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COMMUNITY BASED MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT TOOLKIT

Community-based Mental Health and Psychosocial Support toolkit
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Prepared by: Arz Stephan, Nathalie Nyamukeba & Shona Whitton
Peer review: Omar Salih Rasheed
Lay-out and graphics: Jesper Guhle
Cover photo: Fabeha Monir

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The Red Cross Red Crescent Movement MHPSS Hub
Hejrevej 30 st. 2400
Copenhagen NV Denmark
+45 35 25 92 00
mhpsshub@rodekors.dk
mhpsshub.org

MHPSS INTERNATIONAL MOVEMENT HUB

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INTRODUCTION

The Community-based Mental Health and Psychosocial Support (CB MHPSS) toolkit is designed to provide Red Cross Red Crescent (RCRC) staff and volunteers, and other organisations, with practical and adaptable tools to strengthen Mental Health and Psychosocial Support (MHPSS) at the community level. The toolkit brings together evidence- and practice-informed interventions, grounded in the principles of participation, inclusion, empowerment, cultural relevance, and sustainability. It supports practitioners in designing, delivering, and evaluating activities that are locally appropriate and aligned with RCRC Movement principles as well as global standards.

Disclaimer

This toolkit is not intended to be exhaustive and does not aim to list all possible community based MHPSS activities. Instead, it presents a selection of recommended approaches and points to existing resources that may be relevant for National Societies and other implementing actors. These materials should always be used together with locally developed and contextualized resources. If an activity or tool already exists in a translated or widely used local version, this toolkit does not replace those materials; it is meant to complement and support existing practice, not override it. The toolkit compiles and presents services already used by the RCRC Movement, and other partners, in different contexts and situations. The toolkit aims to support the exchange of practices across diverse cultural and contextual perspectives but is not intended to be a comprehensive compilation of services.

WHO IS THIS TOOLKIT FOR

The primary audience of the toolkit are MHPSS staff and volunteers of the RCRC Movement, and other organisations, who are engaged in designing and facilitating community-level MHPSS activities. This may include staff, volunteers, community focal points, peer supporters, facilitators, and local actors involved in community-based MHPSS. It may also serve as a reference to strengthen community-based approaches to MHPSS.

The primary audience includes:

- RCRC MHPSS staff and volunteers
- Community focal points, peer supporters, and facilitators
- Local actors supported by the Movement who implement community level MHPSS
- Organisations implementing CB MHPSS

In order to stay consistent, we use the term MHPSS practitioners to refer to everyone who has the capacity and responsibility to contribute to community-based MHPSS activities from design and planning to implementation, monitoring, and follow-up.

PURPOSE OF THE TOOLKIT

This toolkit has been developed to equip MHPSS practitioners with culturally relevant, adaptable, and practical tools to strengthen mental health and psychosocial support at the community level. The toolkit is designed to be flexible and relevant across diverse contexts, including urban, rural, emergency, formal

and informal settlements and camps, protracted crisis and recovery settings. It draws on both evidence-informed approaches and longstanding practices within the RCRC Movement.

It is designed to support teams in:

- Preparing and designing CB MHPSS interventions that are participatory, and context driven ensuring cultural relevance and adaptability
- Implementing activities safely, inclusively, and effectively
- Monitoring and evaluating interventions using harmonized standards.

WHAT IS IN THIS TOOLKIT

The outline below reflects how the chapters correspond to the programme cycle:

Chapter 1 provides overview of community-based MHPSS, its definitions, and how it fits within the RCRC MHPSS framework, including the Do No Harm principle.

Chapter 2 outlines step-by-step guidance for conducting needs assessments, mapping existing community capacities, and co-designing activities with communities. Templates included here help ensure that interventions remain participatory, culturally appropriate, and aligned with the do no harm and inclusion principles.

Chapter 3 offers field-tested examples and activity guides that can be adapted to local contexts. These examples illustrate a wide range of CB MHPSS practices; such as child-friendly activities, community led MHPSS activities, community helplines, youth engagement, support for returnees, and inclusive activities for people with disabilities, reflecting the diversity of groups often reached through community-based MHPSS.

Chapter 4 provides practical tools for monitoring and evaluating CB MHPSS activities to ensure accountability, quality improvement, and evidence based learning. It supports teams in tracking outcomes, identifying challenges, and capturing community feedback.

Across all chapters, the toolkit emphasizes **community ownership**, **strengthening local capacities and coping strategies**, and **safe, inclusive service delivery**.

HOW TO USE THIS TOOLKIT

This toolkit guides MHPSS practitioners through the full programme cycle — assessment, planning, implementation, monitoring, evaluation, and reporting — across diverse contexts. It supports practitioners in integrating psychosocial wellbeing into community programming through practical tools, templates, and real-world examples.

MHPSS practitioners are encouraged to:

- Combine the templates and activity guides with community insights to ensure relevance.
- Adapt examples based on local culture, language, and existing capacities.
- Use the monitoring tools to adjust programming in real time.
- Integrate CB MHPSS with protection, health, education, and social cohesion efforts.
- Prioritize staff and volunteer wellbeing through regular peer-support and supervision.

By applying this toolkit as a flexible, living resource, MHPSS practitioners can enhance the quality and impact of their CB MHPSS programming while contributing to longer-term resilience, social cohesion, and community protection across the RCRC Movement.

CHAPTER 1
LAYING THE FOUNDATION FOR GOOD PRACTICE CB MHPSS

WHAT IS CB MHPSS?

CB MHPSS is an approach that engages and builds on the capacities of families, groups, and communities as central actors in wellbeing, recovery, and resilience. MHPSS interventions can be delivered at different levels, including individual, group, and specialized services, however CB MHPSS emphasizes strengthening existing social and relational systems, promoting participation and community ownership, and ensuring that support is accessible, culturally relevant, and embedded in the environments where people live.

While specialized mental health services are essential, they alone cannot address the full range of needs without strong community engagement. Meaningful and sustainable wellbeing requires strengthening locally available resources, culturally grounded practices, and the natural support networks within communities. CB MHPSS helps ensure that care is accessible, relevant, and responsive to the environments where people live and recover.

Objectives of CB MHPSS include:

1. Strengthening the community's resilience and ability to support itself by:
    - Reinforcing existing community support
    - Reactivating previously existing support
    - Introducing new and accepted support when needed.
2. Ensuring meaningful community involvement in informing, conducting, and implementing CB MHPSS activities.
3. Providing culturally appropriate and relevant activities to ensure broad access and ownership among affected people.
4. Supporting appropriate use of services across the MHPSS framework, while minimizing unnecessary reliance on higher-level interventions to prevent further severe MH condition.
5. Facilitating access to other layers of the MHPSS framework through referrals, when necessary.

Key concepts, principles, and approaches:

- **Apply a Do No Harm and protection sensitive approach** by drawing on established Movement tools (e.g., IFRC Better Programming Initiative – Do No Harm[1], draft RCRC Resolution Protection in the Movement[2], ICRC MHPSS Guidelines[3] and RCRC MHPSS Framework[4]). This includes actively minimizing risks of stigma or exclusion, ensuring equitable access, and promoting inclusion and meaningful participation of the most vulnerable and marginalized community members.

1 International Federation of Red Cross and Red Crescent Societies. (2022). *Better Programming Initiative: Do no harm*. Accessed here: https://communityengagementhub.org/resource/better-programming-initiative-do-no-harm/.

2 Council of Delegates of the International Red Cross and Red Crescent Movement. (2024). Resolution: Protection in the Movement: Improving our collective impact in protecting people. Accessed here: https://rcrcconference.org/app/uploads/2024/10/CoD24_R1-Res-Protection-EN.pdf

3 International Committee of the Red Cross. (2017). *Guidelines on mental health and psychosocial support*. Geneva: ICRC.

4 International Red Cross and Red Crescent Movement. (2020). *Movement policy on addressing mental health and psychosocial needs*.

- **Community, identity, and sense of belonging[5]:** A community is broadly defined as any group sharing common characteristics such as geographical location, language, interests, beliefs, values, culture, identity, or a sense of belonging. Belonging to a community is a critical component of personal identity and overall psychosocial wellbeing.
- **Participatory approach[6]:** CB MHPSS requires that communities are meaningfully and actively involved in identifying needs, shaping activities, and participating in implementation. Participation strengthens ownership, relevance, and sustainability.
- **Strength-based approach:** Even during emergencies, communities have existing strengths and local resources and capacities. CB MHPSS builds on these assets rather than focusing solely on problems or deficits.
- **Social ecological model:** Wellbeing is influenced by the broader environment. Strengthening the surrounding environment supports both individual and collective mental health[7].
- **Hobfoll's Five Principles[8]:** All CB MHPSS activities should promote the five evidence-informed elements shown to support recovery after crises:
  - Safety (physical, psychological, emotional and cultural): Ensuring that people feel protected from harm, threats, and overwhelming stress so they can begin to recover.
  - Calming: Helping individuals reduce distress and regain a sense of emotional steadiness and control.
  - Self- and community efficacy: Strengthening people's and communities' confidence in their ability to take meaningful actions that support their own wellbeing.
  - Social connectedness: Fostering supportive relationships and a sense of belonging that helps people feel less isolated and better supported.
  - Hope: Supporting individuals and communities to gradually reconnect with a sense of possibility and dignity, without imposing expectations of positivity. This includes recognising that hope may fluctuate over time and allowing space for people to process their experiences at their own pace.

These principles ensure that CB MHPSS interventions remain safe, culturally grounded, protective, and supportive of long-term resilience.[8]

5 Inter-Agency Standing Committee. (2021). *Community-based approaches to mental health and psychosocial support programmes: A guidance note*. Accessed here: https://interagencystandingcommittee.org/sites/default/files/migrated/2021-10/Community-Based Approaches to MHPSS Programmes- A Guidance Note.pdf.

6 International Federation of Red Cross and Red Crescent Societies. (n.d.). *Community engagement and accountability (CEA) toolkit*. Access here: https://www.ifrc.org/document/cea-toolkit.

7 United Nations Children's Fund. (n.d.). Global multisectoral operational framework. https://www.unicef.org/media/135011/file/Global%20multisectoral%20operational%20framework.pdf

8 Dückers, Michel. (2013). Five essential principles of post-disaster psychosocial care: Looking back and forward with Stevan Hobfoll. *European Journal of Psychotraumatology*, vol. 4.

WHERE CB MHPSS SITS IN THE RCRC MHPSS FRAMEWORK

CB MHPSS in the RCRC Movement is grounded in the Fundamental Principles. It aims to reduce suffering and uphold dignity (Humanity), ensure equitable and inclusive access to support (Impartiality), provide safe spaces (Neutrality), and remain guided by community needs rather than external interests (Independence). CB MHPSS builds on volunteerism and community participation (Voluntary Service), strengthens community cohesion and belonging (Unity), and draws on shared global evidence-informed experience to support local adaptation (Universality).

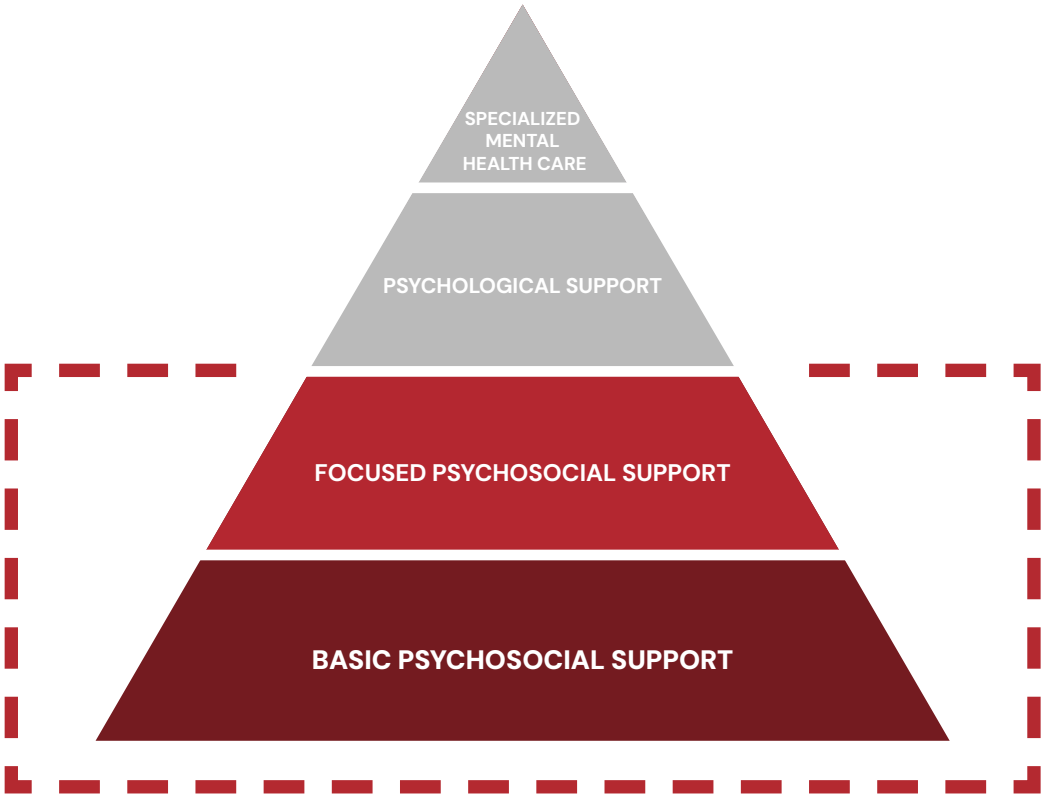


Figure 1: RCRC MHPSS Framework

CB MHPSS falls primarily within **Layer 1: Basic Psychosocial Support** and **Layer 2: Focused Psychosocial Support** of the RCRC MHPSS Framework.

- At **Layer 1**, CB MHPSS the activities promote MHPSS awareness and reduce the stigma by encouraging help seeking and supportive attitudes aimed at the whole population.
- At **Layer 2**, CB MHPSS includes more structured activities for groups or persons at high risk that can be implemented through activities such as youth circles, peer-support groups, child-friendly spaces, community dialogues, and group-based coping and problem-solving sessions.

The RCRC MHPSS Framework adopts a continuum of care, meaning that support should be available and connected across all four layers; before, during, and after emergencies. This continuity ensures that people do not fall through gaps and that care remains both holistic and community-centred. Within this continuum, CB MHPSS activities Layers 1 and 2, promote wellbeing, support early identification and referrals, and play a critical role in supporting individuals, who may also be receiving more specialised services at Layers 3 or 4. People accessing psychological or clinical care should continue to be welcomed, included, and supported through community-based activities to maintain social connectedness, strengthen self- and community efficacy, and reduce isolation or stigma.

Examples of continuum of care across layers:

- A person attending specialised mental health care (Layer 4) can still join community activities (Layers 1–2) that foster belonging.
- Someone benefiting from structured group support (Layer 2) may at times need referral to focused or specialised services (Layers 3–4).
- Community leaders, volunteers, and peer networks can help monitor wellbeing and encourage safe help-seeking without replacing clinical roles.
- Community MH care ensures access to services and continuity care for people with mental health conditions. These services are more specialized in nature requiring qualified MH professionals.

