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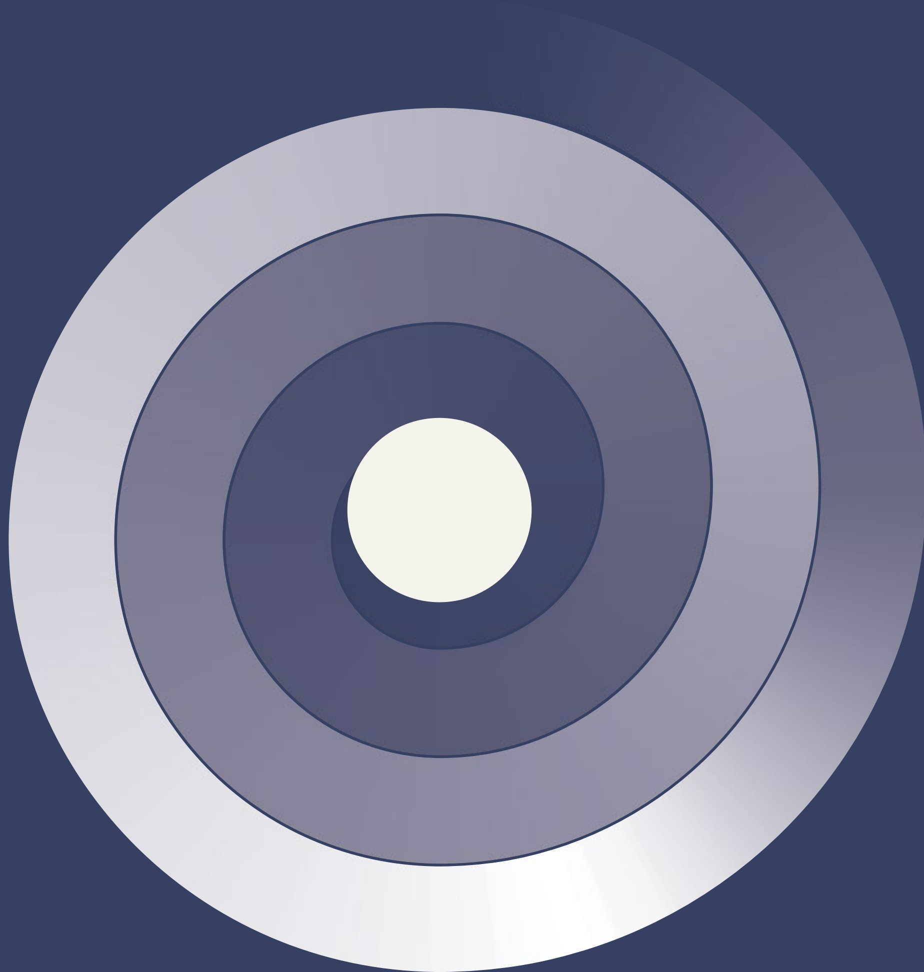
MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT CAPACITY STRENGTHENING FRAMEWORK



Mental Health and Psychosocial Support Capacity Strengthening Framework
July 2026

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Introduction

The Goal

The goal of this Framework is to align and guide approaches across the Red Cross Red Crescent (RCRC) Movement, for volunteers, staff, and partners. It aims to provide a structured, practical approach to strengthening mental health and psychosocial support (MHPSS) capacities of staff and volunteers to work effectively in MHPSS in various environments, including complex crises. The Framework may also be useful for humanitarian MHPSS organizations outside the RCRC Movement, community-based organisations, governments, and donors.

The Framework focuses on workforce and organizational **capacity strengthening** and provides recommendations to ensure sustainability of the capacity strengthening outcomes at a system level. The Framework promotes organizations to establish approaches to continuous **competency** development where supervision and **mentoring** are integral parts of the process.

The Framework does not provide prescriptive session plans, **training** methodologies, or integration models for education, health, protection, or community services, because such guidance must be adapted to specific contexts, settings, and pre-existing capacities. Instead, the Framework aims to identify the conditions required for successful MHPSS capacity building and offers approaches that should be applied alongside context-specific technical resources and implementation plans.

Who is the Framework for

The Framework is for organisations implementing MHPSS programs and interventions that are working to strengthen their own capacity to provide MHPSS or who are supporting partner organisations with capacity strengthening. The Framework is primarily for the RCRC Movement. However, it may also be used as guidance by agencies outside the RCRC Movement that are providing **MHPSS capacity strengthening** within their own organisations, with partners.

This Framework is for:

- MHPSS focal points, responsible for design, planning, implementation and quality assurance of MHPSS programs.
- Management and decision makers in National Societies, the ICRC, and the IFRC.
- MHPSS focal points in National Societies which are providing partner support in humanitarian settings.
- Other providers of MHPSS capacity building, external to the RCRC Movement.
- Agencies funding capacity-strengthening programs.
- **MHPSS providers** (volunteers, staff at the community level and health facilities and mental health professionals).

How to use the Framework

The Framework can be used to guide assessment, design, planning, and implementation of MHPSS capacity strengthening efforts. It is intended that guidance and adaptation for local context, especially in conflict and post-conflict settings and emergencies, will be necessary.

A definition of terms is included on pages 29 to 31. These words appear in **bold** the first time they are used in the Framework.

What works, and what doesn't, in MHPSS capacity strengthening

Mental health and psychosocial needs in humanitarian and fragile settings continue to grow due to protracted conflicts, displacement, epidemics, disasters, climate shocks, and social disruption. While evidence-based MHPSS interventions exist and have demonstrated effectiveness, the dominant challenge is no longer whether interventions work, but whether organisations and the systems they operate within have the capacity to deliver them safely, ethically, and at scale[1].

Across humanitarian, global mental health, and public health literature, there is strong consensus on a core insight: capacity strengthening in MHPSS cannot be reduced to training events. Short, one-off trainings—particularly for relational skills, such as MHPSS—often improve knowledge and confidence but rarely lead to sustained changes in practice or service quality[2,3]. Evidence from crisis settings shows that non-specialists struggle to apply core principles safely without supervision, mentoring, and opportunities for practice, which increases the risk of inconsistency and unintended harm. Evidence from evaluations of mhGAP implementation shows that trained non-specialists may still demonstrate gaps in assessment, confidentiality, and risk management—competencies that are essential for ensuring safe, ethical, and effective support. This highlights the limitations of training-only approaches and reinforces the need for ongoing competency assessment, supervision, and mentoring.

A growing body of literature reframes capacity strengthening as a complex, context-dependent behaviour-change process, rather than a mere transfer of skills. Drawing from public health models, capacity strengthening must address practitioner knowledge, skills, self-efficacy, motivation, and working conditions simultaneously, while also engaging in the development of organisational and policy environments[4]. This framing explains why technically sound curricula often fail in humanitarian settings when power dynamics, institutional readiness, and local realities are not addressed.

Scaling up MHPSS further demonstrates that individual capacity is insufficient without enabling organisational environments. Organisational leadership, coordination mechanisms, policy engagement, financing, and institutional ownership are repeatedly identified as determinants of whether capacity-building efforts translate into sustained service delivery[5,6]. High staff turnover, externally driven curricula, weak supervision, and limited policy buy-in remain persistent barriers.

The literature also highlights the importance of role-specific competencies and national frameworks. Generic training fails to reflect the diversity of MHPSS roles—from community-based workers to clinicians, supervisors, and policymakers. Competencies need to reflect the scope of professional roles, be supported with minimum standards, supervision requirements, and **learning pathways**, to support coherence across humanitarian and formal state system.

These recent findings and initiatives reflect increasing recognition of the quality gap associated with task process-oriented approaches emerge as central to ethical and effective capacity strengthening.

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1 Hanlon, C., et al. (2018). Evaluating capacity-building for mental health system strengthening in LMICs for service users and caregivers, service planners and researchers. *Epidemiology and Psychiatric Sciences*, no. 27.

2 Caulfield, T., et al. (2019). WHO guidance on mental health training: a systematic review of the progress for non-specialist health workers. *BMJ Open*.

3 Horn, R., et al. (2019). The myth of the 1-day training: the effectiveness of psychosocial support capacity-building during the Ebola outbreak in West Africa. *Global Mental Health.*

4 Leeman, J., et al. (2015). What strategies are used to build practitioners' capacity to implement community-based interventions and are they effective?: A systematic review. *Implementation Science,* vol. 10.

5 Troup, J., et al. (2021). Barriers and facilitators for scaling up mental health and psychosocial support interventions in low- and middle-income countries for populations affected by humanitarian crises: a systematic review. *International Journal of Mental Health Systems,* vol 15, no. 5.

6 Hanlon, op cit.

Wessells[7] and GIZ[8] emphasise power sharing, humility, co-learning, and **reflective practice** as essential conditions for sustainability and contextual cultural relevance. Where externally defined expertise dominates and local knowledge is marginalised, capacity strengthening risks becoming extractive, undermining trust, ownership, and long-term impact.

The literature supports several foundational assumptions that underpin the proposed Framework:

1. Capacity strengthening is a long-term, relational, and multilayered process, not a training activity.
2. Competence requires supervision, practice, **feedback**, and quality assurance, especially for non-specialists.
3. Short trainings without organisational support risk low impact and potential harm.
4. Sustainability depends on organisational and policy environments, not individual skills alone.
5. Capacity strengthening must be contextualised and role-specific, grounded in local community and system-level realities.

