the scope of **immediate intervention in acute crises**, compared to face-to-face consultations.

<u>Solutions and Best Practices</u>

To ensure patient well-being and prevent treatment setbacks, **digital technologies** should therefore only be employed with **caution** for the therapy of severe mental disorders.

It is advisable to **discuss reactions to crises** with the service user in advance and offer access to **updated digital emergency referral and service directories**, bearing in mind the costs this entails. Where no referral options exist, for example in remote contexts, further considerations of potential risks need to be carefully assessed before implementing digital interventions.

Moreover, digital MHPSS tools should feature an easily **accessible emergency button** ensuring a prompt response, notably in case of suicidality. Some web-based interventions, such as START Now, offer a digital 'panic' button to get immediate support from selected emergency contacts.[76]

Finally, **clear standard operating procedures** should be established. These are necessary, e.g., to confirm the explicit consent of the user; and for high-risk cases (e.g., cases in which there is a risk of self-harm or identified protection needs) to ensure a prompt and adequate response by practitioners.

1.4 Practitioners' methods and well-being

Challenge 1: **Misdiagnosis and medical error.**

Practitioners' opinions on digital interventions such as teleconsultations are **split**. Some practitioners deem remote consultations equally safe and even prefer them for their flexibility and logistical simplicity, offering enhanced continuity of care as patients tend to miss fewer sessions.[77] Others, however, find themselves to be less service user-centred, more easily distracted in remote consultations, owing mostly to the lack of non-verbal communication. One informant reports an increased susceptibility to **potential misdiagnosis and malingering**.[78] This can lead to **poor quality of care and imprecise diagnosis** in the case of specialised care.

[76] Ibid.
[77] Interviewee 6.
[78] Interviewee 30.

Solutions and Best Practices

To avoid such issues, practitioners have emphasised the need to always **turn on the camera** in consultations, if possible. This enables the practitioner to be more patient-centred and assess elements of non-verbal communication.

Moreover, **professional training** is required to ensure practitioners are sensitive to the particularities of remote therapy. Volunteers and staff should also be sufficiently trained before implementing remote-guided interventions. Supervision should be put in place to allow practitioners' adaptation to the new method.

Finally, **hybrid models** appear most adequate to ensure diagnostical precision and facilitate rapport while simultaneously making use of the flexibility of remote delivery to optimise therapeutic continuity.

Challenge 2: **Impediment on private life**

While remote contact offers higher flexibility and continuity, it also brings constant **access** to practitioners even **outside office hours**. Therefore, practitioners might find it harder to separate duty and leisure and strike an adequate work-life balance.[79] Some practitioners might also be harassed during teleconsulting.[80]

Solutions and Best Practices

Practitioners **shouldn't operate on personal devices** and shouldn't divulge personal contact information. Practitioners should be encouraged not to respond to contact requests outside of working hours. **Organisations** should therefore **provide the necessary devices** to staff and **set clear policies** on working hours.

To manage the increased pressure from constant accessibility, practitioners could benefit from **heightened peer support**, which can be delivered online for flexibility. This approach is taken, for instance, by the Netherlands Red Cross for its volunteers in response to heightened stress related to the COVID-19 pandemic.[81] Moreover, practitioners must be supported in handling caseload, off-hour contacts, etc., through increased **supervision**. To avoid increasing time concerns, supervision should be scheduled during working hours and could be delivered remotely to allow more flexibility, e.g., via video call or messenger.

[79] Interviewee 27.
[80] Interviewee 16.
[81] Interviewee 15.

2. Effectiveness

2.1 Positive impact

Challenge 1: **Lack of exhaustive evidence**

Even though an increasing number of research trials underline the effectiveness of digital MHPSS in specific contexts, the **evidence base is far from complete**. Most evidence on digital MHPSS relates to specialised mental health interventions such as online psychotherapy while there is a **gap in the literature** regarding the effectiveness of digital basic psychosocial support.

Furthermore, many trials are conducted in clinically controlled settings that have limited external validity to real-world circumstances.[82] In addition, most trials were conducted in higher income countries, which may further limit their generalisability.[83] Thus, the use of **digital technology for MHPSS in limited-resource settings still requires substantial research.**[84] Finally, many digital interventions reviewed in this report are still being piloted and are yet to complete evaluation.[85]

<u>Solutions and Best Practices</u>

A possible way to address the lack of exhaustive evidence and avoid the resource-intensive evaluations is to implement **already evaluated interventions** that have been proven effective. Moreover, NS should prioritise treatment approaches whose effectiveness in digital delivery is best-documented. This is the case notably for **interventions based on CBT**.[86] As mentioned above, a 'whitelist' of effective digital interventions could guide providers.

Challenge 2: **Scepticism**

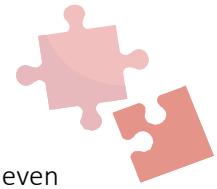
A second challenge to ensure the positive impact of digital MHPSS relates to practitioners' scepticism towards the effectiveness of digital technologies. While some practitioners report successful treatment through digital technologies,[87] others feel the need to observe service users physically (non-verbal cues and behaviours) and do not think that digital interventions can substitute physical contact.[88] This in many cases pertains to personal preferences and professional styles, as well as scepticism on the safety of digital interventions.

<u>Solutions and Best Practices</u>

Practitioners should be able to flexibly choose the way they want to deliver help, keeping in mind that in certain situations such as lack of access, there might be no other options.

[82] Ellis et al., "Implementation Of E-Mental Health For Depression And Anxiety: A Critical Scoping Review, 914.
[83]Carter et al., "The Emergence Of Digital Mental Health In Low-Income And Middle-Income Countries: A Review Of Recent Advances And Implications For The Treatment And Prevention Of Mental Disorders", 224.
[84] Naslund et al., "Digital Technology For Treating And Preventing Mental Disorders In Low-Income And Middle-Income Countries: A Narrative Review Of The Literature.", 11.
[85] See Annex 2 – evaluation column.
[86] Attridge, "Internet-Based Cognitive-Behavioral Therapy For Employees With Anxiety, Depression, Social Phobia, Or Insomnia: Clinical And Work Outcomes" and Venkatesan et al., "Digital Cognitive Behavior Therapy Intervention For Depression And Anxiety: Retrospective Study".
[87] Interviewee 28.
[88] Interviewee 30.

2.2 Acceptance



Challenge: **Lack of engagement**

The sustained engagement of service users is a critical factor for effectiveness, which is even more challenging in digital interventions, especially those that are unguided.[89]

Other factors affecting engagement include **credibility** in the evidence behind the content, as well as the **length** of the program – concise programs having higher rates of engagement - or the perceived **usefulness** of the intervention.[90] Concerning the latter, **expectations** about the intervention might be misdirected, as some users might expect a comprehensive individual therapy when they engage in interventions that do not deliver such.[91]

Solutions and Best Practices

A way to improve engagement is through the inclusion of **notifications** reminding users to regularly use the app/website.[92] In addition, interventions should be designed to be as concise as the therapeutical base allows it, and **expectations** about what to expect from the intervention should be **managed in advance.**

Adequate and targeted promotion is a key factor for take-up and acceptance. For example, the Kenyan Red Cross partnered with the Ministry of Health to promote their MHPSS services by including the NS toll-free number in the Kenyan Ministry of Health awareness campaigns and social media, so that people know how to reach out for support.[93] Similarly, key actors in the community can played a crucial role in the promotion of the intervention.[94]

2.3 Cultural appropriateness

One of the main problems when implementing an already-developed digital MHPSS intervention is that the original content might not be **socially/ culturally relevant** for the target population, which results in low engagement and acceptability. [95] Culture affects the understanding of mental health and psychosocial wellbeing for everyone, and hence, it is essential to carefully consider it when designing and implementing a digital intervention.[96]

Therefore, when implementing an intervention originally developed for a different target group, it is essential to **adapt it to the local context and target audience**. However, this process entails its own challenges.

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[89] Interviewee 19.
[90] Borghouts et al., "Barriers To And Facilitators Of User Engagement With Digital Mental Health Interventions: Systematic Review.", 11.
[91] Interviewee 16.
[92] Interviewee 19.
[93] Interviewee 16 .
[94] Interviewee 4.
[95] Borghouts et al., "Barriers To And Facilitators Of User Engagement With Digital Mental Health Interventions: Systematic Review.", 12.
[96] Interviewee 10.

Challenge 1: Adapting codes

Adapting existing self-guided interventions such as apps and websites requires alterations to the program's code, which might be protected by copyright or difficult to access.[97] Even where the code is accessible, **alterations require substantial technical expertise**. As the example of the Global Disaster Preparedness Center (GDPC)'s First Aid App illustrates, this can be a critical challenge, which can even inhibit the launch of interventions.

Adaption is a process that entails the accommodation of different preferences and interests – a balance needs to be achieved between what is affordable and easy to program, end-users' preferences, and the therapeutical core.[98] During this process, and especially if the intervention requires substantial changes to be transposable, **the evidence base it rests on may become obsolete**. This would have important safety implications.