Maintaining these links across layers strengthens sustainability, encourages participation, supports dignity, and reduces harm by ensuring that no single layer operates in isolation.

WHO CAN PROVIDE CB MHPSS?

Community-based MHPSS can be delivered by a wide range of people, provided they are properly trained, supervised, and supported. Facilitators do **not** need to be mental health professionals. However, they must demonstrate basic competencies in:

- psychosocial support,
- supportive communication,
- group facilitation,
- protection principles,
- confidentiality, and
- recognizing when (and how) to refer someone for more specialized support.

Community members are trusted and effective facilitators of CB MHPSS because they understand the language, culture, and daily realities of affected people. At the same time, community members are not neutral by definition; they may reflect existing power dynamics, stigma, exclusion, or social norms within the community. For this reason, careful selection, appropriate training, active supervision, and ongoing support are essential.

When adequately prepared and supported, staff, volunteers, and community members can safely facilitate activities such as community dialogues, peer support circles, recreational or cultural healing activities, psychoeducation sessions, and community-led wellbeing initiatives.

Workforce for Community-based MHPSS include:

Professionals in education, health, and social services

- Teachers or educators who naturally serve as trusted adults and support the wellbeing of children and adolescents.
- Social workers experienced in casework, community engagement, and protection-sensitive approaches.
- Medical doctors, nurses, and mental health professionals who understand distress, basic psychosocial needs, and safe referral pathways.
- Early Childhood Development (ECD) facilitators working closely with young children and caregivers.

Community-based actors and civil society members

- Community leaders, elders, or respected figures with influence and trust at the local level.
- Faith-based actors such as religious leaders or spiritual counsellors who play a central role in

providing emotional and social support.
- Women's group leaders and members, including those running women and girls-safe spaces.
- Local NGO staff engaged in community programming, protection, or psychosocial activities.
- Community health workers or lay health volunteers, often first responders to wellbeing concerns.

Youth and community engagement roles
- Youth workers, community outreach staff, or health promoters who regularly interact with young people and adults.
- Sports coaches, youth club mentors, and facilitators of structured activities that support social connection and wellbeing.

Protection and case management roles
- GBV caseworkers trained in survivor-centred, protection-sensitive support.
- Case managers supporting persons with disabilities, older people, migrants, or individuals facing protection risks.
- Community mediators or social cohesion facilitators who help reduce tensions and support collective wellbeing.

Additional humanitarian and public service actors
- Camp management staff and community volunteers who interact daily with displaced populations.
- Shelter, WASH, or distribution volunteers/staff who may offer Psychological First Aid (PFA) and safe referrals during routine interactions.
- Local authorities' social service staff collaborating with community structures on wellbeing and protection.

Red Cross Red Crescent Movement actors
- RCRC volunteers trained in PFA, basic MHPSS skills, safe referral pathways, and community-based support.
- RCRC staff and volunteers with MHPSS responsibilities or integrated roles within health, protection, migration, or community programmes.

These individuals can facilitate group discussions, awareness sessions, community dialogues, and other CB MHPSS activities when accompanied by appropriate supervision.

WHEN SHOULD CB MHPSS BE PROVIDED?

CB MHPSS is relevant across all phases of the emergency cycle, preparedness, acute response, and recovery, because communities benefit from strengthened social support, inclusion, and shared coping at every stage.

Preparedness Phase

Before a crisis, CB MHPSS focuses on building community strengths, inclusion, and readiness. This includes training community members, reinforcing social networks, promoting supportive communication, and establishing safe, trusted spaces. Preparing communities in this way enhances collective capability, supports dignity, and strengthens human-centred approaches that make future responses more effective.

Acute Phase

During an emergency, CB MHPSS aims to promote basic safety, emotional steadiness, and social connectedness as early as conditions allow. Activities at this stage should be simple, inclusive, and protective—helping people stabilise, stay connected, and feel supported. Even in rapid response, restoring or maintaining social ties and involving community members in decision-making contributes significantly to wellbeing.

Recovery Phase

As conditions stabilise, CB MHPSS can broaden to reactivate social networks, restore community roles, and support collective recovery. This may include group activities, community-led initiatives, peer support, youth or women's groups, intergenerational dialogue, and other inclusive practices that rebuild trust, identity, and belonging. Recovery is also the moment to strengthen resilience and ensure that communities remain active partners in shaping ongoing support.

TARGET GROUPS AND KEY CONSIDERATIONS FOR TAILORING CB MHPSS ACTIVITIES

CB MHPSS should be adapted to the needs, strengths, and preferences of different population groups. While many activities can be implemented across age and demographic categories, the design, facilitation, communication style, accessibility, and protection considerations should be tailored to each group. Below are key considerations to guide adaptation:

Children (6–12 years)

Key considerations

- Use play-based, creative, and sensory activities (e.g., drawing, movement, and storytelling).
- Ensure safe, structured routines and predictable transitions.
- Provide short, varied activities to match attention spans.
- Use simple language and visual aids.
- Ensure child safeguarding is integrated into all programming.
- Involve caregivers whenever possible to reinforce coping at home.
- Allow expression without interpreting children's drawings or stories.

Adaptation examples

- Replace discussion-heavy activities with role plays or stories.
- Simplify psychoeducation into child-friendly messages using metaphors or puppets.
- Create separate spaces for girls and boys if culturally needed and safe.

Adolescents (13–17 years)

Key considerations

- Provide opportunities for choice, leadership, and peer connection.
- Integrate topics relevant to identity, belonging, and future goals.
- Use activity formats that support autonomy: small-group discussions, creative expression, problem-solving.
- Be mindful of heightened risk of stigma, peer pressure, and protection concerns.
- Consider gender-sensitive groupings based on cultural and safety contexts.

Adaptation examples

- Add brief decision-making or leadership roles (e.g., selecting songs, leading warm-ups).
- Integrate physical activities, sports, or digital storytelling.
- Use psychoeducation with relatable examples and interactive dialogue.

Adults and caregivers

Key considerations

- Acknowledge caregiving burden, household stress, and competing daily pressures, while also recognizing that adults and caregivers often hold significant influence within their families and communities.
- Address barriers to service access, continuity, and help-seeking during displacement or deprivation.
- Use practical, relevant examples linked to caregiving and household roles.
- Ensure privacy, dignity, and non-judgmental discussion of family dynamics.
- Consider diverse caregiving situations (single parents, older caregivers, caregivers of persons with disabilities).

Adaptation examples

- Use brief stress management and problem solving activities grounded in daily caregiving challenges.
- Provide short, actionable psychoeducation on coping and navigating services.
- Offer flexible session formats (short sessions, modular content, child-friendly spaces for accompanying children).
- Facilitate discussions on help-seeking challenges without pressuring disclosure.

Older Persons

Key considerations

- Prioritize accessibility: quiet spaces, seating, ventilation, proximity to latrines, pacing of sessions.
- Integrate movement that accommodates reduced mobility.
- Account for sensory limitations (vision, hearing).
- Recognize and validate life experience; avoid infantilizing tone.
- Consider the impact of grief, displacement-related loss, and isolation on emotional wellbeing.

Adaptation examples

- Include reminiscence-based, dignity-affirming activities (e.g., life stories, sharing strengths, learnings).
- Increase time for instructions and group discussions.
- Avoid activities requiring quick motor responses unless adapted.

People with Disabilities

Key considerations

- Apply to the principles of universal design and offer multiple ways to participate.
- Consult directly with persons with disabilities and their caregivers on preferred adaptations.
- Ensure physical accessibility: ramps, space for mobility aids, seating variety.
- Adapt communication formats:
  - Visual support for people with hearing difficulties.
  - Clear and descriptive explanations for people with visual impairments.
  - Simplified or step-by-step guidance for people with intellectual disabilities.
- Consider sensory sensitivity (lighting, noise, textures).

Adaptation examples

- Provide tactile materials or high-contrast visuals.
- Modify activities requiring fine motor skills.
- Offer quiet or low-stimulation options.

Survivors of Sexual Violence

Key considerations

- Ensure confidentiality, safety, dignity, and voluntary participation always.
- Avoid any activity that requires personal sharing of traumatic experiences.
- Emphasize grounding, stabilization, and coping-focused content.
- Ensure safe group composition based on gender, age, and social dynamics.
- Provide private, predictable spaces with the option to step out any time.
- Do not label groups in a way that reveals survivor status.
- Develop clear processes for services mapping and referral pathways including clarifying roles and responsibilities of staff and volunteers.
- Enable participation in broader community activities without singling out survivors.

Adaptation examples

- Focus on strength-based activities (strength mapping, body-stabilization techniques, creative arts).
- Offer optional individual check-ins before/after group activities.
- Integrate flexible pacing and opportunities to step out without explanation.

CHAPTER 2
ASSESSMENT AND PLANNING FOR CB MHPSS ACTIVITIES

This chapter focuses on empowering community actors and peers including volunteers, people with lived experience, teachers, youth leaders, first responders or religious/faith leaders, to play an active role in nurturing psychosocial wellbeing within their communities. Strong CB MHPSS systems enhance key wellbeing outcomes by promoting social connectedness, strengthening coping abilities, improving subjective wellbeing, and fostering positive social behaviour[9]. When communities are equipped with foundational psychosocial skills, individuals experience reduced distress, including symptoms linked to mental, neurological, and substance-use (MNS) conditions, and show improved daily functioning and engagement in community life.

Peer networks and trusted leaders often serve as the first point of emotional support. By building their skills through mentorship, peer-to-peer mechanisms, and leadership development, practitioners help communities create safe, supportive environments where people can share experiences, regulate emotions, and access timely guidance. These approaches strengthen resilience, deepen community ownership, and bridge gaps between formal services and everyday support systems, creating durable, community-led mechanisms that sustain wellbeing over time[10].

This chapter provides practical guidance for staff and volunteers on how to design CB MHPSS activities based on findings from the MHPSS needs assessment. Communities are placed at the centre of the design phase, serving as key informants not only on the content of activities but also on the format, ensuring sessions are culturally grounded, accessible, and meaningful.

9 Inter-Agency Standing Committee. (n.d.). *IASC Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings*. Accessed here: https://interagencystandingcommittee.org/iasc-reference-group-mental-health-and-psychosocial-support-emergency-settings/iasc-common-monitoring-and-evaluation-framework-mental-health-and-psychosocial-support-emergency.

10 International Federation of Red Cross and Red Crescent and Red Cross Red Crescent Movement MHPSS Hub. (2025). Building Sustainable MHPSS Practices: Guidance for National Societies. Copenhagen.

Overview of the Key Steps in Community-Led CB MHPSS Activity Design

Designing strong CB MHPSS activities begins with a collaborative process that places communities at the centre of every decision. Each step ensures that activities are grounded in evidence from the MHPSS needs assessment, aligned with community preferences, and supported by clear referral pathways. By following these steps, staff and volunteers can create interventions that are culturally relevant, safe, feasible, and owned by the community, ultimately strengthening wellbeing, resilience, and local capacity for care.

1. Identifying needs, interests, strengths, and available resources

Working with communities helps ensure activities build on what communities already know and do well. Areas to explore with communities include:

- What people are currently experiencing (stressors, losses, safety concerns).
- Who is most affected (children, caregivers, older adults, displaced people).
- What strengths already exist (rituals, networks, local coping practices and strategies).
- What resources are available (community spaces, trained volunteers, partnerships), and ongoing activities that can support the needs.
- What barries to participation or access (stigma, mobility, distance and cost, language, cultural norms, and security concerns).

Examples of tools:

1. Multi-sectoral MHPSS Needs and Resources Assessments Toolkit Downloadable Resources - MHPSS MSP
2. Compilation of short mental health and psychosocial assessment tools, monitoring tools and preparedness plans Assessment-monitoring-tools-and-preparedness-plans-for-MHPSS.pdf
3. Contextual key consideration (Annex 1)

2. Community consultation

Structured community consultation helps ensure types of activities respond to actual needs rather than assumptions. This includes:

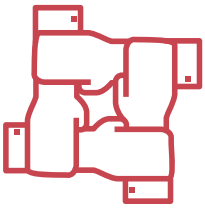
- Meeting with leaders, women's groups, youth, or marginalized or invisible groups of people (people with disabilities, and survivors of sexual violence).
- Understanding preferred formats, safe locations, appropriate timings.

Activity choices should reflect:

- Community expectations, strengths and resources (local practices, peer support structures).
- Cultural relevance and acceptability (gender norms, traditions, language).
- Safety and safeguarding considerations (protection risks, confidential spaces).
- Feasibility (time, staffing, transport, materials, permissions).

Examples tool:

- Community Meeting Guide – MHPSS Hub (Annex 2)



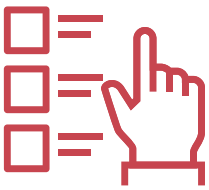
3. Capacity building of staff /volunteers and community members

Before activities begin, it is important to assess:

- What capacities exist among community members and volunteers.
- What additional skills (e.g., facilitation, psychological first aid, referral knowledge) may be needed to run the activity safely.

Example tool:

- Minimum requirements for CB MHPSS capacities (Annex 3)



4. Planning the activity with the community

Planning should be a shared process, including:

- Defining the purpose and expected outcomes together.
- Turning ideas into concrete steps using structured planning templates.
- Clarifying roles, responsibilities, schedules, locations, and referral pathways.
- Ensuring the activity is inclusive and accessible to diverse groups.
- Identifying the monitoring and feedback mechanisms best suited for the community.
- Planning the exit strategy with the community.

Makes sure to establish these steps before starting the activity.

- Safety procedures
- Referral pathways
- Adapting monitoring and feedback mechanisms
- Ways the activity will be adapted if attendance or needs change.

Example tool:

- Activity Planning Tool – MHPSS Hub (Annex 4)

5. Service mapping and/or referral pathways

Clear service mapping and/or referral pathways ensure people can safely access the right level of support when they need it; they are essential for protecting wellbeing and preventing harm in CB MHPSS. At a minimum map the services around the location where you are offering the CB MHPSS activity.

These are indicative activities to choose from based on your context:

- Map formal and informal services across all MHPSS levels with the community.
- Assess accessibility, cultural relevance, safety, and trust in each service.
- Validate service details directly with providers.
- Organize information into clear maps with contacts, eligibility, and hours.
- Co-develop referral pathways outlining quality of service, when, how, and by whom referrals are made.
- Ensure community ownership of mapping and referral decisions.
- Establish simple processes to regularly update service information.

Example tool:

- Referral mapping information sheet (Annex 5)

CHAPTER 3:
EXAMPLES OF CB MHPSS ACTIVITIES

The activities included in this section were selected because they consistently contribute to key community level MHPSS outcomes across a wide range of emergencies. Whether responding to natural hazards, armed conflict, displacement, or sudden-onset crises, these approaches strengthen social connectedness, enhance coping ability, support subjective wellbeing, and promote positive social behaviours and functioning. Each activity is linked to evidence-based outcomes such as improving community cohesion, reducing distress, and enabling safer and more supportive environments during times of heightened stress. Importantly, the RCRC Movement operates in diverse cultural, linguistic, and social contexts. For this reason, the activities outlined here are intentionally flexible and designed to be adapted by communities themselves. Cultural norms, traditional coping practices, collective rituals, storytelling, and local systems of mutual support all shape how communities understand wellbeing and how they prefer to give and receive help. By grounding activities in community participation and cultural meaning, practitioners ensure that support feels safe, relevant, and respectful.