This Framework provides a pathway for the RCRC Movement and broader MHPSS sector to take steps to action learnings from experiences in MHPSS capacity strengthening to date. Drawing from evidence and experience, it offers a structured and practical approach for building the competencies required to design, implement, and evaluate MHPSS programs in complex humanitarian environments. Its focus extends across institutional capacity strengthening, workforce development, and **system strengthening**, recognising that sustainable MHPSS programming depends on strong organisations and systems as much as skilled individuals.

7 Wessells, M. G. (2023). How Process Matters in Strengthening MHPSS: A Reflection. *Intervention*, vol. 21, no. 1.

8 Gesellschaft für Internationale Zusammenarbei (2019). Recommendation Paper on Training and Capacity Development in Mental Health and Psychosocial Support (MHPSS) in Development Cooperation: As Exemplified in the Context of the Crises in Syria and Iraq. GIZ: Bonn.

Approach

Strengthening MHPSS capacity requires addressing interconnected challenges at workforce, organisational, and system dimensions. Organisations that directly implement MHPSS activities often experience high levels of staff and volunteer turnover. During large-scale emergencies or armed conflicts, international partners who join the response also face frequent staff turnover, which can occur without a clear, consistent, or aligned approach to MHPSS capacity strengthening.

Community-based organisations and humanitarian agencies frequently work in silos, and their partnerships often fail to formalize commitments that ensure new skills are applied in practice or to establish agreed accountability mechanisms. This reinforces perceptions of international organisations as short-term "training providers" holding a unique expert power, rather than as long-term collaborators who can support the development of contextualised and adapted capacities. In turn, the process of quality assurance and sustainability of expertise transfer is not well operationalised or clearly communicated.

At the system level, many contexts operate with fragmented or absent MHPSS systems, frequent turnover of government focal points, constrained access due to conflict, or remoteness and/or lack of prioritisation, and unreliable connectivity that limits a consistent process of capacity strengthening. Developing competencies and organisational capacity in these contexts requires time and sustained investment. In many contexts, the lack of mature systems means that MHPSS providers must start building foundational MHPSS competencies, while facilitation and supervision capacities remain insufficient to support rapid scale-up and follow-up.

In such contexts, existing systems may be limited, overstretched, or not yet able to provide adequate MHPSS. While system strengthening remains a key objective, immediate needs often require pragmatic approaches that prioritise workforce capacity to ensure safe and ethical service delivery. Where engagement at system level is not possible or remains limited, this should not prevent efforts to support the available workforce to respond to urgent needs. In such situations, capacity strengthening efforts may initially focus on supporting existing actors and services, while progressively engaging with authorities and partners to strengthen organisational and system-level structures over time. Particular attention should be given to supervision, competency assessment, and clear scope of practice to minimise risks associated with rapid scale-up in constrained environments. These interim approaches should not substitute for system strengthening but rather serve as a bridge towards it, grounded in local capacities and promoting long-term ownership.

Cross-cutting principles

The Framework is grounded in the Fundamental Principles of the RCRC Movement and its policy[9] and resolution[10] on addressing mental health and psychosocial needs, including the RCRC Movement MHPSS Framework. Additional cross-cutting approaches and RCRC Movement commitments relevant for MHPSS are the following:

- **MHPSS is needs-based and person-centered**. To be effective, MHPSS must respond to the actual needs of people, shaped by lived experiences. If this approach is integrated throughout assessment, design, implementation, and evaluation, it helps ensure that support is relevant, acceptable, and does not cause harm. It also helps direct limited resources to areas of greatest impact.

9 International Red Cross and Red Crescent Movement. (2020). *The International Red Cross and Red Crescent Movement policy on addressing mental health and psychosocial needs.* https://mhpsshub.org/resource/the-international-red-cross-and-red-crescent-movement-policy-on-addressing-mental-health-and-psychosocial-needs/

10 International Conference of the Red Cross and Red Crescent. (2019). *Resolution 2: Addressing mental health and psychosocial needs of people affected by armed conflicts, natural disasters and other emergencies.* https://mhpsshub.org/resource/resolution-33rd-international-conference-of-the-red-cross-and-red-crescent/

- **Capacity strengthening is an ongoing long-term process**. Strengthening local capacities and empowering professionals and volunteers as key MHPSS providers supports sustainable, community-owned approaches, while continuous accountability and learning processes ensure adaptability across diverse and evolving humanitarian contexts.
- **Community engagement and accountability (CEA)** is ensuring that all MHPSS interventions are based on meaningful, culturally informed collaboration with communities and community stakeholders (this includes MHPSS providers, Movement partners, local authorities receiving capacity strengthening support). CEA commitments help to build trust and ensure that MHPSS services remain relevant and rights-based. They also safeguard quality, foster ownership, and enhance the long-term impact of MHPSS programming.[11]
- **Cultural and contextual appropriateness** is ensuring that MHPSS interventions are contextually, culturally, and socially appropriate, and that they build on existing local capacities and systems rather than imposing external models.
- **Human rights-based**. It ensures that MHPSS delivery and capacity strengthening upholds dignity, equity and safety; promotes full participation and accountability; addresses discrimination and structural barriers.
- **Do No Harm and trauma-informed approaches** ensure that organisations understand the impact of adversity, distress and trauma; recognise potential vulnerabilities and strengths; integrate this knowledge into policies and practices; and actively seek to avoid causing harm, including re-traumatisation.

11 International Federation of Red Cross and Red Crescent Societies. (n.d.). *Community engagement and accountability.* https://www.ifrc.org/our-work/inclusion-protection-and-engagement/community-engagement-and-accountability

The Framework

The Framework for MHPSS capacity strengthening includes three dimensions. These include:

- Workforce capacity
- Organisational capacity
- System capacity

At the centre of MHPSS capacity strengthening across all dimensions are the MHPSS needs that humanitarian organisations aim to address. While the three dimensions of the Framework are distinct, they are deeply interdependent. Strengthening one dimension in isolation risks creating gaps, inefficiencies, and undermining sustainability. When aligned, they foster an enabling environment for the safe, ethical, and effective delivery of MHPSS services.