<u>Solutions and Best Practices</u>

To facilitate the process of adaptations, **open access codes** should be encouraged and adopted. For example, the WHO's intervention Step-by-Step is licensed under creative commons. Hence, NS could take the code and adapt it to their national contexts freely.[99] Moreover, the First Aid App was provided to NS to make any adaptions in visuals or content that they wished.[100]

To realise the necessary technical adjustments, **technical assistance** to NS could be provided by the IFRC, or other partnerships, including private contractors.

In addition, if possible, adaptations should be made to the interface of a digital intervention (symbols, figures, etc.), **not the therapeutic substance.** Where more profound adaptions are necessary for acceptance, the intervention should be re-evaluated to **ensure compliance with safety standards.**

[97] Interviewee 9.
[98] Interviewee 31.
[99] The WHO would appreciate to be notified (Interviewee 2).
[100] Interviewee 1.

Universal App Program / First Aid App[101]

The First Aid App is a mobile application developed under the Universal App Program by the Global Disaster Preparedness Center, a cooperation between the IFRC and the American Red Cross. The Universal App Program is a "platform to facilitate the adaptation and localisation of mobile applications (apps) for use in countries across the globe."

The First Aid app is one of two mobile apps launched under this program and contains information on first aid. The app platform is centrally developed and can be used at no cost by NS who can adapt its content and design and take on ownership of the app on the national level.

Currently, the GDPC is planning a re-launch of the First Aid App which includes a section on Psychological First Aid. Due to lacking adaptions in the previous version which made the service unavailable in many countries, and because most adaptions were superficial rather than substantial, the new version is likely to launch globally using symbols and designs that are relevant for a global user base

For more information visit: https://preparecenter.org/activity/universal-app-program/

Challenge 2: Tailoring

Even if adaptions are more subtle, **tailoring them to the target group can be challenging**. For example, the Swiss and the Swedish Red Cross reported substantial difficulties in finding the correct terms and adequate tone for translations into Arabic.[102] Moreover, adequate promotion strategies need to be tailored to the specific context and target group.

<u>Solutions and Best Practices</u>

Firstly, to adapt a digital MHPSS intervention it is crucial to **clearly define the new target group** to narrow down the scope of adaptation.[103]

Moreover, to ensure that the adaptation is culturally sensible, potential **service users should be involved in all the phases** of the intervention (see Section 5). Similarly, the **inclusion of native speakers and staff with profound cultural knowledge** of the intervention's context has the potential to greatly improve its acceptance and take-up.

Indeed, **even simple adjustments** such as the intervention's name may have an important effect. For example, UNDP Syria decided to call their intervention Fadfada (i.e., 'talking openly to someone') and avoid the term 'mental health', which is stigmatised in the local population. This example illustrates the importance of understanding the cultural context in which the intervention is going to be implemented.[104]

[101] Participant observation of GPDC First Aid App Roundtable, conducted February 14, 2022 on MS Teams.
[102] Interviewee 7.
[103] Ibid.
[104] Interviewee 4.

Furthermore, it should be noted that **cultural adaptations can be facilitated by digital technology** if designed correctly. For example, being able to choose the features of the avatar, can easily make the intervention more culturally, and individually, appropriate.

To adapt digital interventions effectively, it is necessary to also consider **contextual adaption when selecting the digital technology** and platform through which the intervention is going to be implemented. For example, while in Syria WhatsApp is preferred, in some parts of Kenya the preferred technology is SMS.[105]

Finally, it is worth considering that interventions need not be 100% perfect right away, as long as basic safety is guaranteed.[106] Echoing this, some practitioners encourage NS to pilot interventions **and make adaptions and improvements as-you-go**, based on trial and error, and user feedback.[107]

Sui - Digital psychological and psychosocial support for refugees[108]

The Swiss Red Cross in collaboration with multiple partners, including the Universities of Berne, Zurich, Lausanne, and FU Berlin, develops an internet-based guided self-help intervention called Sui for adult refugees living in Switzerland.

The multilingual digital information and intervention platform for mental health and psychosocial support is intended to sustainably improve the quality of life of refugees in Switzerland, by:

- restoring their sense of control and security and boosting their health literacy by providing psychoeducational information that is relevant to everyday life and offering details of support services. Concerns about family members left behind in conflict zones, an uncertain residential status in Switzerland and difficulties with social integration or not being recognized as a member of society are issues that particularly affect refugees.
- using exercises in emotional, problem and stress management to help reduce the impact of symptoms in their day-to-day life and prevent these symptoms from becoming chronic.
- boosting refugees' resources as well as their self-efficacy and decision-making ability.
- identifying mental stress and de-stigmatizing it, thus lowering the hurdles for requesting support.

The usage and efficacy of the digital information and intervention platform will be optimized with the support of trained helpers from the same target group at an individual time investment of 15 – 20 minutes per week.

The intervention will be evaluated from July 2022 until May 2023 in a RCT with refugees living in Switzerland.

The intervention runs on an open-source platform developed by the Swiss Red Cross and the Freie University Berlin. The platform will be released for adaptation and use in 2023.

For more information, contact: monia.aebersold@redcross.ch

[105] Engels, M, e-mail message to authors, March 19, 2022.
[106] Interviewee 1.
[107] Interviewees 8 and 19.
[108] Interviewee 7.

3. Scalability

3.1 Accessibility

Not all users can access all digital services equally, as some face structural, social, or individual barriers.

Challenge 1: **Structural barriers**

A primary concern is the **lack of internet coverage and/or end devices** for service users.[109] This amplifies concerns over increased digital poverty leading to social inequality and marginalisation for those with lower access, particularly in rural areas.

Solutions and Best Practices

Some technologies, such as mobile apps can be designed for **offline usage**. Thus, internet connection is required only upon download but not throughout usage. This solution has been adopted, for instance, by the Step-by-Step app.[110]

Another solution is to offer access to devices and stable internet in schools, community centres or religious institutions.

Challenge 2: **Social and political barriers**

(a) Social barriers

Mental health issues are still highly stigmatised. Some service users might not have sufficient **privacy** within their homes to confidentially access MHPSS services. This is true in many low-income contexts with overcrowded housing and is most acute in refugee camps.[111] For example, survivors of domestic violence are likely to find it difficult to use digital MHPSS within the vicinity of their families.

Solutions and Best Practices

Again, partnerships with schools, community centres or faith-based institutions could provide **safe spaces** for accessing MHPSS services. Moreover, **engaging community actors** might be beneficial for decreasing stigma in the long run.

(b) Political barriers

In some cases, where stigmatisation is politically institutionalised, these partnerships might not be viable. Some countries have severely repressive mental health legislation that dispossesses of basic rights those who seek help.[112]

[109] Interviewees 12, 26 and 32.
[110] Interviewees 1 and 2.
[111] Interviewees 4 and 28.
[112] For example, under the Nigerian Lunacy Act which originated from colonial times, see Ugochukwu et al., "The Time Is Now: Reforming Nigeria's Outdated Mental Health Laws."

Solutions and Best Practices

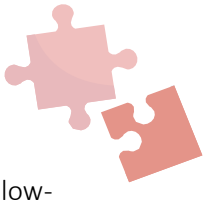
In this case, NS must focus on **mental health advocacy**, alongside government and civil society partners to change and create appropriate rights-based mental health policy and legislation.

(c) Bureaucratic barriers

Even where stigmatisation is not institutionalised, there can be **bureaucratic hurdles** to scaling interventions. For specialised treatments, providers might need to acquire a medical certification which is very costly. Regulations to this effect differ strongly internationally, entailing practical challenges for transposing interventions to different contexts. The same can be true even between provinces regions within one country, as is the case for Canada.[113] Moreover, in Lebanon, for example, digital medical services are generally not licensable.[114]

Solutions and Best Practices

Considering this, interventions on the lower bounds of the pyramid that require less medical proficiency are likely to have higher scalability.



Challenge 3: **Individual barriers**

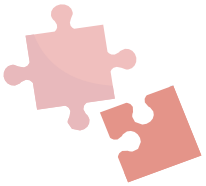
A further barrier concerns **literacy**. Children, marginalised groups, and people in certain low-income countries are particularly affected by this impediment to access care. The issue is less pressing for interventions with personal contact like phone or video hotlines, but more limiting for automatised interventions such as mobile apps. There is also the particular concern of lacking '**digital literacy**' often faced by older persons.[115]

Solutions and Best Practices

Illiteracy can be overcome by prioritising **audio and video content** within the intervention. For example, the Step-by-Step,[116] or Sui mobile applications[117] integrate therapeutic elements with fictional narratives and the use of visuals and audio. **Digital illiteracy** can be remedied by designing simple and intuitive user interfaces, providing IT guidance services, or integrating 'tutorials' on how to use the intervention. The issue is also likely to be less acute for guided interventions.

[113] Interviewee 18.
[114] Interviewee 4.
[115] Interviewee 31.
[116] Interviewee 2.
[117] Interviewee 7.