Across different crisis settings, these activities tap into existing community strengths such as peer networks, safe spaces, youth leadership, faith structures, and/or local volunteers while providing accessible methods to reduce distress, rebuilding routines, and strengthen protective relationships. This people-centred, culturally attuned approach ensures that MHPSS programming not only responds to urgent needs but also reinforces local capacity, dignity, and resilience. This chapter reflects a coherent pathway from early engagement to sustained, community-led psychosocial support, adaptable across diverse cultures, crisis types, and local contexts[11].

The four sections are organized as follows:

3.1 TALKING ABOUT MENTAL HEALTH focuses on normalizing discussions, reducing stigma, and improving awareness, laying the foundation for wellbeing and help-seeking.

3.2 BUILDING SOCIAL CONNECTIONS AND SAFE SPACES expands this by strengthening collective belonging through supportive spaces, peer groups, and social cohesion activities, which are central to recovery in crises.

3.3 RAPID CB MHPSS ACTIVITIES address the urgent need for immediate, accessible support during emergencies through crisis response teams and helplines that reduce acute distress and connect people to services.

3.4 STRENGTHENING PEER AND LEADERSHIP CAPACITIES builds sustainability by equipping peers, volunteers, and community leaders with the skills to support others, improve functioning, and maintain community resilience over time.

11 For examples, see the Successful MHPSS services catalogue - MHPSS Hub during the Ukraine response in Europe, highlighting diversity of services based on the NS needs and resources available.

3.1 TALKING ABOUT MENTAL HEALTH

Talking about mental health is a foundational component of CB MHPSS. This section brings together activities designed to open conversations about stress, coping, and wellbeing in ways that feel safe, participatory, and grounded in local realities. Creating space for communities to talk openly about their experiences is often the first step toward reducing stigma, strengthening protective social norms, and building shared understanding of emotional wellbeing.

The approaches emphasized here reflect long-standing practices across the RCRC Movement. They are aligned with key guidance such as IOM Manual on Community-Based Mental Health and Psychosocial Support in Emergencies and Displacement and the WHO mhGAP[12] principles on recognizing and supporting common mental health concerns at the community level, and global IFRC frameworks promoting safe, inclusive, and culturally attuned engagement[13]. Across crisis settings, these methods help practitioners translate essential mental health information into accessible, culturally meaningful discussions led *with* communities rather than *for* them.

These activities can be adapted to different topics delivered through various formats depending on what best suits the community.

The three activities in this section include:

1. Awareness raising sessions
2. Psychoeducation sessions
3. Art-based activities

12 World Health Organization. (2023). Mental Health Gap Action Programme (mhGAP) guideline for mental, neurological and substance use disorders (3rd ed.). https://www.who.int/publications/i/item/9789240084278

13 International Federation of Red Cross and Red Crescent Societies. (n.d.). Protection, gender and inclusion. Accessed here: https://www.ifrc.org/our-work/inclusion-protection-and-engagement/protection-gender-and-inclusion

Awareness-raising sessions

Overview

This activity provides a structured yet flexible format for community-led awareness-raising on stress, coping, and wellbeing. It strengthens shared understanding of mental health, reduces stigma, and promotes supportive norms grounded in local culture. Sessions are conducted with the community ensuring participation, inclusion, and sensitivity to protection, safeguarding, safe identification and referral, and MHPSS principles.

Objectives

- Improve knowledge of stress, coping, and available support options.
- Reduce stigma, discrimination, and harmful narratives around mental health.
- Promote mutual support, protective social behaviours, and safe help-seeking.
- Strengthen inclusion, dignity, and community ownership of wellbeing initiatives.

Target group(s)

- Adults, caregivers, elders, community leaders, youth.
- Groups should reflect gender, age, and cultural diversity.
- When needed, separate groups may be used (e.g., women-only or youth-only sessions) to ensure safety and comfort.

Preparation

- **Resources:** Flipcharts, markers, culturally relevant stories/examples, leaflets, posters, images, emotion cards, handouts summarizing minimum information on stress and coping, and updated referral pathways or service mapping.
- **Personnel:** 1–2 facilitators with basic psychosocial skills and understanding of safeguarding, confidentiality, and “do no harm” principles.
- **Partnerships:** Community representatives, women’s groups, youth groups, local leaders, volunteers.
- **Context Review:** Mapping community stressors, available services, safe spaces, cultural norms, and potential protection risks.
- **Group size:** Ideal group size is 10–20 participants, facilitated by 1–2 trained facilitators. Larger groups can split into parallel small groups with additional facilitators.

Implementation guidance

1. **Community consultation & theme selection**
   Meet with trusted community representatives, caregivers, or local groups to identify priority topics such as stress, sleep difficulties, family tension, or social strain. Co-decide the session’s goals, format, and best timing to maximize participation.
2. **Session co-design**
   With community input, adapt the session flow so examples, metaphors, and stories reflect local realities. Confirm safeguarding expectations, confidentiality boundaries, and referral options before implementation.
3. **Opening**
   Welcome participants, explain the purpose, and establish simple safety agreements (respect, voluntary participation, no forced sharing, confidentiality). Begin with a brief grounding or breathing activity to create a calm and shared starting point.

4. **Exploring stress & common reactions**
   Use stories, drawings, or simple scenarios to explore how people experience and respond to stress. Highlight that emotional reactions are normal and vary across individuals.
5. **Coping & strength identification**
   Facilitate a discussion on healthy and unhealthy coping using locally relevant examples (e.g., family support, prayer, social gatherings, caring routines). Invite participants to identify community strengths and collective ways of supporting each other.
6. **Sharing key messages & available support**
   Provide clear, simple information on stress, coping, and when additional help may be needed. Share only verified, safe, and accessible services and explain how to approach them. Clarify facilitators' limits and reinforce that no assessment or diagnosis is taking place.
7. **Closing & Grounding**
   Close with a reflection round, one takeaway message, and a quick grounding exercise. Remind participants of available support channels and whom to contact for urgent concerns.

Facilitation tips

- Use accessible, non-medical language and culturally meaningful examples.
- Emphasize participation and respect; protect quieter voices.
- Avoid sharing personal opinions or probing sensitive stories. Oversharing can be harmful.
- Maintain confidentiality, except in cases of imminent harm.
- Ensure emotional safety by recognizing signs of distress and offering one-to-one followup when needed.
- Adapt the activity for local contexts, gender norms, and literacy levels.

Challenges and mitigation

Challenge	Mitigation
Deep-rooted stigma/fear	Normalize experiences; model empathy with clear explanations
Leader resistance	Engage early; show relevance to wellbeing
Misinformation	Provide accurate facts; correct gently
Limited participation	Use trusted networks; schedule accessibly

Feedback mechanisms

- Ask 2–3 reflective questions at the end (e.g., "What was useful?" "What should we change next time?")
- Provide a safe, anonymous way to share feedback

Documentation

- Number of participants
- Main themes raised (non-identifying)
- Any follow-up for referrals
- Any safety issues encountered

Case studies

Yemen Red Crescent Society: Community-led Awareness Raising on Mental Health & Wellbeing in Yemen

In crisis affected communities across Yemen, the Yemen Red Crescent Society (YRCS) has implemented community-led awareness raising sessions to address rising stress, fear, and social tension. Drawing on the YRCS Community-based Psychosocial Support (CB PSS) manual, volunteers began by engaging community leaders and caregivers to identify priority concerns such as sleep problems, family conflict, and chronic worry. These insights shaped a locally designed awareness session on stress, coping, and psychosocial wellbeing. The community mechanisms were in place to support and develop the content of the awareness raising sessions such as the story of Saber that is included in the CBPSS Training Manual.

During the session, YRCS volunteers facilitated an opening exercise on emotional awareness, helping participants articulate how they were feeling. Using relatable stories such as Saber's story from the manual, they explored common signs of stress and how crisis events affect both individuals and families. Participants discussed healthy and unhealthy coping strategies, drawing on cultural practices like shared meals, prayer, and neighbor support. Volunteers also introduced simple breathing and grounding exercises that participants found immediately useful.

The activity reduced stigma around emotional distress and strengthened social connectedness. Many participants expressed relief in learning that their reactions were normal, and some formed an informal peer support group to continue meeting weekly.

Mali Red Cross: CHWs lead local awareness sessions and small-group discussions with families, elders, youth to address wellbeing and protection concerns

Community health workers trained by the Mali Red Cross conduct local awareness sessions and small-group discussions with families, elders, and youth to address psychosocial wellbeing, harmful practices, and protection concerns. These informal gatherings create safe spaces for conversation, improve trust, and strengthen community ties—key aspects of restoring social connectedness in crisis-affected regions.

The Mali Adolescent Health Project (SAM), funded by the Government of Canada, exemplifies the Canadian Red Cross' commitment to comprehensive health programming. Active across three regions in Mali, SAM focuses on empowering CHWs to deliver essential sexual and reproductive health services, prevent early marriage, and improve maternal, newborn, and child healthcare (MNCH). Through targeted training, health education, and collaboration with local health ministries, SAM is fostering resilient, informed communities equipped to support adolescent health and rights. In April 2023, the Canadian Red Cross sent humanitarian experts to support the local team in meeting reporting and planning requirements, ensuring the project aligns with the Government of Mali's health priorities and is improving local ownership.

Psychoeducation sessions

Overview

This activity provides a structured and accessible learning session that offers factual, culturally relevant information about stress, emotions, coping, and wellbeing. It helps demystify common reactions, reduces fear and self-blame, and supports participants in gaining a greater sense of calm, safety, and control.

Objectives

- Improve understanding of stress and psychosocial reactions
- Increase calm, safety, confidence, and capability
- Normalize reactions to crisis; strengthen emotional self-awareness
- Equip participants with simple, practical techniques

Target group(s)

- Adults, caregivers, and adolescents.
- Groups adapted to age, gender, culture, and literacy levels.
- Separate groups may be used (e.g., adolescents only, women only) to ensure comfort and safety.

Preparation

- Resources: Flipcharts, markers, emotion cards, simple grounding/breathing scripts, and handouts summarizing key messages.
- Personnel: 1–2 trained facilitators with basic psychosocial skills and understanding of safeguarding and confidentiality.
- Partnerships: Local leaders, women's groups, schools, youth centres, or health posts.
- Context review: Identify local stressors, common reactions, coping practices, and preferred communication styles through assessments or community mapping.

Implementation guidance

1. **Welcome and introduction**
   Greet participants, explain the purpose of the session, and briefly describe how stress can affect the body, thoughts, emotions, and relationships. Establish simple participation agreements (respect, confidentiality, voluntary sharing).
2. **Emotional check-in**
   Use emotion cards or simple prompts to help participants identify and name emotions in a non-threatening way.
3. **Input on common reactions**
   Introduce common stress reactions (e.g., worry, sadness, irritability, tiredness, difficulties sleeping). Emphasize that these are normal human responses.
4. **Group reflection**
   Invite participants to reflect on how stress shows up in daily life, using general examples rather than personal stories. Normalize variation in responses.
5. **Teach calming techniques**
   Demonstrate grounding, controlled breathing, or simple relaxation exercises. Explain in clear, non-medical language why these techniques help the body and mind.

6. **Everyday coping**
   Discuss culturally meaningful ways people cope (e.g., prayer, routines, social connection, music, movement). Highlight community strengths and adaptive strategies.
7. **Closing**
   Summarize key messages and invite participants to practice one technique daily. Offer a brief grounding activity before ending the session.

Facilitation tips

- Use simple, non-clinical language and validate participants' feelings.
- Respect cultural norms and ensure confidentiality and voluntary participation.
- Use visual aids or demonstrations in lowliteracy settings.
- Avoid probing for personal trauma stories.
- Be attentive to signs of distress and offer private follow-up if needed.

Challenges and mitigation

Challenge	Mitigation
Stigma or self-blame	Normalize reactions; use community stories to reduse further harm
Low engagement	Use interactive activities, not lectures
Emotional triggers	Provide grounding, breaks, quiet space
Misunderstanding advice	Check comprehension; adapt examples

Feedback mechanisms

- Use simple start/end checkins (e.g., "How are you feeling now compared to when you arrived?").
- Ask two or three oral reflection questions (e.g., "What was useful?" "What should be different next time?").
- Provide safe, anonymous feedback options when possible (verbal box, private comment, post-session check-in).

Documentation

- Record non-identifying information only:
  - session date and location
  - number of participants (disaggregated by gender/age when appropriate)
  - general themes discussed (no personal stories)
  - techniques taught
  - any safeguarding concerns addressed (without names)
  - referrals made (type of service, not individual identity)
- Note any adaptations made for literacy, culture, accessibility, or group dynamics.
- Document challenges and mitigation strategies to improve future sessions.
- Store documentation securely and ensure access is limited to authorized staff.

Case studies

Iranian Red Crescent — Psychoeducation to Strengthen Youth Emotional Stability & Agency Training Red Crescent youth volunteers

Iran's trained peer educators relied on psychoeducational sessions that included:

- Drug addiction basics
- Harm reduction principles
- Links between substance use and HIV/hepatitis
- Behavioral change concepts
- Non-judgmental approaches to vulnerable groups.

They facilitated these sessions using interactive methods including group discussions, role playing, and supervised debriefing.

Iranian volunteers also had structured monitoring support, forming an online group to share reports and photos, promoting emotional support and a sense of belonging among the educators themselves.

Psychoeducational outreach to children and youth

One standout psychoeducation example from Iran involved kindergarten children to engage smokers using supportive messaging (giving flowers, requesting reduced smoking for a set time).
This is a clear psychoeducational strategy oriented toward:

- Building positive social behaviors
- Fostering agency and empowerment among children
- Promoting a sense of contribution and control, which is key to subjective wellbeing

Link to subjective wellbeing

The psychoeducation initiatives in Iran supported youth subjective wellbeing by:

- Giving them skills to understand and navigate risk
- Helping them develop emotion regulation skills through group reflection
- Encouraging empathy and reducing internalized stigma
- Creating a sense of purpose and humanitarian identity, as expressed in youth testimonies such as: "I've acquired a lot of new skills, but the most important knowledge I've learnt was to build a friendly relationship with drug users."

British Red Cross – Safe Conversations Around Suicide:

The British Red Cross integrates suicide awareness and "safe" conversation skills into its Mental Health and Psychosocial Support Service. Their work includes:

- Offering one-to-one psychosocial support after emergencies (fires, floods, displacement, sudden crises), where suicide risk may increase due to distress and disconnection.
- Providing resources for the public and practitioners on how to talk safely and openly about suicide without increasing harm.
- Using the psychosocial framework C.A.L.M.E.R to help responders remain present, empathic, and grounded when supporting someone at risk. How to take the C.A.L.M.E.R approach to stress
- Training British Red Cross staff and volunteers through workshops to build skills for conversations around suicide. This helps to equip people to recognise signs of suicidal ideation and respond with calm and supportive communication. The workshop features the "C.A.L.M.E.R." framework, which emphasizes the importance of being calm when delivering support and using six sequential stages.
- Disseminating videos and guidance on safe suicide conversations through the Psychosocial & Mental Health Team. Supporting people in crisis #ThePowerOfKindness - YouTube

The British Red Cross encourages focuses on early supportive communication during crises, reducing stigma and enabling help seeking support. This approach strengthens protective social behaviours, teaches communities how to intervene safely, and builds confidence to respond compassionately when suicide concerns arise.