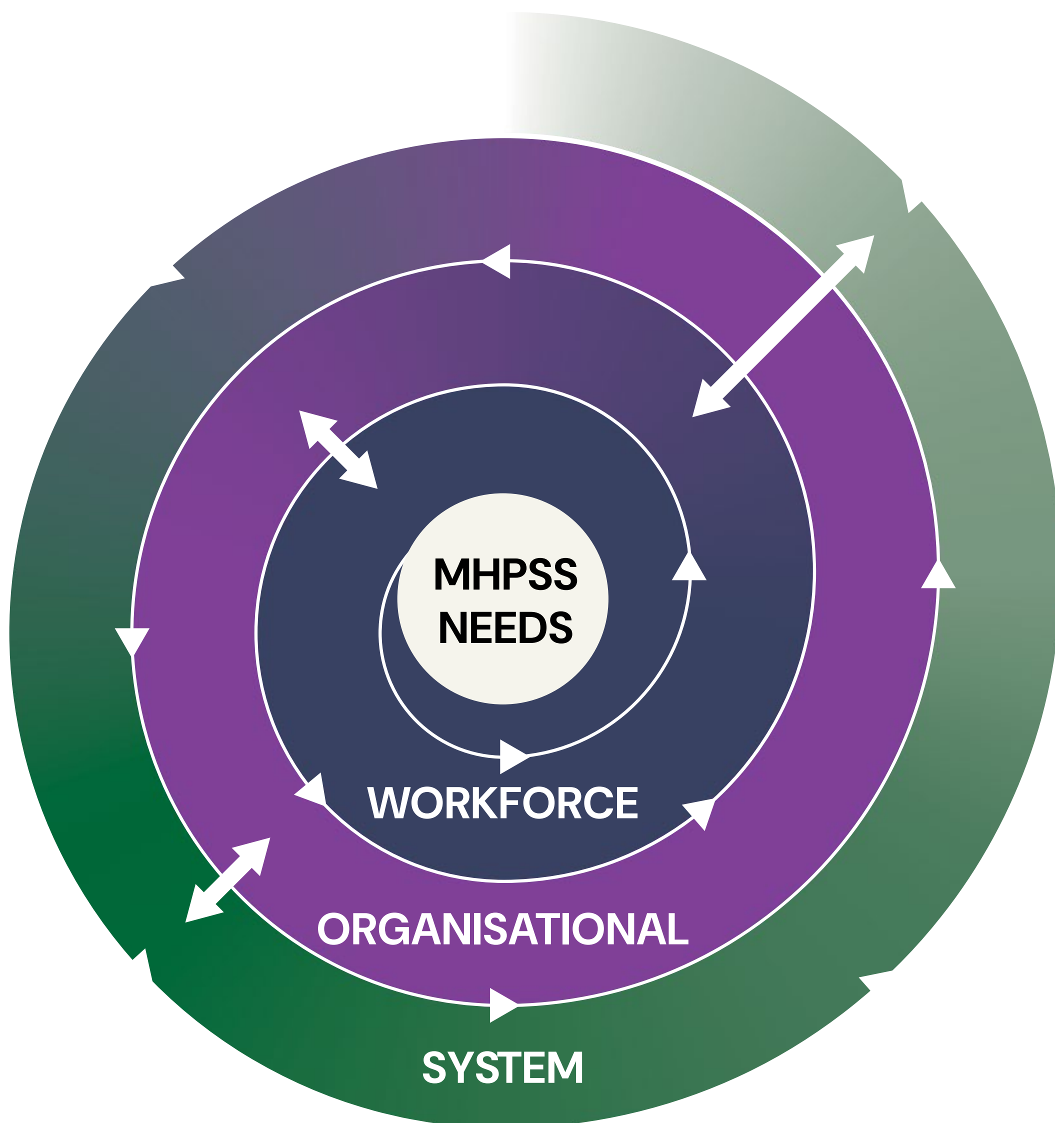

Figure 1: MHPSS Capacity strengthening Framework

Workforce capacity strengthening

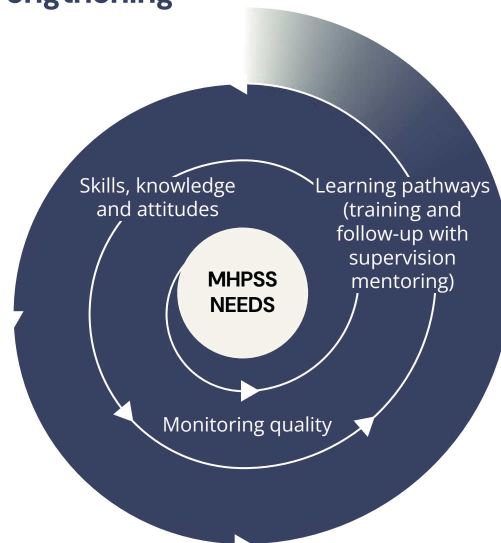

Figure 2: Elements of workforce capacity strengthening

Workforce capacity strengthening builds or enhances the skills, knowledge, and attitudes of individuals who implement MHPSS activities. This process ensures quality MHPSS service delivery which is do-no-harm, by equipping providers with the knowledge and skills, or change in attitude, needed to deliver specific MHPSS interventions that respond to identified needs. It also strengthens self-efficacy, professional confidence, and the overall wellbeing of MHPSS providers. Organisations that use a '**training of trainers**' approach to scale up MHPSS services should ensure that providers selected as trainers already have strong hands-on practice experience and are further equipped with facilitation skills to effectively train others.

Elements of workforce capacity strengthening

Skills, knowledge and attitudes, this includes:

- Assessment of capacities encompassing skills, knowledge, and attitudes related to specific job profiles or roles of practitioners implementing MHPSS-specific activities.

Learning pathways, this includes:

- Development of tailored context-specific learning pathways, which includes design of training content, choice of appropriate training methodology and facilitation methods, with clearly defined learning outcomes.
- Learning pathways must include post-training follow-up activities, including mentoring, **supportive supervision** and program supervision, aiming at continuous learning and skill development. Duration of training and frequency of follow-up must be considered.
- Advocating for evidence-based and evidence informed, ethical, MHPSS practice under ongoing supervision, while informing about the potential risks of harm to quality and effectiveness of care if not applied.

Monitoring quality, this includes:

- Setting up a monitoring and evaluation approach to be able to follow-up and measure the effectiveness of the training program, change in attitudes, knowledge and skills, improved well-being of providers, and professional efficacy. Community feedback on quality and satisfaction with MHPSS service provision serves as an important source of measuring capacity strengthening effect.

Organisational capacity strengthening

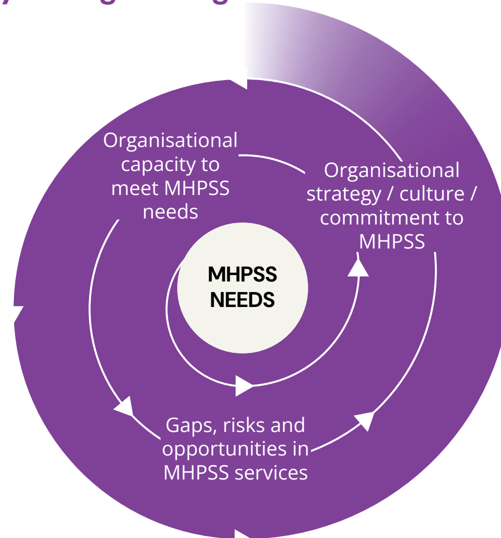

Figure 3: Elements of organisational capacity strengthening

Organisational capacity strengthening for MHPSS refers to systematic actions of enhancing organisational processes, internal systems, resources, and culture to effectively meet MHPSS needs and deliver MHPSS quality services. The key outcome of organisational capacity strengthening is increased organisational capacity to meet MHPSS needs. This also relates to how organisations can deal with, and respond to, natural fluctuations in individual capacities due to context (such as crisis and emergency), and resource changes, through **knowledge institutionalisation**. Organisational buy-in and sense of ownership and accountability is central to the sustainability of MHPSS capacity strengthening. Organisational culture, which promotes integration of MHPSS in other programmatic areas, is essential for institutionalising MHPSS internally.

Elements of organisational capacity strengthening

Gaps, risks and opportunities in MHPSS services, this includes:

- Considering gaps in MHPSS service provision within areas of operation, the organisation's capacity to address these gaps, and the operational and reputational risks associated with leaving them unmet.
- Identifying opportunities for the organisation to scale up MHPSS services and strengthen workforce capacity to respond effectively to MHPSS needs.

Organisational capacity to meet MHPSS needs, this includes:

- Assessing workforce capacity to meet MHPSS needs in areas of operation (e.g. whether the organisation has sufficient staff and/or volunteers with the appropriate skills and knowledge to deliver required MHPSS activities and interventions).
- Engaging human resources and utilising technical expertise, including defining competency requirements in job descriptions according to MHPSS provider profiles and establishing formal learning and development systems.
- Promoting operational learning by evaluating the quality, results, and outcomes of MHPSS services and capacity-strengthening activities (e.g. accountability mechanisms and monitoring and evaluation processes).

Organisational strategy/ culture/ commitment to MHPSS, this includes:

- Strategically adopting and prioritising MHPSS within an organisation, including the development of MHPSS policies and frameworks and standard operating procedures (e.g. MHPSS in emergency response).
- Committing financial resources to MHPSS programming and quality assurance, including for learning and development, and staff and volunteer care systems.
- Considering governance structures and levels of autonomy of administrative units (e.g. local branches), including nationally centralised versus decentralised models, when planning for organisational buy-in and organisation-wide institutionalisation of MHPSS.

System capacity strengthening

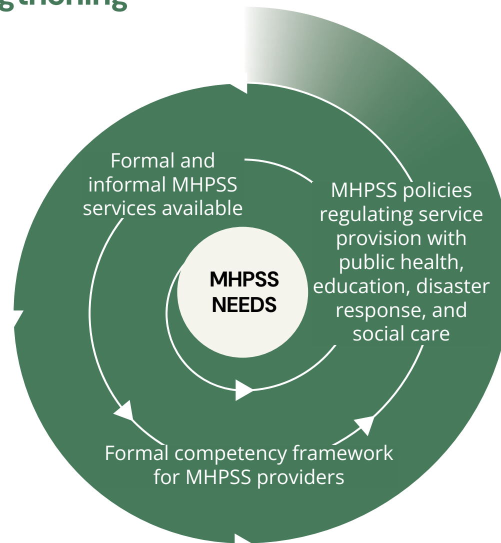

Figure 4: Elements of system capacity strengthening

System capacity refers to the environment in which MHPSS services and programs are implemented, and MHPSS providers are operating. This includes the broader MHPSS policies and services available within a given context of public health, education, disaster response, and social care. The key outcome of system capacity strengthening is to ensure institutionalisation and ownership of knowledge at the system level. System-level capacity strengthening also includes using opportunities that arise from crises, such as the inflow of resources and expertise, and using these for system-level improvement of quality and access to MHPSS services. Cross-sectorial coordination is critical to system-level strengthening and improvement.

Elements of system capacity strengthening

Formal **competency frameworks** for MHPSS providers, this includes:

- Advocacy for, and participation in development, of competency frameworks for MHPSS practitioners across relevant sectors on the national level.
- Participation in setting up quality measures for MHPSS services on national level.
- Building, and working in, partnerships and coalitions with partner organisations in aligning MHPSS quality approaches through joint capacity strengthening activities (e.g. supervision).

MHPSS policies regulating service provision within public health, education, disaster response and social care, this includes:

- Contributing to development and/or national mental health policies.
- Supporting, and advocating for, the regulation and protection of professional roles and titles in mental health, in line with national frameworks, to prevent misuse, ensure quality of care, and promote accountability.

Formal and informal MHPSS services available, this includes:

- Promoting community-based MHPSS, including access to specialised mental health care at community level and through appropriate referral.
- Advocacy for rights-based and human-centred approaches in mental health, including stigma reduction and improving access to MHPSS services.
- Contributing to the local evidence base for MHPSS through monitoring and evaluation and research.

Conditions for success

Sustainable MHPSS capacity strengthening depends on several conditions to ensure that organisations can learn, adapt, and support their workforce, advocate for, and contribute to system-level strengthening effectively.

These include, but are not limited to:

- Capacity strengthening is a collaborative effort. Partners must share accountability for outcomes, which can be operationalised through joint monitoring frameworks or agreements.
- While partners share accountability for outcomes, the partner receiving support remains responsible for developing and sustaining its own capacity. Joint goals and objectives should be developed collaboratively.
- Capacity strengthening must be planned for medium to long-term with relevant resource commitments aligned with the organisation's approach to learning.
- Considering pre-existing MHPSS capacity, i.e. the level of competencies in the organisation, and ensuring this capacity is considered while designing and planning capacity strengthening activities. Frequency, training type, and follow-up supports are determined by level of MHPSS intervention and providers' competencies.
- Organisations are accountable for enabling a learning culture and continuous skill development, including psychological safety. A learning culture that reduces fear and empowers staff to grow.
- Clarifying roles and responsibilities, assigning supervision functions.
- Psychological safety is addressed through safe, inclusive, and supportive learning environments that foster trust, respect, participation, and continuous learning.
- Cultural adaptation is essential for effective capacity strengthening as it ensures that the knowledge, skills, and tools being taught are relevant, usable, and safe within the cultural realities of the communities served.