3.2 Resource limitations



Challenge: **Lack of funding, expertise, and time**

The main challenge that is shared by virtually all NS concerns the **inadequate funding** for technical solutions, in-house expertise to administrate them, and suitably **specialised staff** to design adequate interventions. Digital interventions require high investments not only in software development, but also data storage hardware, and legal expertise to ensure compliance with dynamically changing data protection regulations. Moreover, developing reasonably complex, safe, and adapted digital interventions requires much **time**; one informant estimates an average of three years from inception to launch.[118] Additionally, they require long-term funds for promotion, maintenance, and enhancements.[119]

<u>Solutions and Best Practices:</u>

(a) Adapt centralised apps

Instead of 'reinventing the wheel', NS should 'build from what we have',[120] by **using existing platforms**. For example, the WHO offers the 'Step-by-Step' mobile app, a software filed under creative commons license which can be used and adapted by any organisation.[121] Similarly, the GDPC offers two mobile applications under their 'Universal App Program' that can be used and adapted by NS at '**minimal cost**'.[122] The Swiss Red Cross provides a similar service through its technical platform in cooperation with the Freie University Berlin.
To minimise the running costs for maintenance and enhancements of interventions based on these universal platforms, a Digital System that is centrally updatable could be introduced, for instance by the IFRC.

(b) Partnerships

There are several well-established partnership models in the Movement that facilitate cost-efficient knowledge and technology sharing, which can be leveraged to spread digital MHPSS.

The IFRC in general offers a variety of resources from psychoeducational learning materials, capacity-building workshops (e.g., MHPSS in emergencies, or PFA), staff and volunteer training modules (e.g., on supervision or suicide prevention), to operational guidelines on various topics related to MHPSS. Platforms promoting **collaboration between NS** should also be leveraged. Scaling up interventions that have proven safe and effective for one NS

[118] Interviewee 1.
[119] Interviewee 9.
[120] Interviewee 2.
[121] Ibid.
[122] Interviewee 11.

to another context saves resources, especially in digital technologies which are easy to replicate by nature.

Public partnerships can also offer viable solutions. The Zambian Red Cross successfully streamlined MHPSS in the national response to the COVID-19 pandemic by partnering with the Zambian Ministry of Health, benefitting from collaboration with The Netherlands Red Cross.[123]

Where expertise for adaptions is needed or where building a new system is necessary, collaborations with the private sector may be justified. The Danish Red Cross, for instance, has minimised its technical expenses by partnering with a private company named 'Boblberg' to provide a highly successful psychosocial support intervention for people suffering loneliness.

Experience from the private sector, moreover, suggests that even complex mobile apps can be commissioned at reasonable costs given the growing international market for such services.[124]

(c) Low-tech interventions

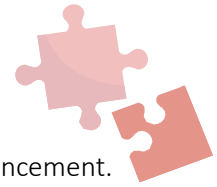
In most contexts, costs may be reduced by implementing simpler technical interventions, employing technologies that are already integrated into the daily workflow of NS.

Phone hotlines by NS have been in operation for various purposes for several decades. More recently, messenger apps are being used for consultations and supervision, e.g., by the Zambian Red Cross for COVID-19 health workers and volunteers.[125] Video calls can be used for the same purposes, as well as conducting training in, e.g., Problem Management Plus (among others by the IFRC Reference Centre for Psychosocial Support), Self Help Plus, or Psychological First Aid. Social media is routinely used for communication, fundraising, advocacy, promotion, etc., and can equally be leveraged to increase awareness about mental health issues and even implement MHPSS.

[123] Interviewee 32.
[124] The App Bipolar Buddy that employs AI technology to predict mood swings of people with bipolar disorder was developed for a total of $30,000 by a specialised technology company from Bangalore, India, (Interviewee 5).
[125] Interviewee 32.

4. Sustainability

4.1 Temporal Sustainability



Challenge: **Limited Financial and Human Resources**

Digital MHPSS may entail **high long-term costs** for maintenance and enhancement. Interventions that are app- or web-based require constant updates to improve user experience, warrant data protection, update information (e.g., local service directories),[126] maintain compatibility with IT software and hardware (e.g., iOS compatibility for apps), and comply with changing regulations.[127] All of these require long-term and continuous financing, which is one of the main challenges, according to many informants. Without long-term funding, digital MHPSS services risk being discontinued.[128]

Maintenance and updates also require **substantial staff time**. For roles that require less specialised and professional knowledge and are performed by volunteers, the instability of their contribution can negatively impact service delivery.[129] Where inputs by specialised staff such as psychologists and psychiatrists are required, the lack of long-term funding could jeopardise their presence, and with it, the safe and effective implementation and evaluation of interventions. For example, a Virtual Reality intervention against chronic pain used in several ICRC physical rehabilitation centres in South Asia was planned and delivered, but in one country, the project was suspended due to the removal of a psychologist from the team.[130]

<u>Solutions and Best Practices</u>

To increase sources of funding, practitioners could reach out to various potential funding sources outside of the Movement, such as **philanthropic endowment** funds by the private sector,[131] donations of **faith-based organisations**.[132] Considering the high costs of rigorous evaluations in money, staff, knowledge and time, **academia** could also be an important partner in evaluating digital MHPSS interventions and engaging in continuous monitoring and improvements and integrating automated evaluations in digital interventions. For example, the Kenyan Red Cross engaged the private sector for funding to support its digital MHPSS initiatives,[133] and the Step-by-Step app is funded by the European Union.[134]

[126] Participant observation of GDPC First Aid App Roundtable, conducted February 14, 2022 on MS Teams.
[127] Interviewee 9.
[128] Interviewee 1.
[129] Interviewee 13.
[130] Ibid.
[131] Interviewee 29.
[132] Interviewee 10.
[133] Interviewee 16.
[134] Interviewee 1.

4.2 Structural Sustainability

Challenge: **Limited Embeddedness**

A systematic review of 14 studies evidenced the **difficulty of institutionalising** new MHPSS innovations.[135] Undoubtedly, the structural sustainability of digital MHPSS hinges on the existing IT and mental health infrastructure they are embedded in. Where levels of IT infrastructure, knowledge/awareness for MHPSS, and availability of MHPSS personnel are reported low,[136] there were considerable difficulties in delivering structurally sustainable digital MHPSS initiatives.

<u>Solutions and Best Practices</u>

(a) Regions with lesser-developed IT and MHPSS Infrastructures

Digital MHPSS can be leveraged to **increase awareness** for MHPSS, **popularising and de-stigmatising MHPSS**, which is a key step to making MHPSS more of a local priority and encouraging resources to be devoted to enhancing MHPSS infrastructure.[137] Digital MHPSS solutions with low investment requirements, such as information sharing on social media sites, are well-suited for this purpose.

(b) Regions with better-developed IT and MHPSS Infrastructures

Digital MHPSS can be more structurally sustainable by **including local healthcare information** and **establishing a referral system** to more specialised care if needed. For example, the Step-by-Step app includes local healthcare information specific to countries where refugees are located.[138] Practitioners can also consider developing evidence-based digital MHPSS into **medical devices**, such as with functions of tailoring treatment programmes to symptom profiles, thereby increasing the chance of being **supported by insurance schemes**. This is instrumental for improving both the temporal and structural sustainability of digital MHPSS.[139]

Moreover, digital MHPSS would benefit from establishing **linkages with the national health system, existing governmental and professional bodies**. Below are two exemplars from the Argentinian and Canadian Red Cross respectively:

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[135] Troup et al., "Barriers And Facilitators For Scaling Up Mental Health And Psychosocial Support Interventions In Low- And Middle-Income Countries For Populations Affected By Humanitarian Crises: A Systematic Review."
[136] Interviewees 22, 25, 26 and 32.
[137] For example in Lebanon, Zambia, Mexico, and some Pacific nations, see Interviews 4 and 26.
[138] Interviewee 1.
[139] Interviewee 29.
[140] Paul et al., "Increasing Psychological Service Access For COVID-19-Impacted Frontline Workers: Canadian Red Cross & Ontario Psychological Association Partnership."
[141] Interviewee 18.

Remote Assistance Service for the Elderly[142]

The Argentinian Red Cross has implemented a remote assistance service that help the elderly with emergency management or accompany the elderly when they need someone to talk to, in order to prevent onset of mental health issues.

The service user has been previously referred to the programme by their general practitioners (GP)/ other services from the national health system. On one hand, this digital intervention can fulfil the national healthcare goal of assisting vulnerable old people. On the other, it can also target particularly old people who have some level of need as identified by their GP.

E-referral System during COVID-19[143]

The Canadian Red Cross developed the e-referral system in the COVID-19 pandemic, aiming to support returning Canadians quarantining in facilities who have top-tiered specialised mental health needs.

The Public Health Agency in Canada and Ontario Psychological Association (OPA) possess a digital system that registers people who need top-tiered specialised mental health support. The Canadian Red Cross leveraged this system, to match individuals who are quarantining with psychologists that suit them (e.g. based on what licenses the psychologists possess).

Initially it started in Ontario, but it spread across urban centres in the nation. More than half of the respondents waited no more than two weeks before their first session with a psychologist.[144] The initiative is structurally sustainable – The Canadian Red Cross managed intake and referrals while OPA provided pro bono access to MHPSS, while the partnership was embedded the infrastructures of the federal government.

Taken together, structurally sustainable digital MHPSS interventions should be integrated into national strategies and structures holistically to build synergy with the broader health system and interventions. This would enable higher operational effectiveness in delivering MHPSS services (such as alleviating the workload of practitioners and targeting people who need the service), more holistic care of service users, and eventually strengthening local IT and MHPSS capacities.

