STANDARD OPERATING PROCEDURE (SOP)

for Mental Health & Psychosocial Support (MHPSS) Call Center

USAID
আমেরিকার জনগণের পক্ষ থেকে

স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়

NCDC

JOHNS HOPKINS
Center for Communication Programs

Breakthrough ACTION
FOR SOCIAL & BEHAVIOR CHANGE

Acknowledgement

We are overwhelmed, humbled and sincerely grateful in acknowledging all those who have helped us to put these ideas, well above the level of simplicity, into something concrete.

We would like to express our special gratitude to Mr. Professor Dr. Md. Robed Amin (Line Director, NCDC, Directerorate General of Health Services) for his moral support. Along with his guidance and advice, we would like to recognize and express gratefulness to other honorable NCDC personnel, Mr. Maruf Ahmed Khan (Deputy Program Manager) and Dr. Shahnewaz Parvez (Deputy Program Manager).

Expressing our thankfulness to Dr. Syed Mahfuzul Haq (NPO, WHO-BAN), Ms. Hasina Momotaz (National Consultant, Mental Health, WHO-BAN), Dr. Moyenul Hoque Khan (Assistant Director, Admin, HRM, Directerorate General of Health Services), Dr. Arafat Rahman (Deputy Program Manager, Planning, Directerorate General of Health Services) and Dr. Hasan Alif (Deputy Program Manager, Hospital Service Management, Directerorate General of Health Services).

We are extending our acknowledgements and show of appreciation to the persons who have contributed to developing this Standard Procedure paper, providing numerous advices and technical support focusing on several aspects. Dr. Mohammad Adnan Khan (Assistant Chief- Medical, MIS, Directerorate General of Health Services), Dr. Helal Uddin Ahmed, Associate Professor Child Adolescent & Family Psychiatry (National Institute of Mental Health), Dr. Jhunu Shamsun Nahar (Professor, Department of Psychiatry, BSMMU), Dr. Kamrun Nahar Koly (Assistant Scientist, Health System and Population Studies, ICDDR,B) were the core individuals who helped to elaborate the importance of the issue in the view of medical expertise.

Our deepest gratitude goes to Ms. Mosammat Nazma Khatun (Associate Professor & Chairperson, Clinical Psychiatry, Dhaka University) and Dr. Mahjabeen Haque (Professor & Chairperson, Department of Education & Counseling Psychology, Dhaka University) for their academic and practical feedback.

Lastly, we would like to express our honor and indebtedness to the persons who made it all possible and without whose help and guidance this idea would not have furnished as it has now, Ms. Liza Talukdar (Project Management Specialist, USAID Bangladesh) and Dr. Kazi Faisal Mahmud (Chief of Party and SBCC Advisor, JHUCCP).

We had received many other humble and potential helps from a number of wonderful people whose names we have not been able to mention here but please receive our warm appreciation and acknowledgement.