Workforce capacity strengthening across the RCRC MHPSS Framework

MHPSS encompasses a broad range of activities and interventions, from basic psychosocial support to specialised mental health care. The multi-layered nature of MHPSS requires a range of skills and competencies to ensure alignment between the activities being implemented and the competencies and skills required of the workforce. As outlined in the **RCRC MHPSS Framework**, the level of formal training, supervision, skills and competencies of MHPSS providers increases as activities and interventions become more specialised. This means that workforce capacity strengthening approaches should vary depending on the layer of the RCRC MHPSS Framework, the existing competencies of MHPSS practitioners, and the time required to ensure safe and quality delivery.

Across all layers of the MHPSS Framework, the depth, duration, and intensity of workforce capacity strengthening should be aligned with both the complexity of the intervention and the baseline competencies of MHPSS practitioners to ensure safe, ethical, and quality service delivery.

Organisational and system capacity strengthening take time

While workforce capacity strengthening can often show more immediate results, organisational and system capacity strengthening typically require longer timeframes to be effective and sustained. These processes involve changes in structures, roles, coordination mechanisms, and institutional practices, which cannot be achieved within short project cycles. In some contexts, system-level engagement may be constrained by limited functionality, capacity, or prioritisation, which can affect the pace and scope of progress. These limitations should be recognised and factored into programme design, without neglecting longer-term system strengthening objectives. As such, organisational and system-level efforts should be considered from the outset of programming and not treated as secondary priorities. Particular attention should be given when planning handover or transition phases, to ensure that sufficient time and support are allocated for capacities to be established, maintained, and progressively transferred, in order to avoid the loss of progress and support sustainability.

Creating an enabling environment for MHPSS capacity strengthening

To sustain capacity strengthening actions the broader organisational environment must also be considered. The table below contains highlights of common pitfalls and potential ways to ensure capacity strengthening is embedded.

Dos	Don'ts
Do start with capacity needs assessment: Understand the existing capacities, gaps, and priorities of the workforce or organizations supported.	**Don't impose external solutions:** Avoid top-down approaches ignoring pre-existing expertise and local context.
Do co-create goals and plans: Involve stakeholders from the community, workforce and organisational and system levels in designing the capacity strengthening plans to ensure ownership.	**Don't treat it as a one-time training:** Capacity strengthening is a continuous process, not limited to a training or a **workshop**.
Do build on existing strengths: Identify, recognize, and build on what is already working well rather than starting from scratch.	**Don't rely solely on online training modules as a standalone approach:** Practice-based learning (e.g. role play, feedback, guided exercises) is essential to develop MHPSS competencies. Theory without practice can leave participants unsure how to respond in real situations. **Blended learning** approaches can help to address access and financial issues while ensuring practice-based learning is available for key MHPSS competencies.
Do use participatory and inclusive approaches: Ensure that diverse, marginalised providers with lived experience are heard and included in capacity strengthening, and that training methods are safe and culturally appropriate.	**Don't focus solely on simple transfer of training content to others**. Presence during the training and active involvement in follow-up are essential, as trainings cannot be effectively replicated through materials alone.
Do use culturally adapted content and facilitation methods. Ensure cultural considerations are integrated when scaling up interventions through capacity strengthening.	**Don't overlook power dynamics:** Be mindful of hierarchies and ensure equitable participation and decision-making.
Do focus on sustainability: Aim for long-term impact by institutionalising knowledge and fostering community ownership, contributing to system strengthening.	**Don't ignore organisational culture:** Tailor approaches to fit the values, norms, and practices of the organisation or community while advocating for protection and inclusion of those marginalised.
Do provide ongoing support and follow-up: Always plan for mentoring, supervision as a follow-up after training.	**Don't rely on ready-imported manuals, but make them culturally fit**. Consult and test the content and approaches with the local group of experts and community.

Cultural adaptation

MHPSS interventions that lack local **cultural adaptation** may be technically sound but practically unusable or even harmful because mental health is shaped by local norms, idioms of distress, gender roles, trust networks, and structural inequalities. Ultimately, capacity strengthening is a process of mutual exchange and change in knowledge and attitudes. Its goal is transforming MHPSS practice, rather than simply transferring technical knowledge. Co-creation of training content and facilitation, introducing evidence-informed good practice approaches, with just enough technical complexity to match the level of providers (especially lay providers) is important for the uptake of new practices.

Adapting MHPSS capacity strengthening approaches

Planning and designing MHPSS capacity strengthening requires considering several layers of adaptation.

Type	What it changes	Example in MHPSS
Surface *Make it familiar*	Language, photos, names, symbols, imagery	• Translating, aligning with cultural norms around respect, directness/indirectness, or authority • Replacing photos and illustrations with images that reflect the local population and settings
Deep *Make it meaningful*	Concepts, meanings, values	• Using local idioms of distress • Using culturally appropriate coping • Ensuring that understanding of symptoms and explanations are compatible with local beliefs about mental health and illness, while safeguarding evidence- and rights-based approaches
Structural *Make it accessible, safe, and sustainable*	Delivery modality, system context, and access	• Adapting training modalities (e.g. in-person, blended) based on access, connectivity, and security constraints • Assessing prevalent learning norms (e.g. didactic vs experiential) and gradually introducing participatory methods where they are unfamiliar • Adapting capacity strengthening approaches to ensure inclusive participation across population groups, taking into account gender, age, disability, and other relevant factors • Assessing pre-existing power dynamics and competency profiles when selecting and grouping participants • Contextualising according to the availability and regulation of mental health professionals, referral pathways, integration within existing health and social systems, access to medication, existing or absent ethical and confidentiality standards, and the availability of clinical supervision and duty-of-care mechanisms
Normative adaptation *Make it valid and aligned with quality standards*	Clinical standards and continuity of care	• Ensuring alignment with national mental health policies and protocols, while safeguarding rights-based and person-centred approaches • Defining scopes of practice and clarifying roles among non-specialised MHPSS providers, psychologists, and psychiatrists • Establishing supervision and case management systems where these are not already available • Ensuring continuity of care, including follow-up and referral

Where to begin?

There are many actions that can be undertaken to build MHPSS capacity across the Framework. Working out where to begin will differ depending on MHPSS needs in the community, the context, the competencies that need to be developed in the workforce, organisational priorities, resources available (both financial and human), risks and opportunities, etc.

The following tool offers a step-by-step process for analysing what is not working in MHPSS delivery and selecting the most appropriate dimension of capacity strengthening to focus on improving.