Photo: ICRC

Art-based activities

Overview

Art-based activities use structured creative processes to support emotional expression, stress regulation, and overall wellbeing. By engaging the senses and offering nonverbal ways to communicate experiences, these activities help participants externalize feelings safely and build agency. When shared in groups, art-making can create a supportive atmosphere, and reinforce cultural identity.

Objectives

- Improve emotional wellbeing through expression, release, and stress reduction.
- Promote social connection and cohesion through shared creative experiences.
- Strengthen coping skills through guided, culturally relevant creative engagement.
- Enhance participants' sense of belonging, agency, and positive identity.

Target group(s)

- Individuals, families, and groups affected by crisis, displacement, or prolonged stress.
- Suitable for all ages (children, adolescents, adults, older adults), with adaptations as needed.
- Especially helpful for participants who prefer nonverbal expression.

Resources

- Paper, markers, paints, collage materials, clay, textiles, natural materials.
- Music devices, calming sound options, tables or floor mats.
- Optional: recycled items (safe to use), culturally meaningful symbols, storytelling objects.

Personnel

- Facilitators trained in basic psychosocial support and creative facilitation methods.
- Co-facilitator recommended for supporting individuals who may need grounding.

Partnerships

- Local artists, cultural centres, community groups, teachers, or youth clubs.
- Ensure activities reflect cultural traditions and materials familiar to participants.

Context Review

- Understand cultural norms around creative expression.
- Consider accessibility needs (lighting, seating, motor abilities).
- Identify safe-space considerations and appropriate referral pathways.

Implementation guidance

1. **Outreach to participants**
   Invite individuals who are interested in creativity-based activities. Emphasize that no artistic skills are required.
2. **Opening, goals, and emotional safety**
   Explain the purpose of the session and co-create simple agreements: respect, confidentiality, voluntary sharing, and "no right or wrong way" to express oneself.
3. **Warmup**
   Start with a brief grounding, breathing, or sensory exercise to help participants settle and become present.

4. **Core creative activity**
   Offer one or a combination of:
   - drawing or painting
   - collage or clay work
   - textiles, weaving, beadwork
   - creative movement or rhythm
   - soundscapes or music expression

   Participants choose materials or methods that feel comfortable.

5. **Voluntary reflection**
   Invite participants to reflect on colours, shapes, movements, or feelings that emerged—verbally or nonverbally.
   Important: avoid interpreting participants' work; let them decide what it means.

6. **Closing and wellbeing message**
   End with a short grounding exercise, a positive message, and optional simple practices participants can use at home.
   Plan followup sessions if interest continues.

Facilitation tips

- Emphasize process over product; there is no "good" or "bad" art.
- Make activities inclusive and adaptable to all ages and abilities.
- Provide grounding or breaks if emotions intensify.
- Use culturally meaningful materials or themes when possible.
- Protect confidentiality and avoid probing personal trauma.
- Work on developing exhibitions for the community when the art work is done.

Challenges and mitigation

Challenge	Mitigation
Insecurity about artistic ability	Use abstract tasks; normalize expression
Emotional activation	Offer grounding; keep support available
Limited materials	Use low-cost or nature-based supplies
Cultural hesitation	Integrate familiar creative traditions

Feedback mechanisms

- Short pre/post check ins (visual, verbal, or gesture-based).
- Facilitator observation notes.
- Brief voluntary reflections or feedback forms.

Documentation

- Record date, location, and number of participants (no identifying details).
- Note main themes and group dynamics observed during the activity.
- Document any adaptations made (cultural, accessibility, materials).
- Record safeguarding concerns or referrals if they arise (nonidentifying).
- Photos of exhibitions, shows or copies of newsletter.

Case study

The Azerbaijan Red Crescent Society, with support from the ICRC, implemented The Book About Me as a focused psychosocial support activity for children living in conflict affected districts. The tool, originally developed within the Swedish Red Cross "Birds in Flight" programme, was adapted into Azerbaijani and used to reduce psychological distress among children exposed to armed conflict. AzRCS volunteers received training from ICRC MHPSS teams, enabling them to deliver structured sessions based on the workbook's themes, including identity, family connections, friendships, emotions, memories, and future hopes. Through guided drawing and reflection activities, children were supported to express feelings safely, strengthen self-esteems, and enhance emotional regulation. The programme reached 334 children across 14 school communities, creating safe, supportive spaces where children could process experiences and rebuild a sense of continuity. The Book About Me became a key component of AzRCS's child focused MHPSS approach.

The Book About Me is an illustrated workbook used in child friendly psychosocial support. It is designed to help children:

- express emotions through drawing and creative exercises
- reduce psychological distress
- process experiences linked to war, torture, or forced migration

It includes a dedicated manual explaining how practitioners should use it, and it is explicitly aligned with the ICRC's approach to MHPSS in armed conflict settings.

Photo: Palestinian Red Crescent

3.2 BUILDING SOCIAL CONNECTIONS AND SAFE SPACES

Building social connections and creating safe spaces are central pillars of CB MHPSS. Across emergencies, people rely on trusted relationships, shared routines, and supportive environments to regain a sense of stability, belonging, and hope. This section brings together activities that help strengthen these protective community structures—through social support networks, peer groups, intergenerational initiatives, and creative or expressive practices that foster connection and emotional safety.

These approaches build on long-standing practice within the RCRC Movement and are rooted in core guidance such as the CB MHPSS resources on the MHPSS Hub[14], and global frameworks from IOM[15], UNICEF[16], and other partners promoting safe, inclusive, and participatory psychosocial environments. They recognize that social connectedness is not only a wellbeing factor but also a critical form of protection during disasters, conflict, and displacement. When communities have access to safe spaces, individuals can share experiences, rebuild supportive networks, and engage in coping practices that are culturally meaningful and accessible.

The activities in this section are designed to help communities reduce isolation, strengthen bonds across different groups, and restore collective resilience in ways that respect local culture, social norms, and existing support systems. They can be adapted to diverse settings, from informal neighbourhood gatherings to structured community centres, youth clubs, women's groups, or faith-based spaces—wherever people naturally come together and feel a sense of safety.

This section includes four key activity areas:

1. Social support networks
2. Support groups for specific vulnerable populations
3. Intergenerational dialogue and support
4. Social cohesion initiatives

14 For examples see a range of CB MHPSS publication here: Community-based MHPSS resources - MHPSS Hub.

15 International Organization for Migration. (2022). *Manual on community-based mental health and psychosocial support in emergencies and displacement (2nd ed.)*. Accessed here: https://www.iom.int/sites/g/files/tmzbdl486/files/mhpss/Manual-CB-MHPSS-2022-2ndEd_0.pdf

16 United Nations Children's Fund. *Operational guidelines on community based mental health and psychosocial support in humanitarian settings: Three-tiered support for children and families (field test version)*. New York, UNICEF, 2018. Accessed here: https://www.unicef.org/media/52171/file/Mental%20health%20and%20psychosocial%20support%20guidelines%202019%20.pdf

Social support networks

Overview

Social support networks are informal or semi-structured groups that strengthen relationships, reduce isolation, and encourage mutual support among community members. These networks mobilize existing social structures such as families, neighbors, peers, faith groups, and local committees, to create safe spaces for connection, shared problem-solving, and wellbeing. When facilitated ethically and with cultural sensitivity, social support networks promote trust, resilience, and collective coping.

Objectives

- Strengthen social connections and mutual support within the community.
- Reduce isolation and increase a sense of belonging, inclusion, and safety.
- Encourage positive social behaviours and supportive communication.
- Mobilize existing community resources and informal influencers.
- Build community-led continuity beyond facilitated sessions.

Target Group(s)

- Adults, caregivers, youth, older persons, people experiencing isolation, informal influencers.
- Groups may be mixed or separated by gender/age depending on safety, comfort, and cultural norms.
- People living with chronic stress, displacement, or social marginalization may particularly benefit.

Preparation

- Resources: simple space, flipchart, prompts, refreshments
- Personnel: 1–2 facilitators with community engagement skills
- Partnerships: leaders, women/youth groups, committees, faith networks
- Context review: map informal networks and isolated individuals

Implementation guidance

1. **Identify existing networks and natural groups**
   Engage local leaders and volunteers to map natural groupings (e.g., neighbours who gather informally, mothers' groups, men's evening gatherings).
2. **Identify and invite participants through trusted messengers**
   Use community volunteers, faith leaders, or women's group representatives to identify potential participants and deliver invitations. Clarify that participation is voluntary and not tied to assistance.
3. **First meeting: shared goals and group agreements**
   Introduce the purpose of the network and invite participants to set expectations (e.g., respect, confidentiality, inclusivity, non-judgment).
4. **Guided discussions on daily stressors, coping, and strengths**
   Use open-ended prompts or short stories to explore shared experiences. Avoid probing personal trauma; focus on common challenges and collective strengths.
5. **Peer connection activities and rotating roles**
   Encourage members to take turns facilitating small tasks (time checks, opening reflections, bringing a story). This reduces power imbalances and increases ownership.

6. **Light wellbeing skills**
   Introduce simple techniques such as grounding, mindful breathing, supportive listening, or communityspecific coping practices.
7. **Closing and next steps**
   Summarise takeaways. Agree on the next meeting time and small tasks. Encourage participants to connect between sessions.

Facilitation Tips

- Keep the format informal and participant-led; avoid turning it into a lecture. Encourage quieter voices and ensure no one dominates.
- Use storytelling and culturally meaningful examples.
- Support exchange rather than giving advice or "fixing" problems.
- Protect emotional and physical safety; maintain confidentiality.
- Be attentive to signs of distress and provide private followup or referral if needed.

Challenges & Mitigation

Challenge	Mitigation
Low participation	Adjust timing; cohost with local leaders; begin with a small core group
Power imbalances	Use rotating roles; hold discussions in small groups to distribute voice
Stigma/mistrust	Begin with neutral topics; build rapport before discussing stress or coping
Sustainability	Identify focal people to further train; establish lowresource routines; transition facilitation to community

Feedback mechanisms

- Short verbal checkins at the start/end
- Facilitator observation notes
- Informal feedback from participants and community representatives
- Simple followup after several weeks to check continuity

Documentation

- Record: date, location, number of participants (gender/age disaggregated if appropriate)
- Note key themes or strengths identified (non-identifying)
- Note any safeguarding concerns or referrals (without personal details)
- Document adaptations for cultural norms, accessibility, or group dynamics
- Avoid collecting sensitive personal data

Case study

The *Broken Links* training programme enhances social connectedness by equipping RCRC staff and volunteers to support people separated from family members during crises. Separation creates profound uncertainty, grief, and social isolation, disrupting family roles, and weakening community ties. The training helps volunteers understand these psychosocial impacts, including ambiguous loss and the emotional strain caused by not knowing a loved one's fate.

Through role play, group discussion, and basic helping skills practice, participants learn to foster connection by listening actively, validating feelings, and creating safe spaces for families to share their stories. This interpersonal support helps restore trust, reduce stigma, and rebuild relationships within families and communities.

The programme also highlights community and family support as essential layers of psychosocial care, emphasizing peer support, collective coping, and rituals that strengthen social bonds.
By empowering volunteers to facilitate compassionate, culturally attuned interaction, *Broken Links* contributes directly to restoring social connectedness among people affected by separation.

Photo: Japanese Red Cross Society/Atsushi Shibuya

Support groups for specific vulnerable populations

Overview

Support groups are small, facilitated gatherings designed for individuals who share similar vulnerabilities, life challenges, or distressing experiences. These groups provide a structured yet flexible environment where participants can build supportive relationships, express emotions safely, practice coping skills, and reinforce positive social norms. By focusing on shared lived/living experiences, the groups reduce stigma, enhance resilience, and strengthen participants' ability to navigate daily stressors.

Objectives

- Encourage empathy, active listening, cooperation, and mutual respect.
- Provide a safe, confidential space for emotional expression and shared understanding.
- Strengthen emotional regulation, communication, and interpersonal skills.
- Build peer networks, foster healthy social norms, and reduce harmful behaviours.
- Promote coping strategies that are culturally relevant, safe, and sustainable.

Target group(s)

- Caregivers, older adults, youth, displaced persons.
- Survivors of violence, people experiencing loss or grief (with careful protection considerations).
- Families experiencing separation or caregiving strain.

Groups may be mixed or separated by gender/age depending on safety and cultural norms. All participation must be voluntary.

Preparation

- Resources: private space, circle seating, visuals, exercise materials
- Personnel: facilitators with psychosocial support and group dynamics skills. Trusted by the community.
- Partnerships: leaders, service providers, associations, which will help in establishing referrals
- Context review: vulnerabilities, cultural norms, safety risks

Implementation guidance

1. **Form voluntary groups based on shared needs**
   Work with community representatives to identify participants who may benefit. Participation must be voluntary and free of coercion or expectation.
2. **Open with purpose, goals, confidentiality, and agreements**
   Explain why the group is meeting and establish shared agreements (respect, privacy, voluntary sharing, no judgement).
3. **Checkin round**
   Invite participants to share how they are feeling and what they hope to gain. Use simple prompts or emotion cards if helpful.
4. **Guided discussion on shared themes**
   Facilitate a conversation on topics relevant to the group—such as caregiving pressures, displacementrelated stress, grief, family separation, or daily coping. Avoid probing personal trauma.

5. **Skills practice**
   Introduce grounding exercises, emotional regulation tools, supportive communication, or cooperative problemsolving activities. Keep techniques simple and culturally familiar.
6. **Peer exchange of strategies**
   Encourage participants to share how they cope with challenges and support each other. Emphasize that different strategies work for different people.
7. **Closing and next steps**
   End with a reflection round, summarizing key insights. Confirm the next meeting plan and offer individual follow-up or referral where needed.

Facilitation tips

- Use inclusive, respectful, nonjudgmental language.
- Ensure equal participation and prevent dominance by any individual.
- Allow breaks and adapt pacing to cultural norms, literacy, and energy levels.
- Emphasize strengths, resilience, and collective problem solving.
- Maintain confidentiality and avoid personal data collection.
- Monitor group dynamics and emotional safety throughout the session.

Challenges and mitigation

Challenge	Mitigation
Dominant voices	Small groups or turn-taking techniques
Emotional overwhelm	Grounding and one-to-one follow-up
Reluctance/stigma	Trusted facilitators and clear confidentiality
Fatigue/low engagement	Rotate activities; adjust length

Feedback mechanisms

- Short verbal checkin/checkout scales
- Observation notes on engagement and group dynamics
- Participant reflections or brief feedback questions
- Followup with focal points to assess continuity

Documentation

- Record: date, location, number of participants (gender/age disaggregated if appropriate)
- Note key themes or strengths identified (non-identifying)
- Note any safeguarding concerns or referrals (without personal details)
- Document adaptations for cultural norms, accessibility, or group dynamics
- Avoid collecting sensitive personal data

Case studies

Papua New Guinea Red Cross Society: Small safe discussion sessions for women, girls, affected families amid tribal fighting; outreach and drama-based awareness to address SV/GBV.