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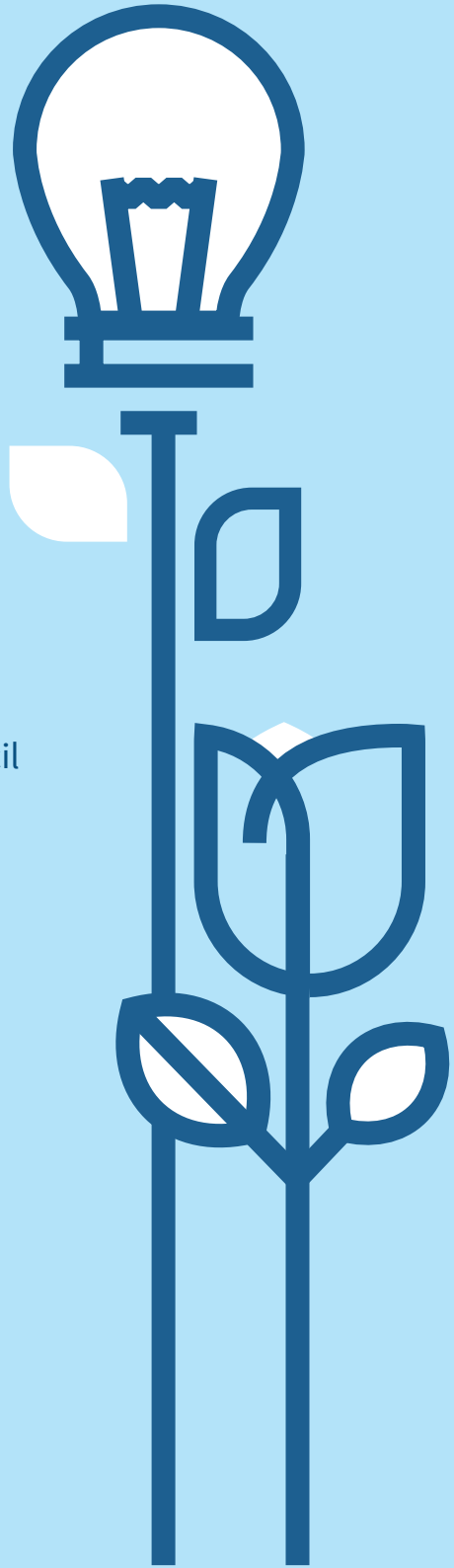
List of Abbreviations

a2i	Access to Information Programme
BMDC	Bangladesh Medical and Dental Council
COVID-19	Coronavirus Disease-19
DGHS	Directorate General of Health Services
MHPSS	Mental Health & Psychosocial Support
MoWCA	Ministry of Women & Children Affaires
NCDC	Non-Communicable Disease Control
NIMH	National Institute of Mental Health
SOP	Standard Operating Procedure



Background

COVID-19 pandemic has different effects on health, education, economic situation in the whole world. Bangladesh is also facing similar challenges as well as the anxiety, fear, stress etc. makes the situation more complex. Health workers, who support active management of COVID-19, patients as well as involved in prevention the spread of the disease, are also facing tremendous psychological trauma. Under this circumstance to have a uniform support mechanism for the Mental Health & Psychosocial Support (MHPSS) call service providers (help line, call centers, telepsychology centers), this Standard Operating Procedure (SOP) will be instrumental.

The draft SOP penned here will provide a skeleton for all the stakeholders'[1], consideration and validation upon agreement.[2] The objective of the validated SOP is to have a standardized service mechanism / protocol for MHPSS call center support providers throughout the country.

Existing helplines providing services are below:

16263 (Health Call Center, DGHS) or 333 (Services at doorstep, an a2i implemented call center), or 10921 (MoWCA established National Helpline Center for violence against women and children). Existing call center of NIMH has limited service (9am-1pm on working days) linked with 94 district hospital and Upazilla health complexes through the health service providers for the patients who visits these hospitals not accessible to the public.

Target audience for the SOP are –

- Trained Volunteers (Para Counsellors)
- Assistant Psychologists (Clinical, Counseling, Education)
- Psychologists
- Final year MD Psychiatry Students
- Psychiatrist