[142] Interviewee 31.
[143] Interviewee 18.
[144] Paul et al., "Increasing Psychological Service Access For COVID-19-Impacted Frontline Workers: Canadian Red Cross & Ontario Psychological Association Partnership."

5. Participation

Challenge 1: **Retaining users**

With less monitoring on the use of and compliance to the intervention, there tends to be a **higher drop-out rate** in self-guided interventions (as compared to MHPSS with more non-virtual elements such as in-person interaction).[145] For example, the Kenyan Red Cross reported that users who seek help via chatbots routinely disengage in mid-process.[146] Unsurprisingly, it is also more difficult to retain users to participate in evaluation processes.[147]

<u>Solutions and Best Practices</u>

(a) Human-centred and participatory approach in protocols

Despite often limited financial and human resources, it would be helpful for practitioners to prioritise a **human-centred and participatory approach in their protocol**.[148] Service users should be involved from consultation, planning, to implementation, and eventually monitoring and evaluation. There are many **toolkits** that guide effective inclusion of service users (e.g., by UNHCR)[149] and adopting a human-centred design (such as that developed by IDEO).[150] Practitioners can integrate and adapt these toolkits to facilitate bottom-up co-creation of interventions that respond and align to users' needs better.

(b) Skilful engagement of target group

In the development of the Sui app, the research team conducted multiple **focus groups** to seek feedback on content and translation.[151] Shah advocates for the approach of **'active invitation of pushback'** where practitioners encourage criticisms and honest feedback.[152] It heavily predicates on creating a safe and welcoming environment, where, for example, consultants engaging with stakeholders and key informants are not defensive, and power dynamics cutting across race, gender, age etc are taken into consideration.[153]

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[145] Interviewee 1.
[146] Interviewee 16.
[147] Interviewee 19.
[148] Interviewee 3.
[149] United Nations High Commissioner for Refugees, "Effective inclusion of refugees Participatory approaches for practitioners at the local level."
[150] IDEO, "Design Kit: The Human-Centered Design Toolkit."
[151] Interviewee 7.
[152] Shah, "Ethical Standards For Transnational Mental Health And Psychosocial Support (MHPSS): Do No Harm, Preventing Cross-Cultural Errors And Inviting Pushback."
[153] One possible way to achieve this is that practitioners could propose an imaginary situation where someone has done something adverse for the community, ask community members what appropriate ways are to channel their concern and adapt those methods in the active invitation of pushback

(c) Representation in the development team

Providers might benefit from not only engaging user groups in participatory exercises but **including them as key team members** in every step of development and implementation.. For example, in Sui by the Swiss Red Cross, a Syrian team member oversaw cultural adaptation and translation processes. In the Step-by-Step app for Syrian refugees, a Syrian colleague was involved in the conception of the project.[154] Undoubtedly, one person cannot represent the entire target population, but given the difficulty of engaging user groups throughout, it might be a reasonable compromise. **Increasing diversity** within teams would certainly help mitigate biases and improve outcome

Below, we summarise the findings of this chapter in a comprehensive table and synthesise key solutions into a practical process chart to guide stakeholders throughout the process of launching digital MHPSS interventions.

Facet	Challenges	Solutions	Addressee	Examples
Safety				
Data protection	Anonymity Data storage	Restricted access to data for some actors	NS	Step-by-Step
		End to end data encryption	NS	Signal
	Commercialisation	Co-ownership of data gathered	NS	Boblberg
Do no harm	Unintended harm of interventions	Evaluate new interventions through RCTs	NS	START Now
		Avoid the dissemination of non-evidence-based interventions using a 'whitelist'	IFRC PSC	
Crisis intervention	Delivering crisis care	Easily accessible emergency button	NS	START Now
		Develop SOPs on high-risk cases	IFRC PSC	
Practitioners' methods and wellbeing	Misdiagnosis and medical error	Use the camera in consultations	Practitioners	
		Training	IFRC PSC	
		Hybrid models	NS	
	Impediment on private life	Use non-personal devices only	Practitioners	
		Increase peer support offers	NS/IFRC PSC	Netherlands RC
		Supervision	NS/IFRC PSC	Zambian RC
Effectiveness				
Positive impact	Lack of exhaustive evidence	Implement already evaluated interventions	NS	
		Prioritise approaches whose effectiveness in digital is well documented (e.g. CBT therapy)	NS	
	Scepticism	Promote flexibility and hybrid approaches when possible	NS	
Acceptance	Lack of engagement	Include notifications and reminders in the case of automated interventions	NS	
		Manage service users' expectations	NS	
		Adequate and targeted promotion	NS	Kenyan RC
Cultural appropriateness	Adapting codes	Use open-source codes	NS	Step-by-step
		Provide technical assistance to NS	IFRC PSC	
		Don't alter therapeutic substance when adapting	NS	
	Adapting correctly	Involvement of the target population in all the phases of the intervention	NS	Swiss RC
		Adapt to the preferred technology		
		Simple adaptations make a difference	NS	Fadfada
		Piloting & continuous adaptations	NS	SAHA

[154] Interviewee 1.

Scalability				
Accessibility	Lack of end devices / stable connection	Design tools that can be used offline	NS	Step-by-Step
	Insufficient privacy	Partner with community actors to provide safe spaces with stable connection	NS	
	Bureaucratic hurdles	Prioritise low-level digital tools for scale-up	NS	
Resource Limitations	Lack of funding Lack of IT expertise Lack of psychology exp. Lack of time	Adapt existing interventions	NS	Step-by-Step First Aid App
		Centralised Digital Platforms	IFRC PSC	
		Leverage IFRC PSC Resources	NS	
		Cooperate with other NS	NS/IFRC	Zambian RC
		Partner with national governments	NS	Zambian RC
		Partner with private contractors ensuring contractual privacy and safety	NS	Boblberg (Danish RC)
		Employ low-tech interventions	NS	#NUJA (Mex. RC)
Sustainability				
Temporal	Limited financial and human resources	Partnerships for funding and human resources (e.g., philanthropic endowments, faith-based organisations, governmental bodies, academia)	NS	Kenyan RC
Structural	Embed in existing infrastructures	Lesser-developed IT and MHPSS infrastructures: — Use digital technology to popularise MHPSS	NS	
		Higher-developed IT and MHPSS infrastructures: — Include local health service information	NS	Step-by-Step
		Higher-developed IT and MHPSS infrastructures: — Establish a referral system	NS	Canadian RC
		Higher-developed IT and MHPSS infrastructures: — Inclusion in insurances	NS	
		Higher-developed IT and MHPSS infrastructures: — Integrate with national health system, gov. & professional bodies	NS	Argentinian RC
Participation				
	Retaining participants	Adopt a human-centred design toolkit	NS	Toolkit developed by IDEO
		Prioritise participatory approach and 'active invitation of pushback' in protocols	NS	Sui App
		Engaging the target group within the development team	NS	Step-by-Step