During ongoing tribal fighting in Papua New Guinea, the **Papua New Guinea Red Cross Society** worked with the ICRC to support communities experiencing displacement, separation, and increased sexual and gender-based violence. Within this response, the programme intentionally engaged **different generations**—youth, adults, and elders—to strengthen community resilience, improve dialogue, and address the silence surrounding sexual violence.

To strengthen community resilience, the initiative trains local facilitators to provide basic psychosocial support and engage vulnerable groups—particularly women, girls, and affected families—through small, safe discussion sessions. These group-based activities function as support groups, offering protected spaces for sharing experiences, learning coping strategies, and reducing isolation.

Community outreach, workshops, and drama-based awareness sessions further address harmful norms and silence around sexual violence, fostering safer behavioural norms and strengthening collective support for vulnerable survivors.

Breaking the silence on sexual and gender-based violence in the Pacific | ICRC

Photo: Ghana Red Cross Society/ Conor Ashleigh

Intergenerational dialogue and support

Overview

Intergenerational dialogue and support activities bring together different age groups to foster trust, mutual understanding, and collective resilience. These interactions help reduce isolation, restore meaningful social roles, and strengthen the social fabric within families and communities. Through structured conversations, shared tasks, and culturally rooted exchanges, participants rediscover the value of learning from one another and contributing to each other's wellbeing.

Objectives

- Strengthen meaningful and respectful interactions across generations.
- Promote empathy, mutual understanding, and collaborative problem solving.
- Reduce social isolation and reinforce belonging, contribution, and dignity.
- Restore positive intergenerational roles within families and communities.

Target group(s)

- Children, adolescents, adults, and older adults.
- Families, caregivers, teachers, youth groups, and elder councils.
- Community influencers or individuals experiencing loneliness or generational disconnect.
- Groups may be mixed or separated initially if needed for comfort and safety.

Resources

- A shared, accessible space with inclusive seating (chairs, floor mats).
- Conversation prompts, story cards, objects of cultural significance.
- Flipcharts or visual aids for capturing ideas.

Personnel

- Facilitators skilled in age inclusive engagement, safe communication, and MHPSS principles.
- A co-facilitator is recommended for support and observation.

Partnerships

- Community leaders, youth groups, elders' councils, family associations, teachers, and faith networks.
- Collaborate to identify appropriate participants and culturally respectful approaches.

Context Review

- Explore local generational dynamics, values, expectations, and communication styles.
- Identify barriers to intergenerational interaction (e.g., stigma, cultural norms, conflict).
- Understand safety risks and ensure accessible referral pathways.

Implementation guidance

1. **Recruit voluntary, diverse participants across age groups**
   Seek balanced representation across ages, genders, and social roles, ensuring everyone participates voluntarily and feels safe.
2. **Opening and group agreements**
   Explain the purpose of the dialogue. Co-create agreements on respectful listening, turntaking, confidentiality, and voluntary participation.

3. **Structured conversations**
   Invite each age group to share experiences, values, challenges, and coping strategies through guided prompts or storytelling. Examples:
   "What helped you during difficult times?"
   "What do you appreciate about other generations?"
4. **Mixed-age collaborative tasks**
   Use simple cooperative activities—shared problem solving, team challenges, cultural games, or creative tasks—to build trust and reduce power imbalances.
5. **Reflection and connection-building**
   Invite participants to reflect on what they learned and how they might use these insights at home or in their community. Highlight new connections formed.
6. **Periodic followups**
   Schedule occasional follow-up gatherings or community events to reinforce bonds and sustain emerging support networks.

Facilitation tips

- Ensure balanced participation so no age group dominates; encourage quieter voices.
- Adapt pacing and communication to accommodate different energy levels, abilities, and literacy.
- Use culturally meaningful metaphors, stories, or rituals.
- Maintain emotional safety and allow participants to step back if a topic feels sensitive.
- Avoid placing pressure on participants to disclose personal hardships.

Challenges and mitigation

Challenge	Mitigation
Age-based power imbalances	Small groups, shared roles, neutral facilitation
Communication barriers	Simple language, visuals, storytelling
Low engagement	Interactive, culturally familiar activities
Sensitive topics	Offer alternatives and breaks

Feedback mechanisms

- Short pre/post checkins (verbal or visual).
- Facilitator observation notes.
- Brief participant reflections or group feedback.
- Informal followup discussions with community representatives.

Documentation

- Record date, location, and number of participants (disaggregate by gender/age only if appropriate).
- Capture strengths and successes shared by National Societies (nonidentifying).
- Note support needs and requests expressed by participants.
- Record any safeguarding concerns or referrals (without personal details).
- Note adaptations made during the session (cultural, accessibility, group dynamics).
- Do not collect sensitive personal data or attribute comments to individuals or specific NSs.

Case Studies

Bolivian Red Cross: CB MHPSS, older adults and community engagmeent.

In several Bolivian communities, older adults face persistent social isolation, chronic health issues, and limited opportunities for meaningful participation. These challenges negatively affect their emotional and social wellbeing, making them a priority group for CB MHPSS. A lack of accessible community level psychosocial services was identified through community assessments, volunteer observations, and feedback from local leaders and older adults themselves.

To address this gap, the Bolivian Red Cross introduced community spaces for emotional expression through dialogue circles and active listening sessions. Facilitated by trained volunteers, the sessions take place in person and last approximately two hours. They offer a safe environment where older adults can share experiences, strengthen emotional expression skills, and support one another. Follow-up actions include community accompaniment and referrals for participants requiring additional support.

The initiative led to improved communication, increased social participation, and stronger peer support networks. Initial low attendance—linked to unfamiliarity with group psychosocial activities—was overcome by adapting methods to local culture and using simple, relatable activities. The trust placed in Red Cross volunteers and the support of community leaders were key facilitators. The experience highlights the importance of culturally grounded, participatory approaches in CB MHPSS for older adults.

Paraguayan Red Cross: Community-based MHPSS Microprojects for Healthy Ageing

Paraguay is experiencing a rapid demographic shift, with people over 60 soon outnumbering those under 15. This creates both challenges and opportunities to strengthen health and social protection systems, particularly in mental health. Historically, care has focused on institutionalization and medication, but there is growing recognition of the need for more inclusive, community-based approaches, especially in addressing depression, anxiety, and gender-based violence among older adults.

In response, the Paraguayan Red Cross developed Community Microprojects focused on Healthy Ageing. These provide small grants to local branches to design activities tailored to the needs of older adults. The approach emphasizes four key areas: promoting autonomy, encouraging self-care in daily routines, strengthening individual and collective identity, and valuing the contribution of older people to their communities.

Currently, five branches are implementing these projects, starting with community assessments to identify priorities. Activities include group discussions, physical movement, and awareness on topics such as fall prevention, helping participants recognize their daily routines as part of healthy living.

These initiatives also address key psychosocial challenges, particularly isolation and feelings of abandonment. By creating spaces for connection and participation, they foster community cohesion and wellbeing, while gradually shifting perceptions around ageing and mental health.

Social cohesion initiatives

Overview

Social cohesion activities strengthen trust, cooperation, and positive relationships between individuals and groups within a community. They help rebuild a sense of safety, connection, and collective identity and that especially in contexts affected by crisis, displacement, or social tension. Through shared experiences, dialogue, and collaborative tasks, communities can reinforce mutual support and reduce isolation or conflict.

Objectives

- Strengthen trust and positive relationships among community members.
- Promote cooperation, shared identity, and collective resilience.
- Reduce isolation, misunderstanding, or tension between groups.
- Encourage inclusive participation and supportive social norms.

Target group(s)

- Mixed community groups (youth, adults).
- Families, neighbour groups, committees, displaced and host communities.
- Groups that may experience tension, separation, or limited interaction.

Resources

- Open space for group activities.
- Materials for games, collaborative tasks, visual prompts.
- Flipcharts or boards for collective ideas.

Personnel

- 1–2 facilitators with skills in group dynamics, PSS, and conflict-sensitive facilitation.

Partnerships

- Community leaders, youth groups, elders, women's groups, host/displacement networks.

Context review

- Understand local sources of tension, trust, diversity, and cohesion.
- Identify safe spaces and moments for mixed-group gathering.
- Carefully choose where the activities to be done with consensual agreement.

Implementation guidance

1. **Outreach and group composition**
   Invite voluntary participants from diverse backgrounds (gender, age, community role). Aim for safe, balanced representation.
2. **Opening and ground rules**
   Explain the purpose of building connection and cooperation.
   Co-create agreements: respect, listening, inclusiveness, confidentiality.
3. **Warmup: Human connection activity**
   Use simple, culturally appropriate energizers that build comfort:
   - shared movement, rhythm, or music
   - paired introductions
   - values or strengths games

4. **Shared storytelling or dialogue**
   Facilitate a structured conversation around common experiences, challenges, or hopes for the community.
   Use non-sensitive prompts that highlight common ground.
5. **Collaborative tasks**
   Offer group activities that require cooperation:
   - building or arranging something together
   - solving a group challenge
   - creating a shared mural or map of community strengths

   These help break down boundaries and reinforce supportive norms.
6. **Reflection circle**
   Invite each person to share something they learned about another age/group/community member.
7. **Closing and next steps**
   End with a positive message on unity and resilience.
   Identify simple followup activities that groups can continue without facilitation.

Facilitation tips

- Keep activities inclusive and accessible for all ages and abilities.
- Encourage quieter voices; prevent dominance by individuals or subgroups.
- Be attentive to emotional or cultural sensitivities.
- Focus on common strengths, goals, and values.
- Avoid forcing disclosure or raising sensitive conflict issues.

Challenges and mitigation

Challenge	Mitigation
Preexisting tension	Start with neutral tasks; build trust gradually over days or weeks
Group dominance or exclusion	Use small groups and rotating roles
Low engagement	Use familiar cultural games and activities
Emotional triggers	Use familiar cultural games and activities

Feedback mechanisms

- Short verbal checkin/checkout.
- Facilitator observations.
- Participant reflections or feedback.
- Followup check to see if group initiatives continue.

Documentation

- Record date, location, and number of participants (no identifying information).
- Note key themes, interactions, and cooperation patterns observed within mixed groups.
- Document adaptations made for cultural norms, accessibility, or group composition.
- Record any safeguarding concerns or referrals (non-identifying only).

Case Studies

Syrian Arab Red Crescent: Strengthening Community Protection, Returnee Reintegration, and Social Cohesion

In 2026, the SARC Community Services and Protection Department implemented an integrated protection and psychosocial support model in a community experiencing a steady influx of returnees. Many families had returned to damaged infrastructure, limited services, and weak social networks, creating heightened protection risks and tension with long-term residents.

SARC established a Community Center that delivered an integrated package of interventions, starting with awareness sessions on protection, mental wellbeing, and available referral pathways. Over several months, more than 1,500 community members participated in life-skills and resilience sessions, while caregivers joined structured psychosocial support groups aimed at strengthening positive coping.

A tailored case-management system supported individuals with heightened protection needs, enabling timely referrals for legal, health, and specialized services. Children engaged in structured recreational and creative activities, fostering emotional regulation and a sense of safety. Persons with disabilities were actively integrated into all activities, ensuring inclusive participation.

Parallel to service delivery, SARC facilitated community-led initiatives focused on improving communal spaces, reducing local tensions, and promoting peaceful dialogue. Local volunteers received ongoing training and peer-support sessions to enhance wellbeing and service quality.

By the end of the cycle, the community demonstrated increased cohesion, improved psychosocial well-being, and stronger local mechanisms for identifying and responding to risks, contributing to long term resilience.

3.3 RAPID CB MHPSS ACTIVITIES

This section focuses on activities that provide timely, flexible, and easily accessible psychosocial support in times of crisis. It highlights community-based mechanisms such as volunteer crisis response teams and helplines, which can offer immediate emotional support, facilitate referrals, and ensure that assistance is available to those who may not access traditional services.

This section includes two key activity areas:

1. Community-based Crisis Response Teams
2. Community-based Crisis Helplines / Hotlines

Photo: ICRC

Community-based crisis response teams

Overview

Community-based Crisis Response Teams (CB CRT) are trained community members who provide immediate practical and psychosocial support during and after emergencies. Their presence helps reduce acute distress, promote safety, stabilize emotional reactions, and ensure individuals are referred to appropriate services. Because they are trusted local actors, they can respond rapidly, navigate cultural norms, and strengthen the community's collective capacity to cope with crises.

Objectives

- Reduce distress during and after emergencies
- Increase safety and stabilization through PFA and basic psychosocial support
- Identify individuals showing escalating distress or MNS symptoms
- Refer at-risk individuals to health, protection, or specialized MHPSS services
- Strengthen community capacity for crisis response

Implementation guidance

1. **Activation of teams**
   Activate CB CRT members following:
   - emergency alerts,
   - community requests, or
   - rapid information from volunteers or local leaders.

   Ensure team members understand the safety situation before deployment.

2. **Rapid safety and needs scanning**
   Upon arrival, assess:
   - immediate dangers (e.g., injured people, unsafe structures, ongoing threats),
   - urgent practical needs (water, shelter, transport),
   - individuals showing visible distress or confusion.

   Coordinate with local authorities or emergency responders where relevant.

3. **Provide Psychological First Aid (PFA)**
   Using a calm, approachable manner, provide:
   - listening without pressing for details,
   - reassurance and orientation,
   - practical problemsolving,
   - connection to family or community support.

Prioritize respect, dignity, and voluntary engagement.

4. **Emotional stabilization**
   Offer simple grounding or calming techniques such as:
   - slow breathing,
   - orientation to surroundings,
   - sensory grounding (touch, temperature)

   Avoid therapeutic techniques—keep it simple and safe.

5. **Identify protection risks and MHPSS red flags**
   Observe for:
   - disorientation, inability to care for oneself, extreme withdrawal, agitation, suicidal statements, or psychosis symptoms.
   - protection concerns such as unaccompanied minors, injured individuals without support, GBV risks, or exploitation.

   Document observations non-identifiably and follow established referral pathways.

6. **Facilitate referral using updated pathways**
   Connect at-risk individuals to:
   - health services,
   - protection actors,
   - safe shelters,
   - specialized MHPSS or social support where available.

   Explain clearly what the referral involves and ensure informed consent where possible.

7. **Share accurate wellbeing messages**
   Provide simple, culturally relevant messages on:
   - coping with stress,
   - available services,
   - how to support children or older persons,
   - myths and facts related to the crisis.

   Help reduce misinformation and fear.

Challenges and mitigation

Challenge	Mitigation
High panic or chaotic environments	Use clear, simple instructions; work in pairs; create visible support points.
Limited specialized services	Keep updated referral maps; coordinate with mobile teams and telesupport where available.
Stigma around mental health	Normalize stress reactions; avoid labels; use non-clinical language.
Responder burnout	Rotate teams, ensure rest periods, and hold short internal support or debrief meetings.