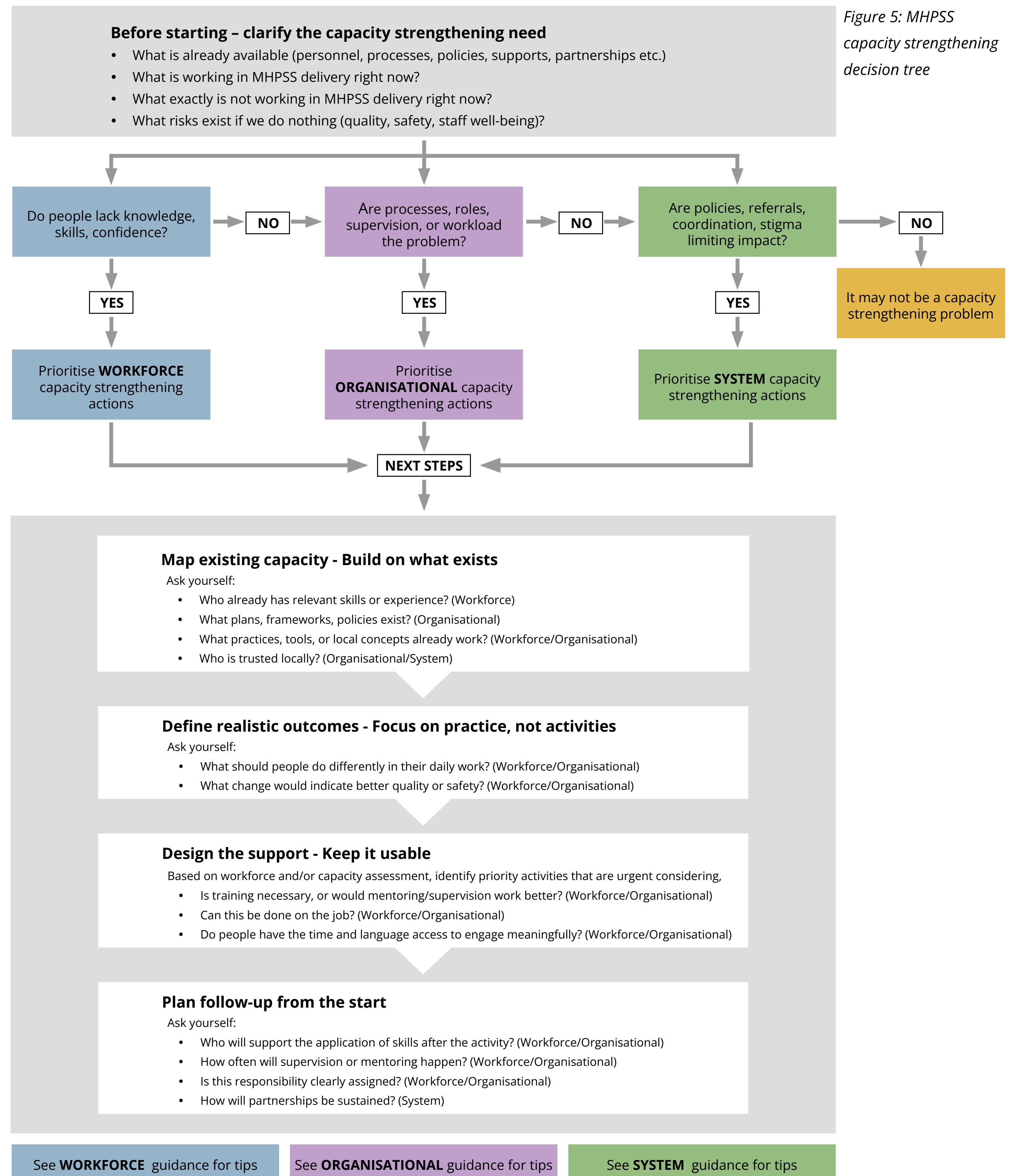

Figure 5: MHPSS capacity strengthening decision tree

Workforce capacity strengthening

Use this diagram as a quick tool to identify workforce needs and determine which actions will most effectively strengthen MHPSS capacity in the operational context.

Figure 6: Workforce capacity strengthening decision tool

PROBLEM	PROMPTING QUESTIONS	ACTIONS
WORKFORCE CAPACITY STRENGTHENING		
Emerging or changing MHPSS needs	• Are new types of distress emerging due to the emergency? • Do existing providers lack relevant experience? • Are new population groups requiring support? • Are existing interventions no longer fully relevant?	If yes, targeted capacity strengthening with close technical support.
High service demand, low human resources	• Are many people affected by the emergency (e.g. conflict, displacement, disaster)? • Is there a lack of trained staff or volunteers to provide MHPSS services? • Are there existing staff or volunteers who could be trained to provide MHPSS services? • Are existing MHPSS services overwhelmed or unavailable?	If yes, consider workforce expansion, task-sharing, and service adaptation. Capacity strengthening should focus on developing safe and feasible competencies among non-specialist providers, with close supervision, referral pathways, and quality assurance mechanisms. rather than rapid scale-up alone.
Limited skills or knowledge amongst providers	• Are helpers unsure how to respond to distress or trauma? • Is basic psychosocial support not yet introduced or understood? • Are team leaders struggling to support their staff? • Are more focused or specialised skills, or services, needed?	If yes, provide training, mentoring, coaching, and supervision to strengthen competence, confidence, and quality of practice *(workforce level). Check for Processes and Tools (organisational level).*
Signs of burnout or stress among helpers	• Are staff or volunteers showing signs of emotional exhaustion or secondary trauma? • Is there no system for supportive supervision or **peer support**?	If yes, introduce caring-for-staff strategies and mental health support *(organisational level followed by workforce level).*

Organisational capacity strengthening

Use this diagram as a quick tool to identify organisational barriers affecting MHPSS delivery and determine which actions can best strengthen organisational systems and support structures.

Figure 7: Organisational capacity strengthening decision tool

PROBLEM	PROMPTING QUESTIONS	ACTIONS
ORGANISATIONAL CAPACITY STRENGTHENING		
No clear processes or tools	• Are there missing or outdated SOPs, guidelines, or referral pathways? • Is there confusion about roles and responsibilities?	If yes, technical support and co-development of tools are needed.
Increase in scale (e.g. emergency induced) but capacity exists	• Are needs increasing faster than staff availability? • Are trained staff overstretched? • Are existing approaches no longer appropriate to the context?	If yes, focus on organisational adjustments, supervision, and workload management rather than new training. Adapt tools, approaches, and delivery rather than introducing new models.
Signs of burnout or stress among helpers	• Are staff or volunteers showing signs of emotional exhaustion or secondary trauma? • Is there no system for supportive supervision or peer support?	If yes, introduce caring-for-staff strategies and mental health support *(organisational level followed by workforce level).*

System capacity strengthening

Use this diagram as a quick tool to identify organisational barriers affecting MHPSS delivery and determine which actions can best strengthen organisational systems and support structures.

Figure 8: System capacity strengthening decision tool

PROBLEM	PROMPTING QUESTIONS	ACTIONS
SYSTEM CAPACITY STRENGTHENING		
MHPSS needs not being adequately met	• Are affected people lacking access to safe spaces, social connection, or basic psychosocial support? • Are community-based activities missing or not inclusive? • Are system-level institutional providers (health, social protection, education) failing to meet the MHPSS needs? • Are focused or specialised MHPSS services unavailable or insufficient? • Are referral pathways between levels of support weak or absent?	If yes, strengthen the level(s) of the MHPSS system where gaps exist. This may include community-based initiatives (ensure they are inclusive, voluntary and do not shift responsibility for care onto affected people without adequate support), focused non-specialist interventions, specialised mental health services, and referral pathways between levels of care. Capacity strengthening should support a coherent, layered MHPSS system that responds to identified needs.
Fragmented or duplicated MHPSS efforts	• Are multiple actors training on similar topics without coordination? • Are standards or approaches inconsistent? • Are referral pathways unclear or poorly functioning? • Are activities overlapping in some areas while gaps remain elsewhere?	If yes, prioritise coordination, shared standards, and alignment before additional capacity strengthening. Promote harmonised approaches and quality assurance across the system.
Weak institutional capacity, integration and governance for MHPSS	• Are health, education, social protection, or protection systems unable to adequately respond to MHPSS needs? • Are policies, strategies, or operational plans for MHPSS absent or weak? • Are roles, responsibilities, and referral pathways unclear? • Are supervision, monitoring, quality assurance, or financing mechanisms lacking?	If yes, strengthen institutional systems and governance. Support integration of MHPSS into existing services, development of policies and standards, establishment of supervision and quality assurance systems, strengthening referral pathways, and sustainable planning and financing mechanisms.

Advocating for capacity strengthening

Influence on effective MHPSS capacity strengthening happens at all levels. Workforce level activities have the strongest immediate direct impact but often cannot be sustained outside of a funded project cycle without organisational processes and systems in place. Therefore, advocacy for strengthening MHPSS capacity requires actions across all three levels, recognising their different speeds of envisaged change and strength of influence.

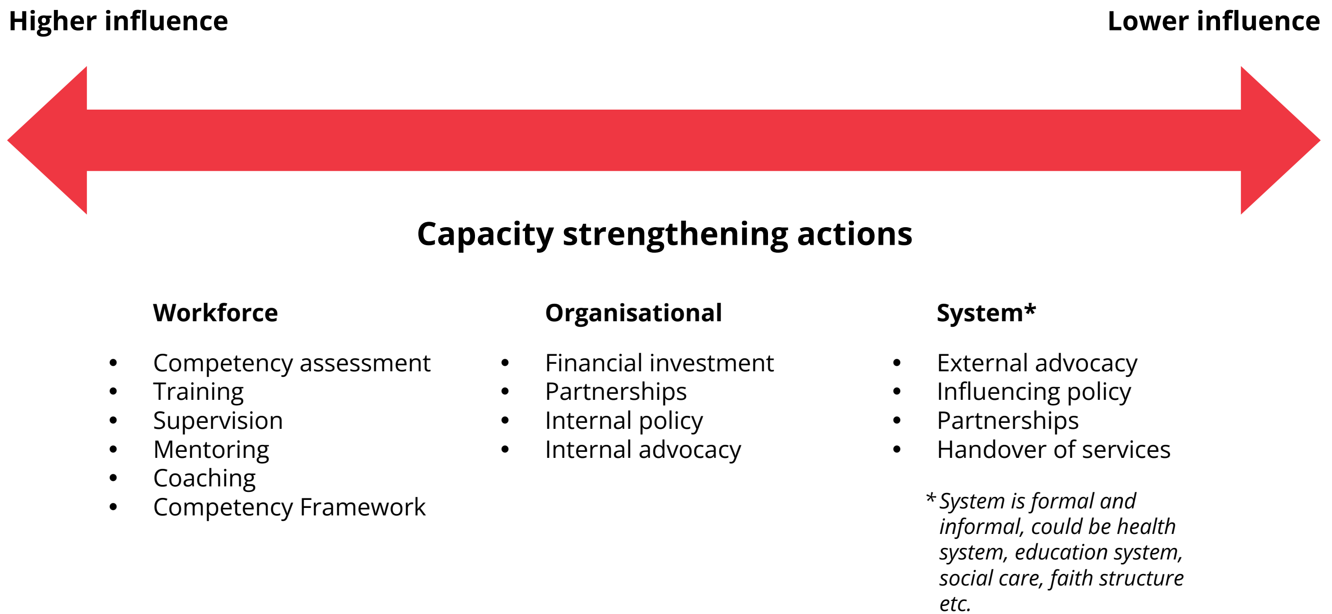

Figure 9: Continuum of influence on MHPSS capacity

All those engaged in MHPSS capacity strengthening must be able to speak on why MHPSS capacity strengthening matters, what it contributes to, and how it influences the organisation's ability to deliver safe, effective and sustainable MHPSS services.