Table 2: Summary Table of common challenges and viable solutions

Illustration: Best Practices in Digital MHPSS

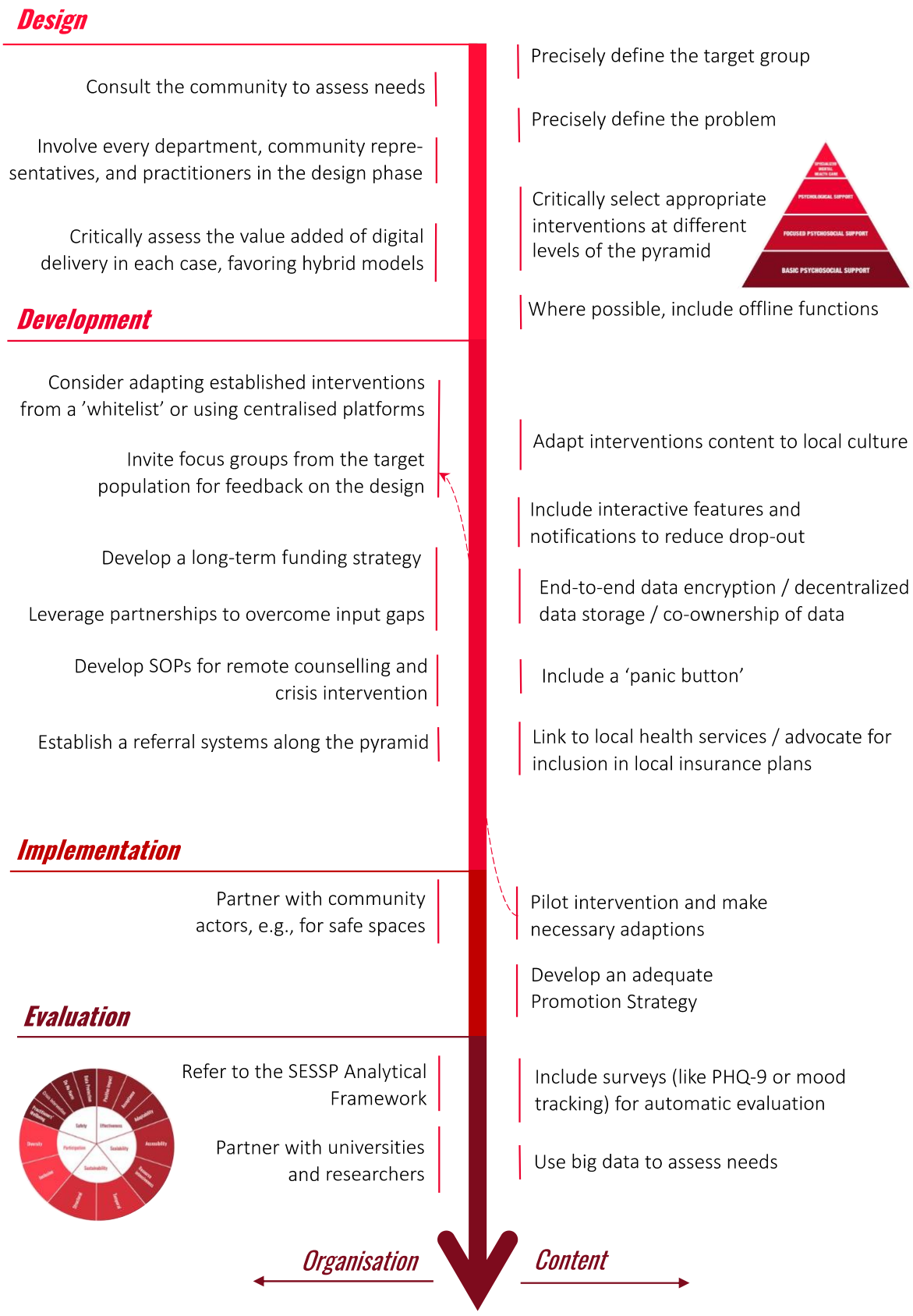
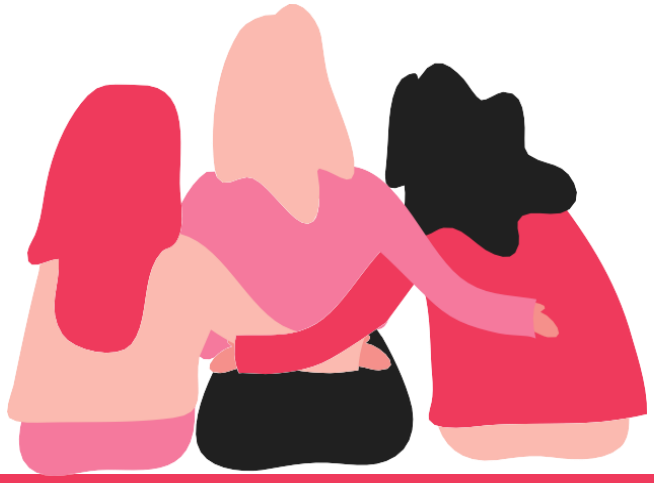
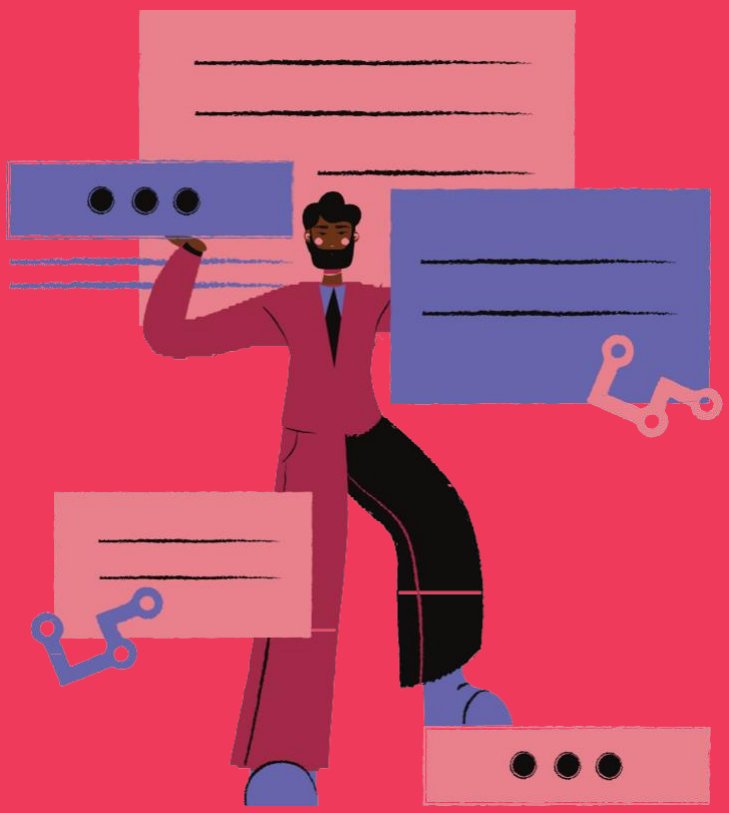


Figure 10: Flowchart Illustration of Best Practices in Digital MHPSS[155]

[155] Authors' own production.



V. RECOMMENDATIONS



V. Recommendations

1. To the Movement: Collect and leverage data

To ensure safety, improve service delivery and contribute to the frontier of knowledge in digital MHPSS, NS should increase data collection and evaluation of their interventions, in partnership with universities. This can include quantitative analyses, as well as qualitative data from interviews, focus groups or key informant interviews.

Where possible, providers should consider integrating **automated monitoring and evaluation** into digital interventions, in partnership with academia. This could include:

- Mood tracking of service users throughout time
- Completion of online questionnaires (such as PHQ-9) throughout time
- Big data analysis of user meta-data

Data gathered should be leveraged not only for scientific research but also for **needs assessment and planning**. Underscoring the potential of both big data and hybrid models, the 'Boblberg' tool, for instance, used big data analysis to identify a geographical cluster of single mothers connecting via their digital psychosocial support platform to launch an in-person family support intervention in their area.

2. To the Movement: Favour hybrid models

Scientific evidence warrants **realistic optimism** with regards to the benefits of digital MHPSS. Nonetheless, given its resource-intensiveness, as well as specific limitations in safety and available evidence, practitioners should always **critically question whether digital delivery is necessary** or whether conventional MHPSS could be equally beneficial. Where reasonable optimism is met by critical assessment, **hybrid delivery models which combine digital and conventional MHPSS modules will often emerge as the optimal option**.

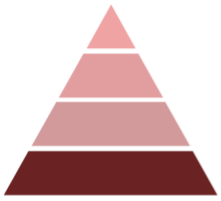
a. Hybrid delivery of single interventions

If carefully designed, neither format must supersede the other and both can reinforce each other within a same intervention.

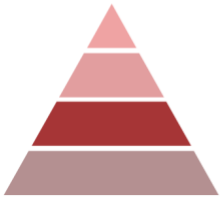
Digital technology can complement face-to-face interventions through:	*Personal contact can complement digital interventions through:*
- Combining face-to-face sessions with flexible on-demand and just-in-time modules that can be followed at individual pace. - Complimentary usage while awaiting treatment or in-between session - Flexible delivery of complementary activities, such as coordination, training, and supervision.	- Building a trustful and empathetic rapport - Analysing behaviours and non-verbal communications - Reassuring and guiding service users - Enabling enhanced crises intervention

b. A hybrid model for integrated MHPSS programmes

Hybrid models are particularly valuable in comprehensive MHPSS programmes that link different interventions across the MHPSS pyramid. Based on the available evidence, we propose a **tentative hybrid MHPSS pyramid** with varying digital inputs at each level, linked to each other via a **digital referral system**.

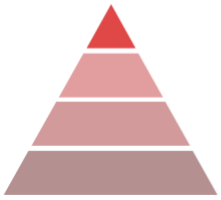


The high scalability of digital interventions is particularly useful for basic psychosocial interventions that target large audiences. Here, self-guided interventions such as mobile/web apps appear the most promising. It should, however, be noted that the evidence for digital interventions at this level is incomplete. Given the relatively lower level of vulnerability of users, this mustn't bar implementation, but warrants **piloting interventions** with heightened monitoring and safety standards, especially for data security and anonymity.



Focused psychosocial support for specific groups at risk can benefit from a range of digital tools. The more successful ones are likely to be **remotely guided**, e.g., remote training (PM+), or targeted hotline services via messenger, phone, or video call.

NS may consider implementing digital psychological support interventions, best complemented through online or in-person **guidance by trained implementers**. In particular, NS can draw on a growing body of **CBT-based mobile/web apps** whose effectiveness and safety are increasingly well established. However, they should strictly monitor and evaluate the intervention as most evidence is based on clinical trials rather than real life emergencies.



Given maximum safety standards for particularly vulnerable service users, **face-to-face delivery by specialists should remain the standard** for specialised mental health care. It could be complemented by digital tools such as mood tracking or gamified exercises awaiting treatment or in-between sessions. Remote therapy is possible, after having established a personal rapport, in accordance with the preferences of practitioners and service users.