Feedback mechanisms

- Short MHPSS activity report or PFA action log.
- Referral tracking sheets (non-identifying).
- End-of-shift team reflection notes.
- Quick verbal or written feedback from community representatives.

Documentation

- Record date, location, emergency type, and number of people supported (non-identifying).
- Note main actions taken (PFA, grounding, referrals, safety scanning).
- Document any referrals or protection/MNS red flags (no names).

- Capture team observations, including challenges, adaptations, and safeguarding concerns (non-identifying).

Case Studies

Armenia Red Cross: Protection & Assistance of Unaccompanied and Separated Children

The Armenia Red Cross Society (ARCS), working with UNHCR, UNICEF, and state authorities, supports unaccompanied and separated children (UASC) affected by displacement, asylum processes, and family separation. These children face heightened risks including violence, exploitation, lack of documentation, disrupted education, disabilities, and severe distress. Many are asylum seekers, refugees, internally displaced or stateless, and considered among the most vulnerable.

The ARCS operates a structured child protection case management system aligned with the essential functions of Community-based Crisis Response Teams (CB CRT). This includes immediate identification of at risk children, rapid assessment through Best Interest Assessments and Determinations, psychosocial stabilization, and referral to health, education, and protection services. Continuous monitoring and urgent case coordination ensure timely intervention for escalating needs.

Since 2017, ARCS has supported thousands of children through this system. Children receiving individual case management include those separated from families, unaccompanied, survivors of violence, or lacking parental care. CB MHPSS activities have supported thousands more children, adolescents, and caregivers. Referrals ensure access to health, legal, education, and social support services, while unaccompanied and separated children receive priority protection.

Finnish Red Cross

Following Easter holidays in 2024 a 12-year-old student attacked an elementary school in Vantaa, Finland, killing one and seriously wounding two classmates, and directly exposing two classes and their teachers for lethal violence. Finnish Red Cross' Psychologists' Emergency Team was called to organize immediate psychosocial support in coordination with other actors. The multi-level approach consisted of professional-facilitated peer groups for parents and children separately based on childrens' level of exposure, working with families of the most affected (crucially, including the family of the shooter), work with principals, teachers, and staff, and impacted communities. Based on previous work with school shootings in Finland in older youth, main aims were to provide immediate psychological support, reintroduce safety, enable communal resilience, and assess need for continued professional support.

The Psychologists' Emergency Team is a group of professionals called to action by the Vantaa and Kerava region Social and Crisis Emergency Services in large-scale emergency situations to organize acute-phase care. This was the first school shooting to occur in an elementary school setting, and required adaptation of previous best practices to consider the developmental needs of the children affected. Active collaboration with the school district and other actors allowed for an adaptive response, adjusting for how the impact reverberated through the system of parents, staff, families, and children, as well as the larger (for example, minority communities).

Community-based crisis helplines

Overview

Community-based Crisis Helplines offer **immediate, confidential, and accessible emotional support** to people experiencing acute distress, confusion, fear, or symptoms related to MHPSS conditions. Operated by trained responders from the community or National Society staff/volunteers, helplines provide a compassionate listening ear, reduce panic, stabilize emotions, offer accurate information, and connect callers to appropriate services. They play a crucial role in emergencies and protracted crises where face-to-face support may be limited or unsafe.

Objectives

- Reduce acute psychological distress through immediate listening and support
- Provide clear, accurate information to reduce panic and confusion
- Identify individuals at risk of harm (self or others) and activate referral pathways
- Offer MNS sensitive support for escalating symptoms
- Strengthen community access to timely crisis assistance

Implementation guidance[17]

1. **Establish helpline infrastructure**
   Set up the necessary systems:
   - dedicated phone lines (tollfree if possible)
   - staffing schedules and rotation systems.

   Standard Operating Procedures (SOPs) for call handling, risk protocols, and referrals clear communication channels with supervisors and emergency responders. Ensure accessibility for people with low literacy, disability, or language barriers.

2. **Train responders**
   Provide training in:
   - PFA adapted for phone support
   - crisis communication skills (calm tone, clear messages, active listening)
   - recognizing MNS red flags (confusion, agitation, suicidal ideation, psychosis-like symptoms)
   - ethical communication, confidentiality, and caller safety
   - call documentation and referral procedures.

   Include role-plays and practice scenarios.

3. **Respond to calls with calm, supportive communication**
   Responders should:
   - introduce themselves and explain confidentiality limits
   - listen without judgement or pressure
   - validate feelings and normalize stress reactions
   - use simple, accessible language
   - avoid giving medical or legal advice beyond their mandate

4. **Stabilize emotions**
   Use grounding and de-escalation techniques:
   - slow breathing

17 See also, Supportive Voices - MHPSS Hub

- orientation to time, place, and safety
- focusing on sensory cues ("Can you notice three things you can hear right now?")
- providing simple, reassuring statements

Aim to bring the caller from high distress to a calmer, more manageable emotional state.

5. **Assess risks**

   Gently and respectfully explore:
   - safety concerns
   - suicidal intent or self-harm statements
   - threats of harm to others
   - severe agitation, disorientation, hallucinations, or unresponsiveness

   Follow emergency protocols when risk is high (e.g., contacting a trusted person, ambulance, or protection service when appropriate and with consent).

6. **Provide referrals**

   Connect callers to appropriate services such as:
   - health facilities
   - protection teams (child protection, GBV)
   - legal support
   - shelters or safespaces
   - social assistance or community volunteers
   - specialized MHPSS providers

Only share verified, accessible, up-to-date referral options. Ensure the caller understands what to expect.

7. **Record calls and follow urgent cases per protocol**

   Record basic, non-identifying information:
   - call date/time
   - general reason for the call
   - key actions taken (grounding, reassurance, information given)
   - referrals made
   - any safety actions

   Follow up with supervisors on highrisk cases.

Challenges & Mitigation

Challenge	Mitigation
High call volume	Use rotation, triage protocols, short stabilization scripts
Escalating MNS symptoms	Use calm grounding + immediate referral pathways
Misinformation and fear	Provide verified, simple messages; avoid speculation
Severe distress or suicidality	Activate emergency protocols and safe referrals

Feedback mechanisms

- Brief distress check-ins (start/end of call when appropriate).
- Helpline activity logs or call summaries.
- Referral tracking sheets (non-identifying).
- Supervisor review and end-of-shift team reflections.

Documentation

- Record date, time, call type, and general distress level (non-identifying).
- Note key actions (PFA provided, grounding, information, referrals).
- Document any risk concerns and actions taken (no names).
- Record adaptations or challenges (e.g., language barriers, high call volume).

Case Study

Palestinian Red Crescent Society Community Helpline as a Rapid, Accessible CB MHPSS Support

During the war on Gaza, entire communities were cut off from services due to continuous bombardment and blocked roads. With movement severely restricted, the Palestine Red Crescent Society (PRCS) helpline, the only helpline receiving calls for the PRCS for any request from people across the Palestinian Territories, became a vital humanitarian link for families with no other access to any support.

In 2024, small communities in northern Gaza found themselves completely isolated. Families sheltered in damaged buildings, unable to evacuate or reach medical care. When one caregiver called the PRCS helpline, the responder provided active listening and used Psychological First Aid (PFA) skills to help her regulate her breathing and calm a distressed child. Together, they created a simple safety plan, identifying the safest areas in the home and the steps to follow during bombardments. The responder offered deescalation guidance, practical coping strategies, and accurate information about the situation. The team also helped reconnect the family with relatives in another governorate and coordinated with health services to ensure followup once access improved.

The case of Hind Rajab was received through the helpline, where urgent support was requested amid active hostilities. The call was documented and referred through available humanitarian and coordination channels, highlighting the critical protection and access challenges faced by civilians.

For more information listen to the podcast: Moral Injury in the line of duty - MHPSS Hub

3.4 STRENGTHENING PEER AND LEADERSHIP CAPACITIES

This section focuses on empowering community actors and peers—volunteers, people with lived experience, youth representatives, teachers, faith leaders, and other trusted figures—to take an active role in promoting psychosocial wellbeing. In many settings, these individuals are the first source of comfort, guidance, and support when community members face stress or uncertainty. Building their capacities not only widens the reach of MHPSS interventions but also strengthens local ownership and long term resilience.

Through peer-to-peer networks, mentorship structures, and tailored training, practitioners can activate existing social support systems and help communities draw on their own strengths. Equipped with basic psychosocial skills, peers and community leaders are better able to recognize signs of distress, provide supportive communication, model healthy coping, and safely guide individuals toward additional services when needed. These approaches bridge the gap between formal MHPSS actors and everyday environments, ensuring support is accessible, culturally grounded, and trusted. The goal is to shift from externally driven support toward community-driven wellbeing, where individuals feel confident, connected, and capable of caring for one another.

This section includes two key activity areas:

1. Mentorship & peer-to-peer programmes
2. Psychosocial training for community leaders

Photo: Danish Red Cross/Anette Selmer-Andresen

Mentorship & peer-to-peer programmes

Overview

Mentorship and peer-to-peer programmes are designed to strengthen emotional resilience, coping capacity, and supportive behaviours among adolescents by teaching them age-appropriate PFA and peer-support skills. These programmes create safe spaces where youth learn to recognize stress, support each other, and practice positive help-seeking during emergencies, displacement, and crises. Adult mentors—such as trained volunteers, teachers, youth workers, or MHPSS staff—play a crucial safeguarding role. They monitor interactions, guide youth supporters, reinforce ethical boundaries, and ensure that peer-to-peer support remains safe, confidential, and appropriate.

Objectives

- Strengthen coping ability and emotional regulation among youth
- Equip adolescents with PFA and supportive communication skills
- Foster trusting peer networks that reduce isolation
- Develop youth leadership and safe help-seeking behaviours
- Ensure ethical and supervised peer support through adult mentorship

Implementation guidance

1. **Select and prepare diverse youth participants and mentors**
   - Identify youth aged 10–18 from different backgrounds, ensuring gender balance and inclusion of vulnerable groups.
   - Select trusted adult mentors with experience in youth engagement, MHPSS, or child protection.
   - Provide mentors with orientation on safeguarding, supervision skills, and programme protocols.
2. **Deliver structured PFAbased training**
   Use modules such as I Support My Friends, PFA for Young Peers, or adapted community-based curricula.
   Training includes:
   - Understanding stress and coping in crises
   - Basics of PFA (Look, Listen, Link)
   - Emotional regulation tools
   - Communication skills adapted for youth
   - Recognizing when someone needs more than peer support.
3. **Practice supportive communication through guided role plays**
   Facilitators simulate common youth stress scenarios (fear, conflict, grief, bullying, displacement).
   Participants practice:
   - Active listening
   - Validating feelings
   - Providing comfort
   - Identifying red flags
   - Encouraging safe behaviours.
4. **Pair youth with mentors for ongoing supervision and reflection**
   Each youth supporter is matched with a mentor who:
   - Provides weekly checkins
   - Monitors wellbeing and boundaries
   - Helps youth reflect on challenges
   - Ensures peer interactions remain safe and confidential.

5. **Youth provide basic peer support and identify signs of distress**
   Trained youth offer lowlevel support in schools, community centers, or informal settings.
   They learn to notice:
   - Withdrawal
   - Mood changes
   - Fear or anxiety
   - Tension in peer groups
   - Situations that require escalation.
6. **Guide peers toward appropriate adult or service referrals**
   Youth supporters are taught to refer when a situation is beyond their role, including:
   - Protection concerns
   - Severe emotional distress
   - Safety risks
   - Medical or psychological needs

   Referral pathways are pre-established and shared with youth in simple, accessible formats.
7. **Hold regular debrief and reflection sessions**
   Facilitators and mentors meet with youth supporters for group discussions covering:
   - Difficult situations
   - Emotional impact
   - Learning and skill-building
   - Adjustments needed for safety
   - Strengthening confidence

Challenges & Mitigation

Challenge	Mitigation
Youth overwhelmed by peers' distress	Reinforce boundaries; close mentoring and escalation protocols
Safeguarding risks	Clear child protection procedures and monitored communication
Unequal peer dynamics	Rotate groups; encourage inclusive facilitation
Low youth confidence	Practice scenarios, coaching, positive reinforcement

Feedback mechanisms

- Emoji Mood Boards: A quick visual check-in tool where youth select emojis to reflect their feelings before and after activities, helping track emotional regulation and coping.
- Confidence Thermometer: A simple rating scale that lets youth indicate how confident they feel in providing peer support at different points in a programme.
- Peer Network Mapping: A participatory activity that visually maps supportive interactions among youth to show how peer networks strengthen over time.

Documentation

- Collect only what is necessary and relevant, ensuring every piece of information directly supports the child's protection, wellbeing, or safe referrals.
- Ensure confidentiality and informed assent, making sure children (and caregivers, when appropriate) understand why information is being collected and how it will be used to support their safety.

Case Studies

Croatian Red Cross: Peer-to-Peer Support for Interpreters in the Ukraine Response

The Croatian Red Cross (CRC) established a peer-to-peer (P2P) support group to address the overlooked emotional strain faced by Ukrainian- and Russian speaking interpreters supporting people displaced from Ukraine. Interpreters—many of whom regularly mediate distressing stories and complex service needs—reported stress, unclear role expectations, and social isolation. Recognizing their essential but often invisible role in ensuring access to health, protection, and MHPSS services, CRC developed a hybrid support model combining structured in person sessions with continuous online engagement.

The group brought together professional and lay interpreters, including psychologists, teachers, doctors, and translators, some of whom were displaced themselves. Through co-designed sessions on emotional regulation, role boundaries, and practical interpretation challenges, participants gained tools for managing stress and navigating demanding field contexts. A dedicated WhatsApp group provided real time peer support, translation tips, and space for emotional check ins between meetings.

This interpreterled model strengthened resilience, improved role clarity, and fostered a community of mutual support. Participants reported reduced emotional burden, increased confidence in their work, and a stronger sense of belonging. CRC expanded the P2P model beyond youth groups to reach individuals who share comparable levels and experiences of psychosocial distress.

Philippines Red Cross: Youth-led MHPSS

The Philippine Red Cross (PRC) has long recognized that in times of disasters and emergencies, people need more than food, water, shelter, and medical aid. They also need care and a safe space to recover from stress and trauma. This is why Mental Health and Psychosocial Support, or MHPSS, has been integrated into PRC's emergency and community programs.

Through Red Cross Youth (RCY), PRC has built a strong network of young volunteers who act as responders, peer supporters, and community leaders. Rather than treating young people solely as beneficiaries, RCY empowers them to take active roles in supporting each other, strengthening ownership and sustainability in MHPSS interventions.

This was seen during PRC's response to the Cebu Earthquake and Typhoons Tino and Uwan, where RCY volunteers helped establish Child-Friendly Spaces in evacuation centers. These spaces transformed available areas into safe and comforting environments where children could play, learn, express their emotions, and slowly regain a sense of normalcy.

RCY members also provided Psychological First Aid (PFA) through one-on-one and group interactions, offering reassurance and helping normalize distress reactions. Because many of the volunteers were young themselves, children found it easier to open up and feel understood.

Beyond child-focused activities, RCY volunteers also helped conduct mental health awareness sessions, taught simple coping strategies, and organized family and community activities that strengthened social connection and mutual support.