To successfully influence across the Framework, the following can be considered:

1. **Define the issue to be addressed** and based on it, define the advocacy goal: Clarify the specific change that needs to be achieved. For example, increasing organisational investment in MHPSS capacity strengthening, improving standards, or including supervision in all capacity strengthening initiatives.
2. **Identify target audiences:** Consider who needs to be influenced, by assessing who has the ability and opportunity to make the needed change happen.
3. **Develop clear advocacy messages**, which are concise and compelling messages, describing the issue, using evidence, explaining why it matters, highlighting the benefits of action, and offering a clear ask.
4. **Select advocacy channels and tactics:** Choose the most effective ways to reach each specific audience, such as: meetings and briefings, presentations, policy briefs, internal newsletters, coordination platforms, informal conversations, workshops or roundtables.

Tips for advocacy efforts for the different dimensions of the Framework

Workforce

Audience:
Peers from MHPSS and other sectors, management, community.

Using non-MHPSS language be ready to explain:

- How a particular capacity strengthening initiative responds to a specific challenge you face in your daily work
- Why training alone is not sufficient to deliver MHPSS safely
- What additional support is needed (e.g. supervision, mentoring, practice opportunities)
- What skill development is relevant for current work tasks, i.e. connecting learning to specific MHPSS need of the population affected
- How capacity strengthening makes MHPSS work more efficient and is aligned with Red Cross and Red Crescent (or other organisation's) principles

Use evidence to support your message:

- Providers often do not feel confident applying skills after training alone
- Gaps remain in assessment, confidentiality, and risk management without follow-up support

Example:
"We have received training, but without supervision, it is difficult to apply the skills safely, especially in complex cases. We don't know how to approach children who have experienced extreme hardships."

Organisational

Audience:
Management, partners, peers from other sectors, donors.

In practice, be ready to:

- Link capacity strengthening activities to:
    - MHPSS needs of the population
    - service quality and safety
    - operational and/or reputational risks if not addressed
    - **staff and volunteer wellbeing**, including risks of **burnout**, retention rates etc.
- Show how it supports:
    - organisational strategy and mandate
    - accountability, efficiency and sustainability
- Provide regular, short, leadership briefings (not one-off advocacy)

Use evidence to support your message:

- Capacity strengthening fails when organisational support, supervision, and leadership are missing
- High staff turnover and lack of support lead to loss of knowledge and reduced service quality

Example:
"Without structured supervision and organisational support, staff are managing complex cases alone, which affects service quality and increases burnout and turnover."

System

Audience:
System-level stakeholders (e.g. ministries), movement partners, donors.

In practice, be ready to:

- Show existing capacity and gaps in the system
- Highlight whether training and supervision structures are available and accessible and how they relate to quality and do-no-harm provision of MHPSS services
- Advocate for:
  - long-term investment (not ad hoc training)
  - integration into existing systems
  - standards, processes of quality assurance, i.e. supervision, and coordination mechanisms

Use evidence to support your message:

- Individual capacity is insufficient without enabling organisational and policy environments
- Fragmented systems, weak supervision, and lack of policy buy-in are major barriers to sustainable and safe MHPSS services

Example:
“There are limited opportunities for structured supervision and competency development. Without long-term investment, services will remain inconsistent and difficult to scale safely.”

Sample evidence-informed[12] and usable advocacy messages for MHPSS capacity strengthening

- Training alone does not change practice — people need practice, reflection, mentoring, and supervision.
- Providers need time and space to practice and apply skills safely.
- Capacity strengthening requires continuous learning, not one-off activities.
- Without organizational prioritization and support, capacity strengthening cannot be sustained.
- MHPSS capacity strengthening is essential, not optional—it directly affects service quality, safety, and provider wellbeing.
- Capacity strengthening requires systems and processes, not isolated training events.
- Human resources, organisational development, volunteer engagement, community engagement, accountability, monitoring and evaluation must be involved to embed MHPSS capacity strengthening in the organisation.
- Lack of investment in MHPSS capacity strengthening leads to burnout, turnover, and loss of institutional knowledge.
- Capacity strengthening is a shared responsibility across providers, managers, and the organisation.
- Staff and volunteers can only deliver quality services when they feel supported, safe, and heard.
- Capacity strengthening cannot be added on top of already overloaded workloads.
- Capacity strengthening efforts fail when staff are overstretched or unsupported.
- Capacity strengthening is one part of a broader system of care for staff and volunteers.
- Regular feedback and safe learning environments are essential to identify and address gaps. Without feedback mechanisms, learning needs remain hidden.
- MHPSS capacity strengthening cannot replace a system of care for staff and volunteers; it is only one part of it.
- MHPSS needs evolve — providers must continuously adapt their skills and approaches.
- Supervision is critical for quality and for preventing harm.
- Strong systems are needed — individual skills alone are not enough.
- The more specialised the MHPSS service (psychological support and specialised mental health care levels of MHPSS Framework) the greater the time and resources required to build and sustain workforce capacity.

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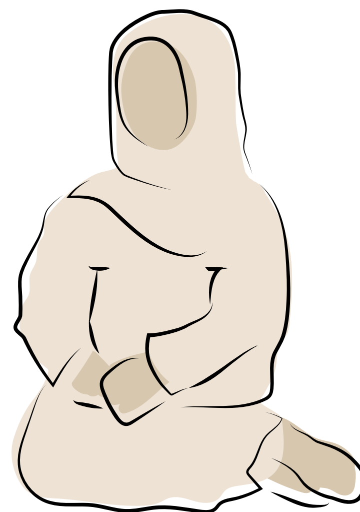
12 See the References on page 32 for list of research papers and sector guidance that informed the development of these sample advocacy messages. These messages were also informed by the literature review included on pages 5 to 6.

Stories of capacity strengthening

Malika

THE PROBLEM - New MHPSS needs, but limited skills and knowledge amongst providers

Malika is a psychologist working within public social services. When her organisation is commissioned by the government to support women and children returning from a warzone, the work feels heavy. The cases arrive quickly. They are unlike anything she has handled before. Children startle at small sounds. Adolescents are carrying anger and silence in equal measures. Caregivers speak cautiously, eyes scanning the room. Stories are partial, broken, sometimes absent altogether.



She studied psychology at university, passed her exams, and worked with families before. But this work feels different. Heavier. Riskier. During the first months, she often leaves sessions wondering if she had said too much—or not enough. She is worried about raising painful memories and emotions without knowing whether she can adequately support people through them. She knows theory but is unsure if what she is doing is right...

THE ACTIONS

Her organisation seemed to recognise the unease Malika was feeling. Rather than pushing staff to "get on with it," they welcomed an experienced MHPSS partner to work alongside them. They began with a question: "What does your work actually look like on a difficult day?". The approach was not speed, but safety. Not just giving tools or training alone but building expert judgment.

The initial training course lasted a week. It was practical, grounded, and sometimes uncomfortable. They role-played real cases, practiced stabilization and grounding, and talked about stigma, fear, and ethical boundaries. They were mapping stressors, family roles, and ongoing pressures alongside past experiences. They talked about follow-up as essential, not optional. One of the trainers said something that Malika wrote down and circled: "Competence grows in layers—skills, reflection, and support."

THE OUTCOME

Back at work, Malika changes how she structured sessions. She focuses on stabilization and building a sense of safety and trust, while progressively strengthening her assessment of each situation. Over time, she develops a clearer understanding of each person's experiences, allowing her to build simple case formulations and think more intentionally about next steps. Her sessions become more structured, moving between listening, assessment, and making sense of what she hears, and gradually shaping a support plan adapted to each family. She returns to the same families consistently. She uses a shared monitoring tool—brief, translated, familiar—not to prove progress, but to notice it. Follow-up becomes steadier. So does she.

Supervision makes the biggest difference. Every second Tuesday, Malika joins a small group of colleagues. The sessions were no longer improvised or dependent on goodwill; supervision had become a standard part of organisational practice. Time was protected. Attendance expected. Colleagues joined from different regions, sharing stories that sounded surprisingly familiar. Though their contexts varied, they used the same approaches, the same outcome tools—translated and tested in the local language. These tools were not used to measure performance, but to notice change. "Bring the case as it is," their supervisor often said, "Especially the parts that worry you."

Colleagues from different offices speak with a shared clinical language now. They use the same approaches, refining them together through peer exchange. Uncertainty is placed on the table and examined, not hidden.

Later came advanced training in a trauma-focused method. The MHPSS partner was careful. “This is not for every case,” the trainer said. “And never without supervision.” Malika assesses her readiness slowly. She discusses each step in supervision. The method became part of her work—not a solution, but one option among many, held carefully within relationship and follow-up.

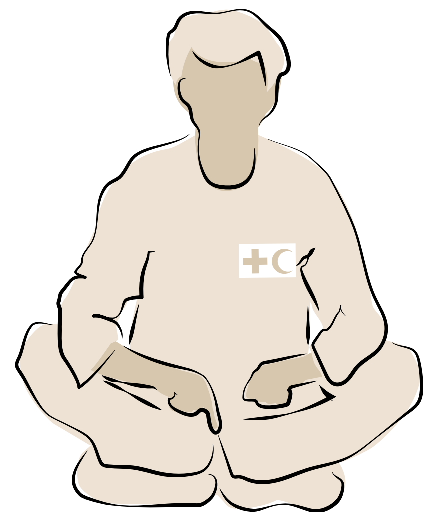
THE IMPACT
Beyond her office, Malika has noticed yet another change. Practices that had grown out of trainings and supervision sessions—case discussions, ethical safeguards, supervision standards—were being discussed beyond the organisation. Government counterparts were listening. Guidelines were drafted. Supervision and structured case discussions were written into official procedures, informed by what practitioners like Malika had learned through practice. Their MHPSS partner has been working closely with the government to accompany the system-level change.