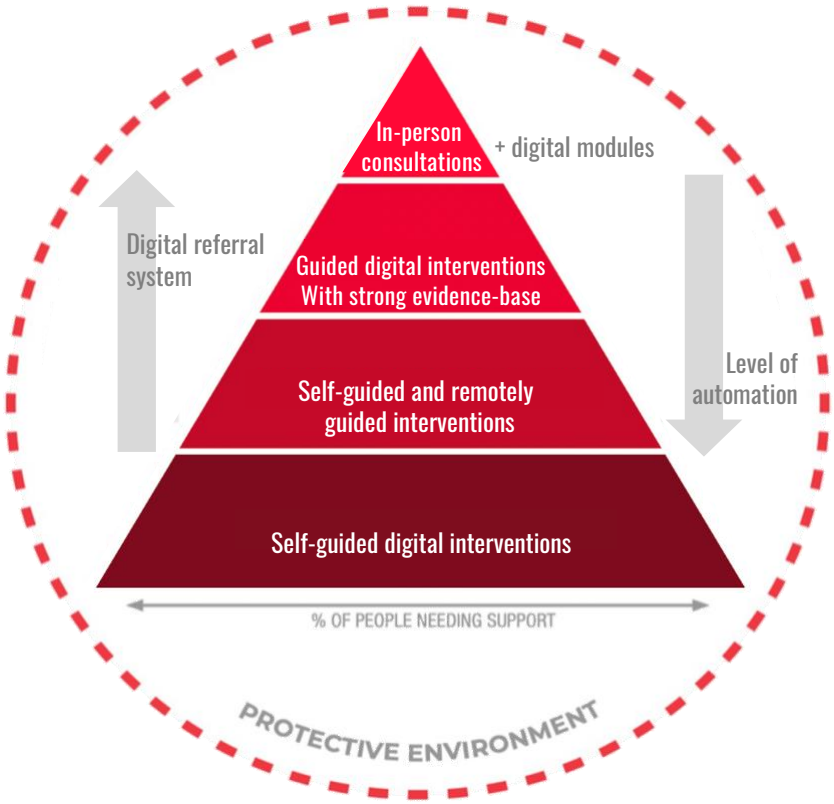


Figure 11: A Hybrid Model for integrated MHPSS programmes

3. To the Movement: Adapt available digital tools

Developing reasonably complex, safe, and adapted digital interventions requires substantial staff and financial commitments and is estimated to take approximately three years from inception to launch. To overcome resource gaps and ensure safety, NS should instead make use of the unique advantage of digital tools by replicating available digital tools. The following recommendations should be observed:

First, the IFRC should map existing digital interventions:

a. A "**whitelist**" of safe and effective interventions should be established,
   - prioritising open-source models, e.g, Step-by-Step, PM+, SH+ from the WHO and SUI from the Swiss Red Cross
   - drawing on the robust evidence base for digital CBT-based interventions in particular

b. A "**blacklist**" of unreliable interventions should be established in coordination with academia, to identify non-evidence-based interventions that should not be disseminated

c. Both lists should be
   - disseminated amongst donors for reference on which projects to support
   - disseminated to national authorities to improve regulation of the private sector
   - regularly updated

Second, NS should focus available resources on making necessary **adaptations** to local culture and context to warrant take-up and effectiveness of the interventions, using **human-centred and participatory approaches.**

Third, the IFRC should establish a **Movement-wide MHPSS innovation centre** that centrally develops, maintains, updates, and evaluates new open-source digital interventions that are warranted by international needs. This will **minimise marginal costs** for NS. A relevant example is the Technical Platform developed by the Swiss Red Cross in cooperation with the Freie Universität Berlin, or the GDPC's Universal App Program which already developed two custom-made and adaptable IRCRCM apps, namely the "Hazard App" and the "First Aid App". The latter is currently being redesigned to include PFA.
Again, adaptions to local culture and context that increase take-up and effectiveness of the intervention are key.

4. To the Movement: Engage in principled partnerships

NS should leverage partnerships to benefit from the diverse expertise of, and synergies with, different entities in digital MHPSS. Partnerships may include working hand in hand with:

Entity	Objective
Universities	To develop and evaluate projects and build upon existing research
Local community actors	To provide safe spaces for access to internet-based interventions. E.g., schools, faith-based organisations, municipalities, or community centres To facilitate participatory, inclusive design and acceptance from user groups
Philanthropic organisations	To mobilise financial resources and increase the visibility of digital MHPSS
Governmental agencies	To raise awareness about the accessibility of MHPSS digital tools, ensure integration into the broader health care system and ensure equal access
Private companies	To perform complex technological tasks and benefit from knowledge-transfers

Since private companies have a competitive edge in technological solutions, increased reliance on digital solutions will entail a certain dependence on private companies. The profit maximisation imperative of private actors may, however, collide with humanitarian principles. For instance, private companies might engage in partnerships for conscious laundering purposes or to gain access to the data of vulnerable populations.[156]

Therefore, Business-Humanitarian Partnerships should be critically assessed.[157] According to IRCRCM guidelines, the following needs to be taken into consideration:[158]

- Private companies should assist the humanitarian organisation in fulfilling its mission and not its own business interests. Particular caution should be applied with regards to non-commercialisation of data.
- The business partner must not be engaged in activities running counter to the Movement's objectives and principles and should not endanger its neutrality and independence.
- Companies that could compromise the reputation, neutrality, and impartiality of the Movement, e.g., by being materially involved in armament, health-endangering activities, or contributing to humanitarian emergencies are unfit for partnerships.[159]

Bearing in mind the inherent power-asymmetry between humanitarians and populations in need, for instance concerning the issue of 'informed consent', partnership agreements need to observe at least the following elements:

- Non-commercialisation of services and user data
- Data security
- Prohibition of implementing non-evidence-based interventions

5. To the Movement: Build synergies with local structures

Digital MHPSS interventions should be integrated holistically into national strategies and structures to build synergies with the broader health system. This would allow:

- The task transfer within MHPSS between the Movement and the broader health structures
- Enhanced referral options to specialised services
- Accessing more data for more accurate needs assessments
- Higher reach for mental health advocacy and promotion

To maximise sustainability, interventions should also aim at building local capacities:

- Experts, preferably from the local community, should be included initially to build the capacities of local volunteers through a 'Train the Trainer' format (e.g., in PM+ or PFA)
- Implementers could guide end-users of MHPSS digital interventions, enhancing local IT literacy
- Support groups between volunteers should be developed as a network to transfer knowledge

Finally, where the institutional environment creates barrier for (digital) MHPSS, the Movement should partner with local stakeholders to advocate for de-stigmatisation and enhanced legislation.

[156] Burns, "New Frontiers Of Philanthro-Capitalism: Digital Technologies And Humanitarianism."
[157] Carbonnier and Lightfoot, "Business In Humanitarian Crises For Better Or For Worse?"
[158] Council of Delegates of the International Red Cross and Red Crescent Movement, *International Review of the Red Cross.*
[159] Ibid.

6. To the IFRC: Increase offers in digital training, SOPs, and supervision for practitioners

The digitalisation of services is an era-defining trend that will only become more relevant as the digital infrastructure continues to grow. This warrants swift and extensive organisational investments, not only in budgets and IT systems, but also staff capacities.

To enhance the quality of care and the wellbeing of staff and volunteers, the IFRC PS Centre should develop SOPs that guide practitioners engaged in digital interventions, and train and supervise them in their implementation.

The SOPs should cover aspects of telediagnosis, methodological advice (e.g., leaving the camera on to observe non-verbal communication), technical assistance (user guidelines for relevant tools), and practitioner's wellbeing (e.g., no contact outside of office hours). Specific SOPs should furthermore be developed to improve remote crisis intervention. To ensure effectiveness, the guidelines should leave room for adaptation to different cultural contexts and individual preferences.

The IFRC PS Centre should moreover offer training to diffuse the SOPs, and increase supervision for practitioners to ensure correct implementation and sustainable wellbeing. Digital technologies should be harnessed to efficiently scale up these services.

VI. CRITICAL CONSIDERATIONS

VI. Critical Considerations

1. ‘WEIRD bias’ in psychology publications

There are systematic biases in psychological studies from excessively relying on samples from Western, Educated, Industrialised, Rich, and Democratic (WEIRD) societies.[160] This implicitly assumes that participants from WEIRD countries represent the ‘standard’ or ‘norm’, creating post-colonial epistemological biases, omitting the fact that norms of human behaviour and perceptions differ substantially across cultures. Thus, the external validity of the evidence base on which (digital) MHPSS interventions rest must be critically reviewed.

2. Inequitable access to digital MHPSS

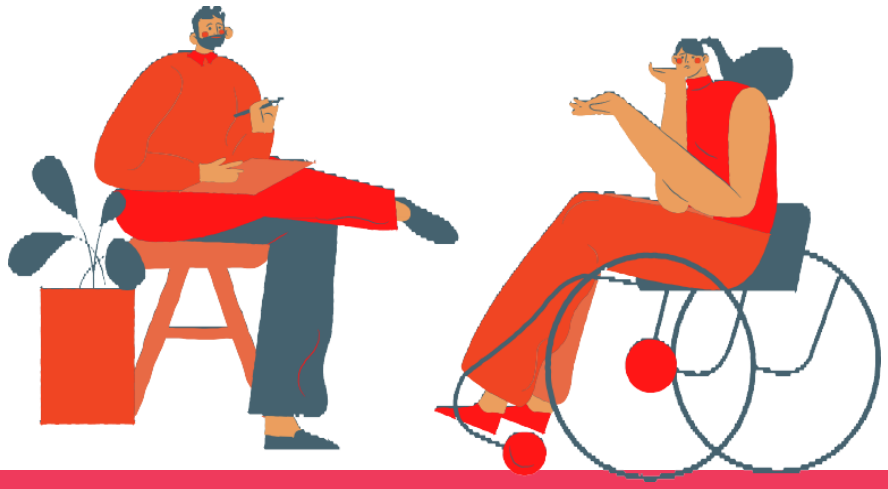
Currently, the Global North is generally more well-resourced for provision of (digital) MHPSS than the Global South. The rate at and extent to which Global North and South benefit from digitalisation is not uniform and might thus reinforce and exacerbate existing inequities.