By empowering RCY volunteers to take part in MHPSS, the Philippine Red Cross shows that young people are not only the future of humanitarian work. They are already active humanitarian leaders today—bringing comfort and care to communities when they need it most.

Photo: The Red Cross Red Crescent Movement MHPSS Hub/Jesper Guhle

Psychosocial training for Community Leaders

Overview

Psychosocial training for community leaders builds the capacity of trusted local figures to communicate clearly and guide communities through stress and disruption during emergencies. Leaders often serve as the first point of contact after disasters, and their ability to listen, orient, and support others directly influences community functioning. Training equips them with basic psychosocial skills, including PFA, supportive communication, stress-management techniques, and identification and referral pathways. It also strengthens leaders' ability to help communities rebuild daily routines, resolve conflict, mobilize resources, and foster safety and inclusion—key contributors to restoring functioning in crisis settings.

Objectives

- Strengthen leaders' capacity to support their communities during and after crises.
- Improve communication, listening, and problem-solving skills in high-stress environments.
- Build leaders' ability to identify distress, provide supportive guidance, and facilitate referrals.
- Support leaders in helping communities stabilize routines and re-establish functioning.
- Promote inclusive practices, ensuring diverse groups feel represented and supported.

Target Group(s)

- Community leaders, elders, local committee members
- Religious leaders, youth leaders, women's group leaders
- Local volunteers and focal points responsible for community coordination
- Informal leaders recognized for trust and influence in their communities

Preparation

- Resources: PFA materials, community toolkit exercises, local coping strategies, referral lists
- Personnel: Trainers familiar with MHPSS, local context, and adult learning
- Partnerships: Local authorities, NGOs, community-based groups
- Context Review: Identify stressors, community roles, cultural norms, existing support networks

Implementation guidance:

1. **Identify and engage leaders representing different community groups**
   Map and reach out to trusted figures representing different groups (e.g., women, youth, religious leaders, teachers, volunteers).
   Ensure diversity and inclusion in selection.
   Build trust through introductory meetings that explain the purpose, expectations, and benefits of their engagement.

2. **Deliver training sessions using interactive methods (dialogue, role-plays, scenarios)**
   Conduct training using practical, participatory methods such as group discussions, role-plays, and real-life scenarios.
   Focus on creating a safe learning environment where participants can reflect, practice skills, and relate content to their community context.

3. **Introduce basic psychosocial skills: calm communication, grounding methods, active listening, empathy**
   Train participants on essential interpersonal skills including calm and non-judgmental communication, active listening, empathy, and simple grounding techniques.

Emphasize how these skills help reduce distress and improve supportive interactions in daily community life.

4. **Teach leaders to recognize distress, conflict triggers, and signs of risk**
   Support leaders to identify signs of emotional distress, escalating conflict, and potential protection risks.
   Provide simple guidance on when a situation requires additional support or referral, while clarifying their role and limits as community actors.
5. **Practice community messaging to reduce fear, promote safety, and counter misinformation**
   Guide leaders in communicating accurate, non-stigmatizing information about stress, mental health, and available support.
   Practice how to address misinformation, reduce fear, and promote protective behaviours in culturally appropriate ways.
6. **Strengthen problem-solving and coordination skills for navigating local challenges**
   Support participants to reflect on common community challenges and identify practical, locally appropriate solutions.
   Encourage coordination with other actors and promote teamwork, referral linkages, and shared responsibility in addressing needs.
7. **Guide leaders on referrals and how to connect community members with services**
   Train leaders on how to identify situations that require referral and how to safely connect individuals to available services.
   Emphasize confidentiality, informed consent, and clear communication of available options without overstepping their role.
8. **Support leaders in planning community-level coping and wellbeing strategies**
   Facilitate leaders in identifying and strengthening existing community coping mechanisms (e.g., social support, cultural practices, group activities).
   Encourage them to plan simple, inclusive initiatives that promote collective wellbeing and resilience.

Facilitation Tips

- Build on leaders' existing knowledge and social roles.
- Use culturally meaningful examples and language.
- Promote inclusive leadership—ensure women, youth, and marginalized voices are represented.
- Address leaders' own stress and coping to sustain their functioning.

Challenges & Mitigation

Challenge	Mitigation
Leaders overwhelmed by responsibility	Provide peer support groups and reflective sessions
Misinformation spreading in crises	Train leaders on clear communication and trusted messaging
Power imbalances excluding groups	Encourage shared leadership and diverse representation
Limited referral options	Map local resources; coordinate with partners to expand support

Feedback mechanisms

- Pre/post tests on knowledge of psychosocial impacts, stress reactions, grounding techniques, and trauma-informed practices.
- Skills demonstration through role-plays, peer assessments, or mentoring logs.

Documentation

- Training attendance sheets
- Competency check-lists
- Mentor feedback forms

Case studies

Australian Red Cross: Strengthening Community Leaders' Psychosocial Capacity

The Australian Red Cross (ARC) plays a leading role in preparing and supporting community leaders to guide their communities through crises. Their Psychosocial Support Community Toolkit provides structured resources that help leaders understand the psychosocial impacts of disasters, recognize common stress reactions, and learn evidence-based strategies to support recovery. The toolkit equips leaders to facilitate calm, constructive communication, promote social cohesion, and help individuals re-establish routines—core functions that strengthen community functioning during emergencies.

ARC emphasizes that effective community leadership begins with knowledge and confidence. Through community information sessions, leaders learn how crises affect wellbeing, how to support others without overwhelming themselves, and how to identify when someone requires additional help. They also practice simple grounding exercises and practical coping strategies that can be shared community-wide. By empowering leaders in this way, ARC ensures that support is localized, culturally aligned, and available immediately, even before formal services reach affected areas.

A key element of ARC's approach is the belief that leaders are multipliers of resilience. When leaders model calm behaviour, share accurate information, and encourage mutual support, entire communities recover more quickly. The toolkit supports leaders in organizing neighbourhood discussions, promoting safe social connections, and helping people identify their own strengths and coping mechanisms. This directly aligns with the goals of the Psychosocial Training for Community Leaders activity, demonstrating how trained leaders can significantly enhance community functioning, emotional stability, and recovery pathways.

Bulgarian Red Cross, Czech Red Cross, Polish Red Cross, Romanian Red Cross, Ukrainian Red Cross Society. Training Sport Coaches on basic psychosocial support

In partnership with the MHPSS Hub and the Olympic Refuge Foundation, as well as several National Olympic Committees and other actors, the five National Societies piloted and implemented throughout 2024 and 2025 the Sport Coach+ initiative across the Europe Region. The purpose of the project has been to support the mental health and psychosocial wellbeing of young people through sport, with a focus on young refugees and internally displaced people from Ukraine and their host communities, by providing **sport coaches** with the knowledge, skills and techniques to create safe and supportive sport environments and recognize and respond to cases in trauma informed ways. The participating National Societies staff were trained on the methodology and carried out trainings for sport coaches at community level, followed by the provision of mentoring and guidance to support the coaches in their work with young people. The programme reached over 1900 sport coaches across ten countries.

The Handbook and the Training Package are available on the Sport Coach+ website in more than 10 languages.

CHAPTER 4
MONITORING AND EVALUATING CB MHPSS ACTIVITIES

CB MHPSS activities are increasingly recognized as a core component of humanitarian response. As these activities expand across contexts, there is a growing need to ensure that they are not only implemented effectively, but also systematically monitored and evaluated to demonstrate quality, relevance, and impact. Monitoring and evaluation (M&E) in CB MHPSS serve a dual purpose: it supports accountability to affected populations and donors, while also strengthening the quality of programming through continuous learning and adaptation.

This chapter introduces an outcome and activity matrix for CB MHPSS, linking programme activities to related outcomes of connectedness, awareness, and access to support; as well as broader psychosocial outcomes such as functioning, subjective wellbeing, disabling distress or symptoms, coping, social behaviour, and social connectedness[18]. It presents key monitoring questions to track reach, participation, and perceived changes. It also highlights practical tools to guide data collection. This chapter is linked to existing resources such as the IFRC and IASC M&E frameworks for MHPSS[19] that include basic monitoring forms, structured observation tools, and activity/outcome matrices. Not all questions or tools need to be applied in full; their use should be adapted to the context, needs, and scope of implementation. They can also support the design, planning and implementation of activities, not only their monitoring.

Ultimately, effective M&E of CB MHPSS is not only about measurement, but about learning. It enables practitioners to understand what works, for whom, and under what conditions, thereby strengthening the overall impact, accountability, and sustainability of community-based psychosocial support interventions.

18 Inter-Agency Standing Committee. (n.d.). *IASC Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings*. Accessed here: https://interagencystandingcommittee.org/iasc-reference-group-mental-health-and-psychosocial-support-emergency-settings/iasc-common-monitoring-and-evaluation-framework-mental-health-and-psychosocial-support-emergency

19 IFRC PS Centre. (2017). IFRC Monitoring and evaluation framework for psychosocial support interventions. Accessed here: https://mhpsshub.org/resource/monitoring-and-evaluation-framework-guidance-note/

Outcome and activity matrix

Goal:

Improved mental health and psychosocial wellbeing, resilience and capacity to alleviate human suffering

Activity:	Awareness raising activities
Outcome:	Community members are connected, more aware of the MHPSS impacts of emergencies
Monitoring questions	How many people have participated in awareness raising activities? How many community events have been facilitated by your team? How many community events have the MHPSS team supported? What proportion of people involved in MHPSS activities reported that RCRC activities helped them to feel more supported or connected to others? What proportion of people involved in MHPSS activities reporting knowing where and how to access MHPSS supports? Were community MHPSS activities organized in collaboration with community members? Were representative community groups (e.g., women, youth, minority groups) included in planning and implementation? How satisfied were community members with their level of involvement?
Tools	Knowledge, attitude, practices surveys (KAPS) See Program Management and Training reporting tools in IFRC Monitoring and evaluation framework for psychosocial support interventions - Toolbox

Activity:	Psychoeducation sessions
Outcome:	Target population achieves and sustains personal and interpersonal wellbeing and capacity
Monitoring questions	Were identified key community members provided with psychoeducation relevant to their roles and context? How many individuals received psychoeducation, and what topics were covered? Did participants report increased knowledge or confidence in fulfilling their community role?
Tools	Knowledge, attitude, practices surveys (KAPS)

Activity:	Social support networks
Outcome:	Community members are connected, more aware of the MHPSS impacts of crisis and are better able to support one another
Monitoring questions	Have community members participated in trainings on social support and coping strategies? How many community groups received these trainings? Do participants report increased knowledge or confidence in applying these strategies within their families or community? Are community-appropriate materials on social support and coping available and distributed? Are the materials culturally and linguistically appropriate for different groups in the community? Do community members report using or benefiting from the materials?
Tools	Knowledge, attitude, practices surveys (KAPS) See Program Management and Training reporting tools in IFRC Monitoring and evaluation framework for psychosocial support interventions - Toolbox

Activity:	Support groups for specific vulnerable populations
Outcome:	Target population achieves and sustains personal and interpersonal well being and capacity
Monitoring questions	Are support groups for the identified vulnerable populations established, accessible, and regularly implemented? Do participants feel safe, respected, and included? Are groups facilitated in ways that promote sharing, connection, and coping? Do participants report improved emotional well being and coping ability? Do participants report improved interpersonal relationships or increased social support? Are improvements in coping and wellbeing sustained over time?
Tools	Knowledge, attitude, practices surveys (KAPS) Focus group discussions with sample of target group IFRC Monitoring & Evaluation Framework Toolbox Domains depending on focus: Functioning, Subjective wellbeing, Disabling distress/ symptoms, Coping, Social behaviour, Social connectedness IASC MHPSS M&E Framework (Version 2.0)

Activity:	Intergenerational dialogue and support
Outcome:	Target population achieves and sustains personal and interpersonal well being and capacity
Monitoring questions	Are support groups for the identified vulnerable populations established, accessible, and regularly implemented? Do participants feel safe, respected, and included? Are groups facilitated in ways that promote sharing, connection, and coping? Do participants report improved emotional well being and coping ability? Do participants report improved interpersonal relationships or increased social support? Are improvements in coping and wellbeing sustained over time?
Tools	Knowledge, attitude, practices surveys (KAPS) Focus group discussions with sample of target group IFRC Monitoring & Evaluation Framework Toolbox Domains depending on focus: Functioning, Subjective wellbeing, Disabling distress/ symptoms, Coping, Social behaviour, Social connectedness IASC MHPSS M&E Framework (Version 2.0)

Activity:	Social cohesion initiatives / Art therapy
Outcome:	Community members experience improved emotional well being, reduced stress, and strengthened supportive relationships through creative and dialogue based activities.
Monitoring questions	Do participants feel calmer or less stressed? Do creative activities support emotional expression? Is mood or wellbeing improved? Are coping strategies from sessions being used? Do participants feel welcomed and included? Do shared activities foster positive interactions? Do participants feel more connected to the group or community?
Tools	Knowledge, attitude, practices surveys (KAPS) Focus group discussions IFRC Monitoring & Evaluation Framework Toolbox Domains depending on focus: Functioning, Subjective wellbeing, Disabling distress/ symptoms, Coping, Social behaviour, Social connectedness IASC MHPSS M&E Framework (Version 2.0)

Activity:	Community-based Crisis Response Teams
Outcome:	People in distress or at risk are identified and supported through appropriate MHPSS services and referral pathways
Monitoring questions	How effectively are teams identifying people in distress or at risk? Are they providing appropriate initial support (PFA, safety support)? Are safe referral pathways in place? Are referrals used consistently? Do community members know how to access the teams? Is documentation timely and appropriate? Are urgent cases escalated appropriately? Do supported individuals feel better after intervention? Is community feedback incorporated?
Tools	Focus group discussions IFRC M&E Framework Toolbox IFRC CEA Guide & Toolkit

Activity:	Community-based Crisis Helplines / Hotlines
Outcome:	People in distress or at risk are identified and supported through appropriate services and referral pathways.
Monitoring questions	Are callers in distress identified consistently? Are supportive communication techniques used? Are callers informed about available services? Are referrals made appropriately? Do callers feel calmer or more supported? Are safety and escalation protocols followed? Are follow up calls conducted when needed? Is documentation confidential? Is the helpline accessible to diverse groups? Are responders receiving supervision?
Tools	Focus group discussions IFRC CEA Guide & Toolkit and Community Engagement and Accountability (CEA) Toolkit | IFRC Supportive Voices (pp. 44–47)

Activity:	Mentorship & Peer to Peer programmes
Outcome:	Participants demonstrate improved coping abilities through problem solving, emotional regulation, and support seeking
Monitoring questions	Do participants manage stress better? Are problem solving skills used in daily life? Do participants feel more confident? Are emotional regulation skills improving? Do participants have someone to seek support from? Are coping strategies shared? Do participants feel less isolated? Do they describe increased resilience or motivation?
Tools	Knowledge, attitude, practices surveys (KAPS) Focus group discussions IASC MHPSS M&E Framework – Coping & Social Connectedness domains: IASC Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings- With means of verification (Version 2.0).pdf IFRC Psychosocial M&E Framework: https://mhpsshub.org/resource/monitoring-and-evaluation-framework-toolkit/