The government remained engaged, listening as practitioners described what the work required. Supervision and case discussions were written into formal procedures. Referral pathways were reviewed, strengthened where possible. Responsibility began to be shared.

One late afternoon, Malika closed a folder after a long-term follow-up. The changes were quiet, but real. The fear that once sat in her chest had not disappeared—but it no longer ruled her work. She thought of the training room, the supervision circle, the organisational care system around her, and the fact that the way she worked was now recognised beyond her office walls.

Ari

THE PROBLEM - MHPSS capacity exists, high needs, signs of burnout
At first, Ari, the MHPSS focal point, tells himself the exhaustion will pass. The organisation continues to grow faster than anyone could plan for. It is only the second year of work in an armed conflict. Needs expand almost overnight, grow more complex, and the response expands with them. New volunteers arrive. Staff numbers increase quickly. Services multiply—outreach teams, group activities, helplines, safe spaces—each addition necessary, each one stretching the team further.



Capacity exists at the workforce level. Commitment is there too. But burnout builds quietly. Volunteers come but leave fast . Staff apologise for being tired, for struggling, for needing rest. Some quit without announcement, and the knowledge leaves with them. The ones who stay are less present, less engaged.

Working hours stretch far beyond what was once acceptable. Mornings slide into late evenings, and days off become flexible rather than protected. Messages move through too many channels at once. Decisions are made informally. Roles blur. Responsibility settles quietly on the same people again and again.

THE ACTIONS
The organisation responds as it knows how. Trainings are organised—many of them. Introductory sessions for new volunteers. Refreshers for staff. Specialised workshops layered on top of already full schedules. People attend between shifts, sometimes after long working days. Knowledge accumulates, but it does not change practice, nor does it bring order. Ari notices it after yet another training. People know more, but the feedback gathered shows slight drops in satisfaction of support received.

Someone says, half joking, half serious, “I have more certificates than energy.” Decisions return to familiar language: more skills, more training. Ari feels the mismatch. The teams are not unskilled. They are overstretched, under-supported, and holding too much. He says it once, carefully: “I don’t think more training is what’s missing here. We need to change the approach—to remove the pressure, not add more.”

Team support meetings are introduced both for staff and volunteers—not as occasional support, but as a protected time within working hours. At first, it feels uncomfortable to pause while needs remain urgent. Someone mutters, “We don’t have time for this.”

Yet the space begins to change how people carry the work. Difficult situations are examined together. Uncertainty is allowed. Emotional weight is shared instead of absorbed silently. People begin to realise they are not failing individually; they are operating inside an overloaded system.

Alongside team support, the organisation looks at workload honestly for the first time. Long working hours are named rather than normalised. Workloads are adjusted. Rotations are introduced. Roles are clarified so responsibility no longer expands by default. During one supervision session, someone says quietly, “I thought I was the only one falling behind.”

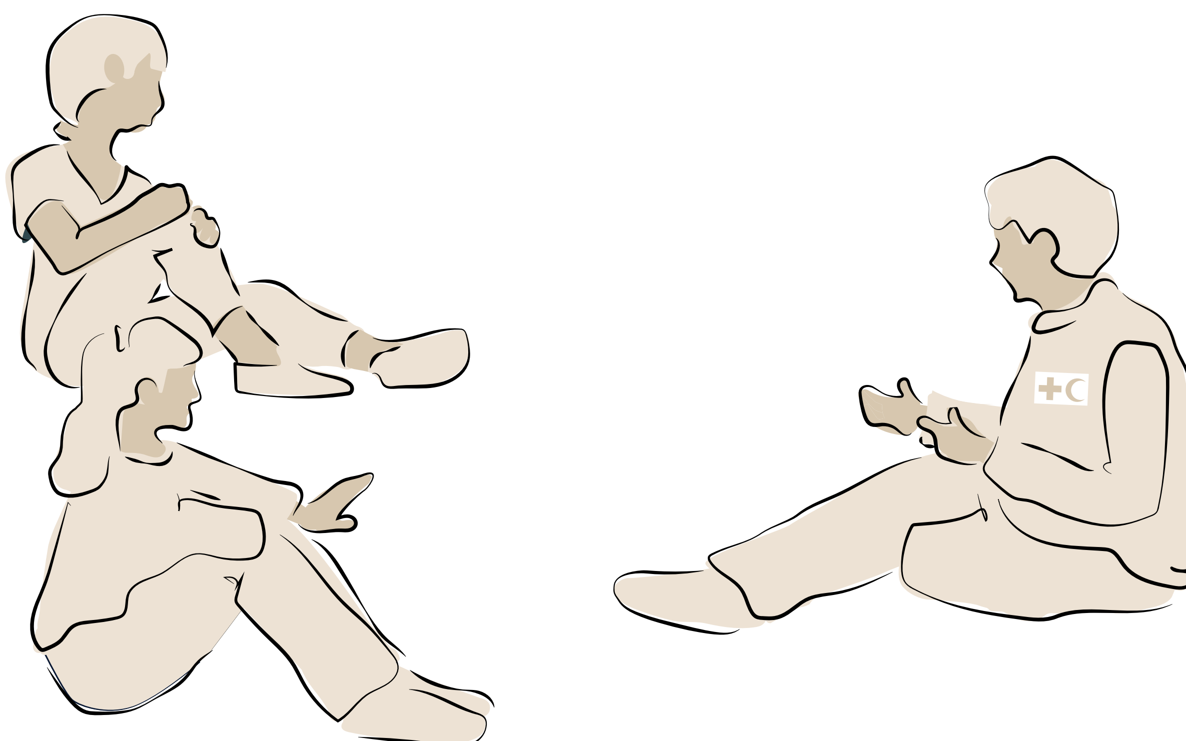
Information becomes easier to follow. Fewer channels. Clear routines. Teams begin to understand who holds what and when to stop.

THE OUTCOME
The armed conflict does not ease. Needs remain overwhelming. People are still tired. But the chaos loosens.

Volunteers begin staying longer. Staff stop proving commitment through exhaustion. Peer support emerges naturally, because there is space for it. Caring for staff and volunteers becomes part of how the organisation functions, not something added once people are already breaking.

Late one evening, reviewing schedules and supervision plans, Ari pauses. Someone says earlier that day, almost with surprise, “This feels possible now.”

Capacity, he realises, was never about how much people are trained. It was about creating conditions where people could be well enough for the work to remain ethical. That understanding settles. And for the first time since the scale up began, the work feels more sustainable.



Suggested Tools

This section includes a selection of tools that can support MHPSS capacity strengthening across workforce (W), organisational (O), and system (S) levels. The tools included are NOT exhaustive and are intended to serve as practical examples rather than prescriptive requirements. Selection and use of tools should be guided by clearly defined capacity-strengthening goals, the phase of the MHPSS response, and the specific context and settings of MHPSS programming. Adapting and combining the tools based on pre-existing capacities, resources, to ensure relevant application is encouraged.

Tool	W	O	S
IFRC Monitoring and evaluation framework for psychosocial support interventions – Toolbox for program management, supervision, caring for volunteers, quality assurance, training reporting	✓	✓	✓
Integrated Model of Supervision for supervision tools	✓	✓	
MHPSS in emergencies: Monitoring and evaluation tools for the RCRC Movement for theory of change, indicators, sample activities related to National Society capacity strengthening in emergencies	✓	✓	
WHO–UNICEF EQUIP (Ensuring Quality in Psychological Support) for competency assessment	✓		
Foundational helping skills training manual: a competency-based approach for training helpers to support adults for designing competency-based training for foundational helping skills	✓		
MHPSS Minimum Service Package (MSP) for minimum workforce capacities and training needs assessments, for cultural adaptation Downloadable Resources - MHPSS MSP	✓	✓	
IMS Advocacy Package - The Integrated Model for Supervision for advocating for supervision		✓	
IMC MHPSS Capacities and Needs Assessments https://www.mhinnovation.net/collaborations/toolkit-integration-mental-health-general-healthcare-humanitarian-settings/mhpss-0 for workforce capacity needs assessments	✓		
IMC Guidelines for Remote MHPSS Programming – Step 1: Anticipate, Assess and Plan. for planning blended approaches in remote settings https://internationalmedicalcorps.org/remotemhpssguidelines/step1/		✓	

IASC Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings: With means of verification (Version 2.0) | IASC for MHPSS programming, can be applied for cultural adaptation		✓	
Organisational capacity assessment, MHPSS Hub	✓	✓	
mhGAP Operations Manual for situational analysis, integration in health	✓	✓	✓
Psychological interventions implementation manual: integrating evidence-based psychological interventions into existing services for cultural and contextual adaptation, selecting, training, supervising MHPSS providers	✓	✓	✓
MHPSS in emergencies: Monitoring and evaluation tools for the RCRC Movement for theory of change, indicators, sample activities related to RCRC National Society capacity strengthening in emergencies		✓	
IASC Handbook, Mental Health and Psychosocial Support Coordination.pdf (Core Action 4BUILDING CAPACITY, KNOWLEDGE EXCHANGE AND PEER SUPPORT)		✓	✓
Caring for Volunteers: A Psychosocial Support Toolkit for strengthening volunteer support and supporting their well-being in crisis situations.	✓	✓	✓

Definition of terms

These key terms are not aimed at setting definitions for the MHPSS sector or RCRC Movement but to ensure that key aspects of the Framework are understood by users. MHPSS terms and definitions can be organisationally specific and are prone to disagreement.