Moreover, the gender digital divide affects the accessibility of women to digital devices in comparison to men. Women, especially in developing countries might be less able to engage with digital MHPSS solutions than men.[161] Furthermore, MHPSS needs are affected by biology, and socio-cultural norms around gender. Men, for example, seek psychological help less while women are more likely to suffer from SGBV. Beyond binary definitions of gender, intersectional oppression, and marginalisation along lines of race, sexual orientation and nationality create vulnerabilities that must be considered in targeting interventions. Practitioners should strive for more equitable access in their design and implementation of digital MHPSS.

3. Enabling environment for the holistic wellbeing of individuals and community

MHPSS is just one puzzle pieces for advancing the wellbeing of individuals and communities and should be complemented by other health support interventions. For example, practitioners can use digital MHPSS to direct users to different resources suitable for their mental health needs, such as medicine and government facilities. However, practitioners and users alike reach a dead-end when medicine is unaffordable, or when transport cost to government facilities is high.[162] Moreover, apart from health concerns, it is also crucial to address root causes of vulnerabilities,[163] such as unemployment, poverty, and disruption of social networks. Digital MHPSS is meant to address specific needs but many more aspects are vital to the holistic wellbeing of individuals and communities.[164] Digital MHPSS should be used in conjunction to structural measures that aim at improving overall quality of life, such as legal and economic security.

[160] Henrich, Heine and Norenzayan, "The Weirdest People In The World?."
[161] Antonio and Tuffley, "The Gender Digital Divide In Developing Countries."
[162] Interviewee 16
[163] Interviewee 32
[164] Interviewee 18



VII. CONCLUSION

VII. Conclusion

Globally, there is a persistent gap in MHPSS provision that has become shockingly apparent in the COVID-19 pandemic. Digital technologies have emerged in recent years as an innovative solution to this provision gap, offering solutions to many of the specific needs faced by the Movement in delivering care to populations in emergencies and beyond, such as resource gaps and lack of access.

In light of this potential, the Movement has committed to increasing digital MHPSS in its MHPSS Roadmap 2020-2023 and has started digitalising some MHPSS services. To contribute to these efforts, this report reviewed 37 digital MHPSS interventions (Annex 2) inside and outside the Movement to identify common challenges and practical solutions (Table 2) which were synthesised into a process chart (Figure 10). Our analysis has highlighted that digital technologies are not only useful for the delivery of services to end-users but can be employed throughout the process from engaging with focus groups, supervision, and training, to planning, monitoring, and evaluation.

Based on the above, this report has formulated six overarching recommendations to effectively leverage digital MHPSS tools:

1. Collect and leverage data for monitoring, evaluation, and planning
2. Favour hybrid models
3. Adapt existing evidence-based interventions
4. Engage in principled partnerships
5. Build synergies with local structures
6. Increase offers in training, SOPs, and supervision

Their adoption could mean a significant step forward in providing effective and efficient care. Not least, we hope that the SESSP Analytical Framework outlined in the report will help guide future development and evaluation.

In acknowledgement of the many limitations of this report, we hope that our contribution is the start of a growing dialogue. Further research is needed to consolidate our knowledge of the field. This includes in-depth analyses of technical solutions, reviews of private sector interventions, and precise guidelines on how to structure business-humanitarian partnerships without compromising humanitarian principles, among others. In particular, the Movement could make a highly valuable contribution in growing the evidence base on basic psychosocial interventions in which it is strongly engaged.

Finally, to generate and share further insights on how to improve MHPSS provision, we would encourage the Movement to create a durable platform for knowledge transfer and dialogue within the MHPSS community. We are confident that digital tools will reliably facilitate these exchanges.

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ANNEXES

Annexes

Annex 1: Interviewee List

#	Region	Organisation	Date
1	Europe	WHO	27/01/2022
2	Europe	WHO	28/01/2022
3	Europe	University of Bern	14/02/2022
4	Middle East	UNDP Syria	02/02/2022
5	Europe	Bipolar Buddy	02/02/2022
6	Africa	Psychiatrist	02/02/2022
7	Europe	Swiss Red Cross	26/01/2022
8	Europe	Danish Red Cross	09/02/2022
9	Asia-Pacific	Australian Red Cross	20/01/2022
10	North America	American Red Cross	15/01/2022
11	North America	Global Disaster Preparedness Center (GDPC)	02/02/2022
12	Latin America	IFRC Panama Regional Office	02/03/2022
13	Asia-Pacific	ICRC	13/01/2022
14	Africa	ICRC	19/01/2022
15	Europe	Netherlands Red Cross	22/02/2022
16	Africa	Kenyan Red Cross	23/02/2022
17	Asia -Pacific	New Zealand Red Cross	02/02/2002
18	North America	Canadian Red Cross	16/02/2022
19	Europe	Linköping University	07/02/2022
20	Europe	University of Amsterdam	11/02/2022
21	Europe	IFRC	16/02/2022
22	Latin America	Mexican Red Cross	22/02/2022
23	Latin America	Brazilian Red Cross	15/02/2022
24	Africa	Ethiopian Red Cross Society	29/02/2022
25	Africa	Zambian Red Cross Society	21/02/2022
26	Asia -Pacific	IFRC	15/02/2022
27	Middle East	Medical Corps	15/02/2022
28	Middle East	Medical Corps	22/02/2022
29	Europe	University of Basel	16/02/2022
30	Middle East	Medical Corps	21/02/2022
31	Latin America	Argentinian Red Cross	02/03/2022
32	Africa	Zambian Red Cross Society	22/02/2022

Annex 2: List of Interventions

Name	Technology	Pyramid Level	Type	Guided	Target Group	Region	Organisation	Partnerships	Description/Objective	Status	Evaluation
Get Prepared	Mobile App	1	Restoring family links, emergency preparedness	no	General	Australia	Australian Red Cross	/	Reconnect key contacts after an emergency, organisationally and mentally prepare for emergencies	available	/
MyTeam	Mobile App	1	Self-care awareness, peer support	no	General	Australia	Australian Red Cross	Beyond Blue	Organise peer support to achieve set mental health goals	available	/
After the Emergency	Podcast	1	Psychoeducation / Stress Management	no	General	Australia	Australian Red Cross	Australian Broadcast Company	Podcast with psychology experts to help people recover from traumatic experiences	available	/
After the Emergency	MP3/Website	1	Psychoeducation / Stress Management / Self-care awareness	no	Young people	Australia	Australian Red Cross	/	Website from which MP3 files containing interviews with material on psychoeducation, stress management and self-awarenesscan be sourced. Distributed on MP3-players in the 2009 bush fires.	suspended	/

Sui	Mobile App / Web App	2/3	CBT, Self-care awareness, stress management, structural help	both	Adult, literate Arabic-speaking refugees	Switzerland	Swiss Red Cross	University of Bern; Freie Universität Berlin	Mobile Application that offers practical information on housing, health services, etc. to attract users and then engages them in autonomous or peer guided mental health exercises.	upcoming	2 RCTs
SAHA	Mobile App	3	Cognitive Behavioural Therapy	yes	Arabic refugees suffering depression	Sweden	University of Linköping	/	9 training modules on different mental health topics on which homework is done that is reviewed by practitioners	upcoming	RCT showing positive effect
Self Help Plus (SH+)	Online Training	2	Stress Management, Psychoeducation	yes	Adults	Global	WHO	/	Guided Workshops of approx. 20 participants	available	3 RCTs, for offline use
Problem Management Plus (PM+)	Online Training	2	Stress Management, Psychoeducation	yes	Adults	Global	IFRC PS Centre	WHO	Guided Workshops of approx. 20 participants	available	RCTs for offline use
Step-by-Step	Mobile App / Website	2/3	Psychological Intervention for depression	both	People affected by adversities in any contexts with access to the internet	Global	WHO	Egyptian Caritas / National MH Programme Lebanon, Free University Berlin, University of Zurich, VU	Psychoeducation and training through an illustrated narrative with additional therapeutic techniques such as stress management, identifying strengths, positive	Available (publication expected in 2022) contact psych_interventions@who.int	2 fully powered RCTs in Lebanon (papers in preparation). 3 RCTs under the STRENGTHS project in Germany, Sweden,

								University Amsterdam, Fondation d'Harcourt, elhra / R2HC	self-talk, increasing social support and relapse prevention		Egypt. Results due in 2022
STARS	Chatbot	1/2	Psychoeducation / Stress Management / Self-care awareness	no	Adolescents 15-18	Global	WHO	Fondation Botnar	Chatbot which imitates human interaction to provide adolescent with adequate treatments / exercises according to their reported symptoms	upcoming	/
mhGAP	Mobile App	3	Clinical Intervention Guide	no	Practitioners	Global	WHO	/	Intervention Guide for mental, neurological and substance use (MNS) disorders in non-specialist health settings for integrated management of priority MNS conditions using algorithms for decision making.	available	/
START Now	Mobile App / Website (still piloting)	1	Psychoeducation / Emotional regulation training	piloting with and without	young people (aged 14-24)	Switzerland	University of Basel	Private company, Philanthropic sponsor	START Now is a skills training to promote resilience and improve stress and emotion regulation. Piloting to turn a paper-and-pencil into web-based training.	upcoming	RCT