Activity:	Psychosocial training for community leaders
Outcome:	Community leaders apply psychosocial knowledge and skills to support others, communicate effectively, and manage challenges
Monitoring questions	Do leaders feel more confident supporting others? Are psychosocial skills applied in practice? Do community members report receiving helpful support? Are leaders able to identify distress? Do leaders communicate effectively? Do they use problem solving approaches? Do leaders manage their own stress better? Are they strengthening community support mechanisms?
Tools	Knowledge, attitude, practices surveys (KAPS) Focus group discussions IASC MHPSS M&E Framework – Functioning & Social Behaviour domains IFRC Psychosocial M&E Framework

ANNEX 1

Key Culture and Context Considerations

What to know about culture and context when planning CB MHPSS activities

- **Languages in use**, including the main languages spoken by affected populations as well as those used by minority groups.
- **Local ways of expressing distress**, including culturally specific terms, idioms, or expressions people use to describe emotional difficulties, grief, fear, or mental health conditions.
- **Customary ways of supporting people in distress**, such as family networks, community leaders, religious figures, or traditional practices that people turn to for comfort and guidance.
- **Local explanations for mental health conditions**, including beliefs linked to spirituality, social harmony, family relationships, traumatic events, or the supernatural.
- **Gender-specific stressors and expressions of distress**, and how gender roles influence coping, help-seeking, or access to services.
- **The role of religion, faith, and traditional healing**, including whether spiritual leaders or healers play an important role in wellbeing and recovery.
- **How cultural practices or identities have changed during the crisis**, such as shifts in traditional roles, reduced participation in cultural rituals, or new stressors affecting community cohesion.
- **Community resources and coping strategies**, and whether these differ across age, gender, disability, ethnicity, or other social groups.
- **The political context**, including perceptions of fairness, stability, corruption, favoritism, or structural inequalities that may influence access to support.
- **Local power structures and social dynamics**, including hierarchies based on age, gender, kinship, social status, or spiritual authority, and how these shape wellbeing and access to care.
- **Inter-group dynamics**, such as relationships between ethnic, linguistic, or religious groups, and any existing tensions or sensitivities.
- **Socially vulnerable or marginalized groups**, and how social exclusion affects their ability to access support or participate in community activities.
- **Past experiences with aid organizations**, including any concerns, unmet expectations, or trust issues related to external actors.
- **Help-seeking behaviours**, including whether people are willing to access mental health or psychosocial services, and their acceptance of support offered by local organizations, the Red Cross Red Crescent, or international actors.

Ref: Key Considerations - MHPSS MSP

ANNEX 2

Community Meeting Guide – MHPSS Hub

The purpose of this guide is to meet with a group of community members to identify needs, interests, and relevant CB MHPSS activities. This guide is intended for implementing staff and volunteers at the branch level and is based on the IFRC Community Engagement and Accountability toolkit.

Before the community meeting, consider the following:

- Meeting participants: Limit the number of participants to 12 maximum. While community leaders are a valuable source of information, they can also affect the answers of the other participants in a meeting. A good tactic is to arrange an individual key informant interview with the community leader separately.
- Facilitation: It is recommended that there be a facilitator and a notetaker.
- Language: Will an interpreter be required?
- Location: Is the location clear and easy to find for the meeting participants? Is it accessible for those with mobility issues (e.g. wheelchair accessible, elevator, etc.)? Is the meeting location private and comfortable for the participants?
- Refreshments: Consider providing refreshments if available and arrange ahead of time.
- Room arrangement: If possible, arrange the room with seats in a circle. Formal conference rooms with large tables can create an intimidating environment for some participants.

During the community meeting, consider the following:

- Provide a clear explanation of the purpose and duration of the meeting. Allow the participants to introduce themselves.
- Ask for people's consent to participate and permission to take notes.
- Explain clearly that part of this meeting's purpose is to identify potential activities of interest and relevance to the community but that not all activities can be guaranteed.
- Set ground rules for the discussion, such as one person speaking at a time, confidentiality, and different opinions being permitted.
- Encourage everyone to speak.
- Do not judge what people say – listen openly, even if you disagree.
- Avoid "yes/no" questions. Instead, ask open ended questions (example: Do you like football? vs. What sports are you interested in?).
- If people raise issues linked to protection or sexual exploitation and abuse, let them talk as much as they want to but do not press them for details in front of the group. Speak to them separately at the end of the meeting and ask their permission to follow up on the issue and take their contact details. You may need to refer to a Protection specialist or your manager.
- At the end, ask people if they have questions for you. Explain the next steps and when they will hear next from you about the outcomes of the meeting, while setting realistic expectations.

After the community meeting, consider the following:

- Review the notes and add any additional details so they are not forgotten.
- Communicate the results to your manager and other relevant staff or volunteers to begin the activity planning process.
- Set a clear date and reminder to communicate with the community in the coming weeks.

Community consultation questions

These questions are intended for an initial community meeting to inform CB MHPSS activities. They are not a comprehensive needs assessment but should identify key needs and priorities. The questions should be adapted as needed depending on the community.

1. What are your main concerns right now?
2. What are the impacts of these issues on your daily life and wellbeing?

Note to facilitator

Depending on the participants, they may or may not be comfortable talking openly about their mental health. Instead, you can ask about how these issues affect them on some of the following: mood, social relationships, ability to do normal daily activities, sleep, etc.

3. How are you coping with them? What community practices (formal or informal) or associations are active and available in your community?
4. What kinds of activities would be helpful and interesting for you?
5. Are there any barriers to accessing or doing these activities?
6. Would you or anyone from your community like to be involved in planning and conducting these activities? Who would be important to involve?
7. What locations, days, and times are convenient for you to access future activities?
8. What is the best way for us to communicate with you after this meeting?

Feedback questions after a CB MHPSS activity:

These feedback questions are intended for a community meeting but can also be asked through other methods, including digital or paper forms or key informant interviews. Ultimately, the questions and method of feedback should be adapted to fit the community. One of the goals is to continue identifying ways to stay engaged with the community through these questions.

1. How was your experience with this activity?
2. Do you feel that this activity helped you cope with life's challenges? If yes, how?
3. Has this activity helped improve how you feel? If yes, how?
4. What went well during the activity? What did you enjoy?
5. What can be changed to improve this activity (e.g. date, location, size, content)?
6. Would you recommend this activity to others? Who else do you think should be invited to or involved in the activity?
7. What other activities would you like to have? What would be helpful or interesting for you?

ANNEX 3

Minimum requirements for anyone providing CB MHPSS

All facilitators, regardless of background, are suggested to have:

1. **Foundational psychosocial support skills**
   - Basic skills in psychosocial support, supportive communication, and psychological support principles appropriate to their role.
   - Ability to use verbal and non-verbal active listening, establish contact, and build trust.
   - Capacity to convey empathy, warmth, genuineness, and care in interactions.
2. **Communication and inclusion skills**
   - Clear, respectful verbal and non-verbal communication that is culturally and contextually appropriate.
   - Ability to maintain a non-judgmental attitude, uphold dignity, and respect diverse values, experiences, and identities.
   - Skills in ensuring inclusive participation, especially for individuals at greater risk of exclusion.
3. **Contextual and cultural understanding**
   - Knowledge of the local context, community dynamics, cultural norms, and factors that support or hinder participation.
   - Sensitivity to diversity, power dynamics, and protection considerations within communities.
4. **Group facilitation and community engagement**
   - Competence in facilitating group activities, including setting up shared agreements, providing clear instructions, managing group dynamics, and maintaining confidentiality.
   - Ability to engage community members in ways that strengthen existing supports, reactivate social networks, and encourage participation and ownership.
5. **Protection and safety**
   - Understanding protection principles, confidentiality, safe documentation, and the safeguarding responsibilities of the Movement.
   - Familiarity with referral pathways and the ability to recognise when someone may require additional MHPSS or protection support, ensuring safe and dignified referrals.
6. **Teamwork, leadership and professional conduct**
   - Ability to work effectively independently, as a co-facilitator, and within a team structure.
   - Skills in giving and receiving constructive feedback, supporting peers, and contributing to a safe and supportive working environment.
   - Flexibility and adaptability in changing or challenging contexts.
7. **Self-awareness and wellbeing**
   - Skills in self-reflection, self-observation, and emotional awareness, recognising personal limits.
   - Ability to maintain healthy personal and professional boundaries.
   - Commitment to self-care practices and strategies that support personal wellbeing and prevent stress or burnout, as well as supporting the wellbeing of co-facilitators and team members.
8. **Supervision, mentoring and quality assurance**
   - Engagement in regular supervision and mentoring to ensure safe, ethical, and high-quality CB MHPSS delivery.
   - Participation in monitoring and feedback processes to support continuous learning and improvement.

ANNEX 4

Community-based MHPSS Activity Planning Tool and important considerations for planning

Information: This is a general tool that can be used by staff and volunteers to collaboratively plan CB MHPSS activities with the community. This should be adapted as needed for any context. It may also be used as a standardized form that staff and volunteers fill in.

National Society or Branch:

Date of activity:

Location of activity:

Number of participants:

Activity Name:

Participants:

Who is being targeted for this activity? This could be groups of a specific age or gender or groups with similar background, interests, life experiences, or specific vulnerabilities or needs.

Community Needs, Interests, and Strengths:

- How was the community consulted and their needs and interests identified?
- What are the community's needs and interests?
- What are the community's resources and strengths that can be incorporated into the activity? Are there any individuals or groups who can be involved in planning or implementing the activity?

Activity Objective:

How will this activity address the community's MHPSS needs? How will it improve the community's psychosocial wellbeing?

Activity Description:

- What is the activity?
- How many sessions will this activity be?
- Will this be an open or a closed group?
- How long will the activity last?

Preparations and Costs:

- What supplies and preparations are required for the activity? Are there any specific accommodations needed to ensure access?
- What procurements are needed?
- What are the costs for the activity?
- What staff, volunteers, or community members are needed to facilitate the activity? Are there any training considerations?

Important considerations for planning

1	**Time and date**	**What time and dates work best for the community?** Find different options for times and dates that work for the community during activity planning. Specific groups, such as parents or caregivers, may have limitations due to their children's school schedule (including school holidays). Others may feel comfortable with an evening activity while others may not feel safe going out at that time.
2	**Location and venue**	**What location is convenient and safe for the community? What venue would work best for the activity?** Certain locations and venues may be more familiar and more easily accessed than others for the community. Some community members may not be able to afford transportation or know how to find certain locations. Certain venues may also be uncomfortable or unsafe for some community members. Take the time to understand what the best fit for the community members and the desired activity would be.
3	**Accessibility and specific accommodations**	**Is the location and venue accessible? Are there any accommodations or venue specifications needed in order for all to participate?** Activity locations and venues should not just be affordable to access but also enable the full participation of the community. There may be people with mobility issues or physical disabilities who need wheelchair access or a building with an elevator. Some participants may need to bring their children with them due to lack of childcare; is there a space appropriate for the children to play in during the activity?
4	**Language**	**What language will the activity be conducted in? Is interpretation or translation needed?** Depending on the facilitators and the backgrounds of the participants, there may be more than one language being spoken in the activity. Check if interpretation will be needed or if activities need to be planned based on language grouping in order to provide accessibility.

5	**Format of the group**	**Will the activity be "closed" and limited to a set group? Or will it be "open" to new participants on an ongoing basis?** There are advantages and limitations for both closed and open groups. Some groups may benefit from being a closed group due to a very specific shared set of experiences, stressors, or interests. Other activities may be better suited for newcomers to join. Clarify this with the community when planning the activity.
6	**Number of sessions**	**How many times will this activity be conducted?** It is important to have clear expectations on this for the community and also for programming purposes. Suddenly stopping an activity can be disruptive to the community and negatively impact relations. Programme managers and other responsible persons need to have clear information for budgeting and programme planning purposes as well.
7	**Communication**	**What is the communication plan for the activity?** There should be an agreed upon method of communicating to the community for the activity. This could be approved for messaging applications, announcements on the National Society's social media, phone calls, or other options. Not all community members may have the same access to the internet or familiarity with digital communication. It is also good to have clarity on how often communication will happen for the activity and who will be communicating. Will there be reminders a day before the activity? Who will be the focal point for scheduling and announcements?

ANNEX 5

Referral services mapping information sheet[20]

TYPE OF SECTOR	DETAILS OF SERVICES OFFERED	CONTACT INFORMATION	ELIGIBILITY CRITERIA	LANGUAGES	PROCEDURES FOR INTAKE
HEALTH	Medical Clinical Care for SGBV survivors Reproductive health Mental health and sychosocial services Maternal care services Vaccinations Health education, dignity kits and related provisions HIV clinic	**Information:** **Focal Points:**			
WATER AND SANITATION	Clean water Safe latrines Distribution lists Water points for washing clothes/ laundry	**Information:** **Focal Points:**			
TYPE OF SECTOR	DETAILS OF SERVICES OFFERED	CONTACT INFORMATION	ELIGIBILITY CRITERIA	LANGUAGES	PROCEDURES FOR INTAKE

20 International Federation of Red Cross and Red Crescent. (2020). PGI in Emergencies Toolkit. Accessed here: https://www.ifrc.org/document/pgi-emergencies-toolkit

PROTECTION	Birth registration/legal documents Refugee/displacement related services Legal support Information provision Restoring family links/tracing Safe house Information provision Restoring family links/tracing Safe house	I**nformation:** **Focal Points:**			
CHILD PROTECTION	Psychosocial support Interim care/alternative care Family tracing and reunification Justice for children Child friendly spaces Child protection specialists	I**nformation:** **Focal Points:**			
SGBV AND HUMAN TRAFFICKING	Services for survivors (medical, legal, security, livelihoods and financial assistance) Counseling/psychosocial support	I**nformation:** **Focal Points:**			

TYPE OF SECTOR	DETAILS OF SERVICES OFFERED	CONTACT INFORMATION	ELIGIBILITY CRITERIA	LANGUAGES	PROCEDURES FOR INTAKE
EDUCATION	Education for out of school children Enrollment in school (classes/after school clubs) Negotiating barriers to entering schools Informal education opportunities Specialist schooling Scholarships Vocational Training Internships Volunteer programs	**Information:** **Focal Points:**			
ECONOMIC RECOVERY	Economic programming for vulnerable families Livelihood opportunities Financial assistance	**Information:** **Focal Points:**			
CAMP MANAGEMENT	Security Housing Distribution planning Coordination meetings Distribution lists	**Information:** **Focal Points:**			

TYPE OF SECTOR	DETAILS OF SERVICES OFFERED	CONTACT INFORMATION	ELIGIBILITY CRITERIA	LANGUAGES	PROCEDURES FOR INTAKE
NUTRITION	Nutritional support Distribution lists	I**nformation:** **Focal Points:**			
OTHER	Nutritional support Distribution lists	**nformation:** **Focal Points:**			

The Red Cross Red Crescent Movement MHPSS Hub
Hejrevej 30
DK-2400 Copenhagen
Denmark

+45 35 25 92 00
www.mhpsshub.org
mhpsshub@rodekors.dk

MHPSS
INTERNATIONAL
MOVEMENT
HUB

ICRC