Capacity strengthening: a deliberate, systematic process of developing and enhancing the skills, knowledge, systems, resources, and leadership of individuals, teams, organisations, or communities so they can perform effectively, adapt, and sustain results over time. The term 'capacity strengthening' is preferred over 'capacity building' as it better reflects that capacity already exists within individuals, teams, organisations, and communities.

MHPSS capacity strengthening is the process of rebuilding and improving mental health systems, including after emergencies, by developing sustainable workforce competencies across sectors, integrating MHPSS services, reforming policies and governance structures, and establishing coordinated, long-term mechanisms that ensure accessible, rights-based mental health and psychosocial support for affected populations in public health, social protection, civil protection and education.

RCRC MHPSS Framework: The RCRC MHPSS Framework is organised as a four-layer pyramid (shown in Figure 6) representing complementary layers of mental health and psychosocial support. At the base, Basic psychosocial support activities target the entire population to promote resilience and awareness of common psychological consequences of emergencies and violence and of available services. Focused psychosocial support provides more targeted interventions for at-risk individuals and groups through structured activities, peer support, and group work. Psychological support addresses individuals experiencing more severe psychological distress through individualised counselling and therapeutic group interventions. At the top, Specialised mental health care delivers advanced psychological and psychiatric services for those with chronic mental health conditions or severe, persistent distress that significantly impairs daily functioning. This multi-layered approach ensures that different levels of need are met through appropriate interventions, with referral pathways connecting the layers to provide comprehensive care across all contexts where the RCRC Movement operates. The level of formal training, supervision, skills, and competencies of MHPSS providers increases at higher layers of the Framework.

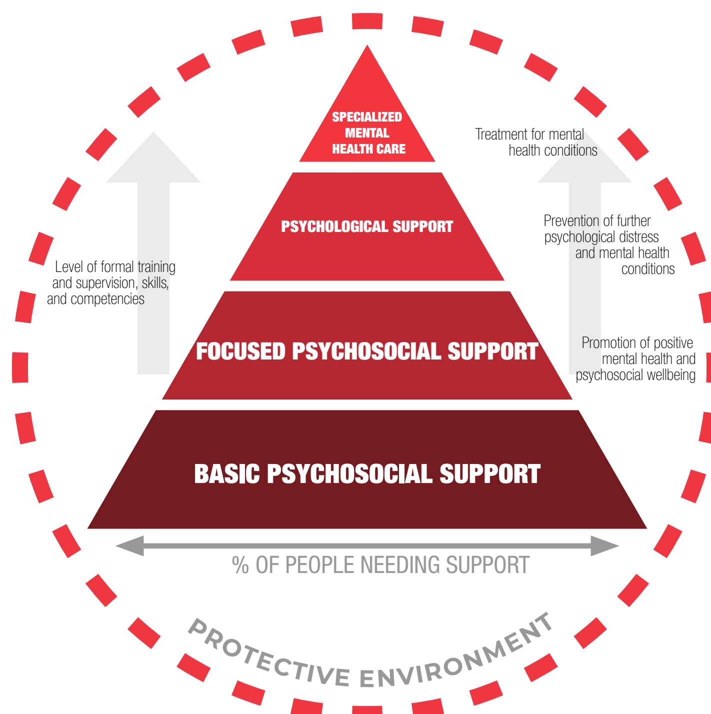


Figure 10: The Red Cross and Red Crescent Movement MHPSS Framework

Workforce level

Blended learning: an educational approach that combines traditional face-to-face learning (such as in-person classes, discussions, or workshops) with digital or online learning (such as e-modules, videos, virtual activities, or self-paced tasks).

Burnout: an emotional state due to long-term stress, characterized by chronic emotional exhaustion, depleted energy, impaired enthusiasm, and motivation to work, diminished work efficiency, a diminished sense of personal accomplishment, pessimism, and cynicism.

Coaching: a structured, collaborative process that supports individuals or teams to improve performance, effectiveness, and well-being by strengthening self-awareness, building skills, and enabling people to find their own solutions to challenges.

Competency: the observable skills and knowledge MHPSS practitioners apply through their work.

Cultural adaptation: the process of modifying MHPSS interventions so that they are aligned with the cultural values, beliefs, norms, languages, and lived experiences of the individuals and communities being supported. Its aim is to ensure that interventions are relevant, acceptable, safe, and effective within a specific cultural context.

Feedback: a structured process through which MHPSS practitioners receive and exchange observations and reflections on their work with supervisors or peers. It supports learning, ethical decision-making, and safety by helping to reflect on strengths, challenges, and areas for improvement. Effective feedback is timely, non-judgmental, and grounded in do-no-harm and quality care standards.

Just-in-time learning: a training approach where people access the information or skill they need at the moment they need it, rather than learning everything in advance.

Learning pathway: a structured, progressive sequence of learning experiences that supports individuals to develop specific competencies over time, moving from foundational knowledge and skills to more advanced practice, with opportunities for reflection, supervision, and application.

Mentoring: a developmental relationship in which a more experienced or knowledgeable person (the mentor) supports, guides, and advises a less experienced person (the mentee) to help them grow professionally, academically, or personally. Mentoring can be formal (structured programs with defined goals) or informal (naturally emerging relationships), and it is usually focused on long-term growth rather than short-term task completion.

MHPSS providers: people, staff or volunteers, who deliver MHPSS services and activities.

Non-specialised providers: staff or volunteers without formal mental health qualifications who have received training, are supervised, and are engaged in the delivery of MHPSS services (including identification and referral), however they do not deliver clinical care.

Specialised providers: professionals with formal mental health training who provide clinical assessment and treatment, including psychological and psychiatric interventions and, where relevant, medication management.

Peer learning: a process in which MHPSS practitioners with similar roles learn from each other through shared reflection on practice, case discussions, and collective problem-solving. It complements but does not replace supervision.

Peer support: an intentional process in which staff or volunteers in similar roles support one another through shared reflection, mutual encouragement, and practical problem-solving related to their work. It provides psychologically safe spaces to normalise stress reactions, reduce isolation, and identify early signs of overload.

Reflective practice: refers to the deliberate process of examining and learning from one's actions and experiences in order to improve practice, adapt to context, and uphold ethical and safe MHPSS delivery.

Staff and volunteer wellbeing: refers to the overall physical, mental, emotional, and social health of individuals engaged in an organisation's work, and the degree to which the working environment enables them to feel safe, supported, valued, and able to perform effectively and sustainably.

Supportive supervision: a safe, supportive, confidential, and collaborative relationship between a supervisor and supervisee, and/or supervisees in which supervisees can voice their difficulties, discuss challenges, and be recognised for their successes, receive constructive feedback and emotional support, build their technical skills and capacity, and enhance quality of service provision. Supportive supervision is a cross-cutting set of principles that can be applied to various types of supervision used in MHPSS work across sectors, such as clinical and technical approaches.

Training of trainers (ToT): training conducted with individuals who already have strong, hands-on experience in the practice to enable them to train others.

Training: a planned process to modify attitudes, knowledge, skills/ behaviour through a learning experience, in order to achieve effective performance in specific activities or roles. Trainings have clearly defined learning objectives and a minimum duration of six hours.

Workshop: a structured, interactive learning session with a clear learning objective/s that focuses on building skills, or solving problems related to MHPSS practice.

Organisational level

Competency framework[13]: a document that defines the skills, knowledge, behaviours, and attributes required for people to perform effectively in specific roles.

Individual capacity assessment: a process used to identify the specific skills, knowledge, competencies, and support needs of a particular staff member or practitioner, so that tailored capacity-strengthening or professional development plans can be designed.

Institutional or organisational capacity: refers to the systems, structures, policies, resources, and competencies that allow an organisation or institution to function effectively, make decisions, deliver services, and sustain its work in the long term.

Knowledge institutionalisation: refers to the process of embedding knowledge within an organisation.

Organisational capacity assessment: a process used to evaluate an organisation's systems, structures, resources, competencies, and overall ability to plan, deliver, monitor, and sustain its programmes or services. It identifies existing strengths and gaps across key organisational functions to inform capacity-strengthening, strategic planning, and organisational development.

System level

System strengthening: the process of improving the structures, policies, coordination mechanisms, human resources, tools, and processes within a broader service system—such as health, education, protection, or MHPSS—so that it can deliver more effective, equitable, sustainable, and high-quality services.

Formal systems: the structured, organised, and officially recognised institutions, services, and mechanisms—often governmental or professionally regulated—that provide support, services, governance, and accountability within a society.

Informal systems: the community-based, non-institutional networks and support structures that operate outside of official or government-regulated services. They are typically based on social relationships, cultural norms, traditions, and community practices, and often serve as the first source of support for individuals and families.

Task-sharing: an approach that delegates clearly defined tasks to people with less specialised training (e.g., mhGAP for primary health care providers, lay counselling for community-based PSS volunteers), while mental health specialists retain responsibility for supervision, quality assurance, and the management of complex cases.

13 For example: IFRC Competency Framework for Mental Health and Psychosocial Support (MHPSS) Personnel in Emergencies - MHPSS Hub

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