Stay fine App	Mobile App	3	Relapse prevention	peer guidance	young people (13-21) recovered from anxiety and/or depression	Netherlands	University of Amsterdam	Private company	A personalized monitoring and intervention app to prevent relapse of anxiety and depressive disorders with 8 tailored modules	upcoming	/
Universal App Program	Mobile App	/	/	/	General	Global	Global Disaster Preparedness Center	/	Efficient and cost-effective access to an easily-adaptable mobile app platform. The GDPC works with NS to facilitate the localization and customization of app content.	available	/
First Aid App	Mobile App	1	Psychological First Aid	No	General	Global	Global Disaster Preparedness Center	IFRC PS Centre	Based on the existing First Aid App launched under the Universal App Program, the GDPC is planning to launch an update which includes a section on Psychological First Aid.	upcoming	/
Bipolar Buddy	Mobile App	4	Mood tracking	no	People with bipolar disorder	United Kingdom	Bipolar Buddy	Microsoft Health	Digital guide to track moods, recognise triggers, and identify patterns to gain more control. The intervention complements psychiatric treatments by making the data	upcoming	/

									accessible to clinicians for enhanced diagnosis and treatment		
Boblberg	Mobile App / Website	1	Peer Support / Social Media	no	General	Denmark	Danish Red Cross	Boblberg	Boblberg is simply a digital message board where users can create a "bubble" to seek new friendships, pursue common hobbies, etc., bringing people together in communities and fighting loneliness	available	400,000 users, 90,000 monthly users, Positive surveys
SnakSammen	(Video)Phone Hotline	2	Peer Support	yes	People suffering loneliness	Denmark	Danish Red Cross	/	Lonely people can book video calls with Red Cross volunteers	available	/
Julevenner	Phone hotline	2	Peer Support	yes	People suffering loneliness	Denmark	Danish Red Cross	/	People who are alone at Christmas are matched with people who have an extra seat at the table on Christmas Eve, supported by a call centre with Red Cross volunteers.	available	/
Remote psychiatric therapy	Videocalls	4	Psychiatric treatment	yes	General	General	General	/	Using video call technology to conduct psychiatric treatments, mostly during COVID and as blended	available	/

									therapy (online + offline)		
Tele-counselling	Phone hotline	3	Psychological Counselling	yes	General	Kenya	Kenyan Red Cross	IFRC, Mastercard, Global Fund	Channel for people to seek help/ have an ear	available	/
Mental health chat	Messenger hotline	2	Psychological Counselling	yes	General	Kenya	Kenyan Red Cross	IFRC, Mastercard, Global Fund	Another channel for people to reach out	available	/
Remote supervision	Videocalls	2	Supervision	yes	Practitioners	General	General	/	Using WhatsApp to facilitate peer support and supervision among mental health care workers in Covid-19 isolation facilities	available	/
Remote supervision	Text Messenger	2	Supervision	yes	Volunteers	Zambia	Zambian Red Cross	Zambian Ministry of Health	Using video call technologies for supervision of mental health care professionals	available	/
Remote group therapy	Videocalls	2/3	Group counselling	yes	Victims of domestic violence	Brazil	Brazilian Red Cross	/	Using video call technology to conduct group therapy. Recreation of in person therapy	available	(Symptoms evolution)
Remote group therapy	Videocalls	2	Group counselling	yes	General	Lebanon	International Medical Corps	/	Using video call to conduct group therapy: awareness session (depression, anxiety)	available	(Client feedback)

Remote psychological therapy	Videocalls	3	Counselling	yes	General	Lebanon	International Medical Corps	/	Using video call technologies to conduct psychological therapy	available	/
Remote assitance service (TAD – Telea(sistencia Domiciliaria)	Mobile App + Phone hotline	2/3	Support network	yes	Elderly (adapted to other groups during COVID-19)	Argentina	Argentinian Red Cross	Telemed care (private company)	Bracelet, or mobile phone application) to put elderly in contact with a Telecare Centre of the Argentine Red Cross with the aim to (a) help the elderly with emergency management, (b) accompany them when they need to talk/feel lonely and (c) help them in their daily activities	available	(12 years of experi-ence)
Peer-support	Mobile phone	2	Peer Support	yes	Volunteers and Staff	Netherlands	Netherlands Red Cross	/	Peer support conducted through text messages and phone calls	available	still in pilot stage
WhatsApp helpline	Mobile phone	1	Peer Support	yes	Undocumented Migrants / General	Netherlands	Netherlands Red Cross	/	Using WhatsApp to facilitate peer support to those in the Netherlands that do not speak Dutch. The service is provided in different languages and ensures confidentiality and anonymity. The main goal is to provide	available	survey

									information about practical questions such as where to get a vaccine		
E-referral system	Database	4	Needs matching	/	People in hotel quarantine	Canada	Canada Red Cross	Canadian Public health agency / Ontario Psychologists Association	The Public Health Agency in Canada and Ontario Psyc Association have digital system of people who need top tier specialized mental health support. The Canadian RC is leveraging those systems, doing matching those who are quarantining with psychologists that suit them	available	conducted by the Ontario Psychologist Association
PFA remote training	Videocalls	1	PFA Training	yes	Staff and Volunteers in the Pacific Region	Pacific Islands	IFRC (Pacific)	/	Training through video calls on PFA to staff and volunteers of the NS of the Pacific Region	available	/
Fadfada	Website Platform	2/3	Varying from family counseling to psychiatric therapy	yes	Everyone can access it, but focus groups affected by 'double stigma'	Syria	UNDP Syria	WHO	Online Psychosocial support platform providing confidential support through virtual media. Service users	available	client feedback

									register in the platform and after having assessed the risk and the type of needs, UNDP calls back and conducts around 6 sessions through the phone (depending on needs)		
PEARL Database	Database	/	Supervisory tool + needs matching	/	Clinicians and practitioners	Africa	ICRC	/	Digitalisation and recompilation of medical files in a centralised manner with the goal of improving psychological interventions and supervision, increasing ability to make predictions about needs, and improving accountability towards donors	not available due to technical problems	/
PFA remote training	Videocalls (online webinars) + learning platform online	1	PFA Training and disaster preparedness	yes	NZRC staff and volunteers + General public	New Zealand	New Zealand Red Cross	Spire - online learning company	Using videocalls to organise webinars and train on PFA to volunteers and staff as well as the public. For internal training, these webinars are complemented by materials uploaded to the Spire online-learning platform	available	/

Necesito Un JuveAmigo (#NUJA)	Social Media	1/2	Peer support and counselling	yes	Young people	Mexico	Mexican Red Cross	OPS (WHO), Contacto Joven	Through the hashtag #NUJA, it is possible to identify those in need of MHPSS. Once they have been identified the Mexican Red Cross calls them, assess their needs and supports and counsels them accordingly. In addition, the intervention has created a network of peer support among young volunteers	available	/
Virtual Reality-based Physical Rehabilitation	Virtual Reality Imagery	3	Rehabilitation / Chronic Pain	yes	chronic pain patients	Southeast Asia	IFRC	ICRC	Virtual reality – guided imagery-based intervention (seeing a waterfall, soothing, voice-over guiding into relaxation), once each day for 10 days. After 10 days users would already associate mental imagery and relaxation with the audio, and can take away audio tape to practise at home	available in the Philippines	anecdotal client feedback

Annex 3: Interview Guide

Best Practices in Digital MHPSS

Interview Guide

Topic	Interview Questions	
Professional profile	• What position do you hold in your organization?	
Project Details	• **What digital MHPSS interventions did your organization implement?** • What was the aim of the project? • What was the context of the intervention (non/emergency setting, localities, target group, size)?	
Project Design	• Why did you implement this intervention digitally? • How big is your team? • Did you partner with other organizations or outsource tasks? • What is the business model / financing scheme of the intervention?	
Challenges in Implementation	• **Do you think your intervention was successful? If not, why?** • What challenges did you face during the implementation (IT, data protection, legal advice, trained staff, availability of participants)? • What would you have done differently? • What would you have needed to make your interventions even better? • **What structural needs do you think there are for better digital MHPSS in general?**	
Project Evaluation	Effectiveness	• Positive effect on mental health (clinical trials?) • Acceptance of intervention by the target population • task-transfer
	Scalability	• Accessibility • Ease of adaptation • Resource-intensiveness
	Sustainability	• Temporal sustainability • Structural sustainability
	Safety	• Do no harm • Adherence of ethics (data security) • Referral system
	Participation	• Inclusivity • Diversity
Wrap-up	• **What lessons learnt do you want to pass on to other National Societies / Organizations doing digital MHPSS?** • As a member of the Movement, would you be interested in joining the digital mental health WK or know more about the pledge? • Are you aware of any other intervention of interest/ other stakeholders in the field we should talk to? Could you introduce us?	