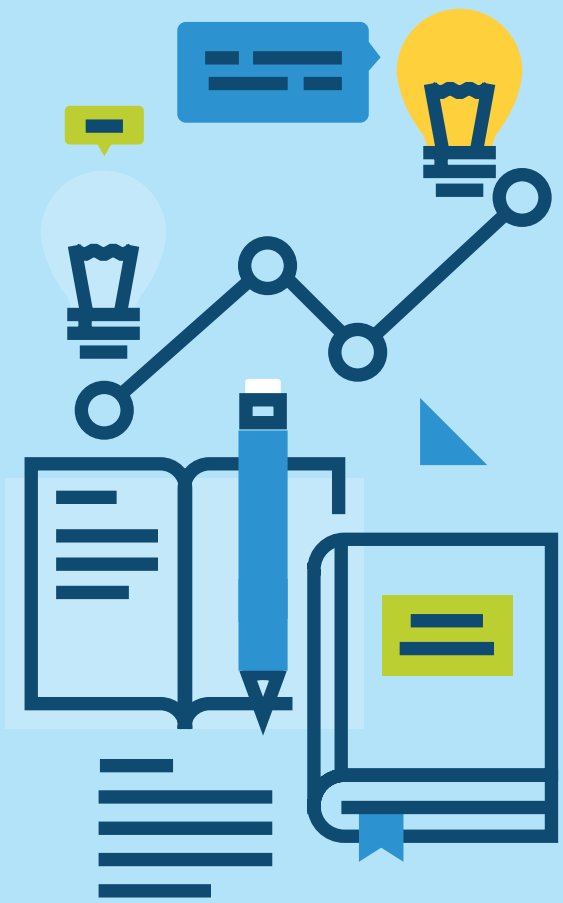
Overall Implementation Guideline

On a mental health and psychological support service center/facility, management should consider the following steps while – planning, implementing and monitoring the services.

PLANNING AND LOGISTICS:

While implementing a mental health and psychological support call center leadership/ program management should consider the following:

1. Ensure supportive logistic arrangements – i.e. dedicated phone lines, comfortable sitting arrangements, maintaining confidentiality etc
2. Ensure availability of all record keeping documents/devices and maintain confidentiality and security of the documents and devices
3. Identify a supportive supervision mechanism that will oversee integration efforts and develop a workplan for planning and oversight of integration efforts
4. Carry out training and orientation for the service providers including sharing the objective and scope of service providers
5. Develop referral network / mechanism
6. Develop mechanism for capturing and integrating data
7. Develop a mechanism for monitoring and evaluation as well as quality assurance.



IMPLEMENTATION

Program managers need to ensure the following services and support mechanism:

1. Ensure supportive supervision on a regular basis
2. Develop mechanism to ensure effective referral mechanism on a regular basis
3. Organize and ensure availability of updated job aids
4. Maintain quality and ensure that first responders are efficiently referring to the relevant responders to ensure proper services and management.

MONITORING AND EVALUATION

1. Routinely monitor and validate the accuracy of data collection
2. Ensure reporting forms are maintained in accurate manner and utilized for improving the services
3. Implement specific quality improvement mechanisms through identifying the gaps and equipping with most recent information /service mechanism.

MHPSS Call Center checklist: A living document Guideline

The following checklist will be maintained by different level of professionals and this checklist will be revisited at least once a year as well as as and when necessary and will be considered as a living document.

The resource person at every level (low risk, moderate risk, high risk & severe risk) must follow clinical supervision, ethical, legal and emergency (concerning ambulance, law enforcement and local administrative authority) protocols. If existing helpline (16263, 333 and /or 10921) have these protocols prepared. Coordinated approach for the operation of the helpline among all the stakeholders (call center, ambulance service, law enforcement agency and local administrative authority) to be designed for this initiative.

Risk Declaration Checklist Presenting Features / Symptoms	Resource Person	Description of Risk Level	Resource Person	Checklist (standard tools' questionnaires and other instruments for clinical supervision & M&E to be finalized as mentioned in page 5)	MHPSS Action/ Response	Additional Action to Consider
To identify caller's risk level	**To identify caller's risk level**		**To provide consultation**			
• Stable and at low risk of harm in waiting period • No agitation or restlessness • Cooperative • Gives coherent history • Symptoms of mild to moderate depression, anxiety, adjustment, behavioral or developmental disorder • Early cognitive changes in older person	**First responders:** Trained Volunteers (Para Counsellors)	**Low risk:** Caller is in need of intervention due to subjective distress and/or mild level of dysfunctional or difficulty in coping with current stressors.	**2nd Responders:** Assistant Psychologists (Clinical, Counseling, Education)	• Risk declaration checklist • Clinical supervision checklist • M&E checklist for service providers (already developed) • Caller satisfaction checklist • Data recording checklist • Referral indicators	• Identify caller risk level (by 1st responder) • Provide consultation, advice and/ or brief counseling if required and/or mental health service to collect further information	• Facilitate appointment with Professionals • Follow-up phone contact as deemed necessary • Referral to Professionals as per referral indicators

Risk Declaration Checklist Presenting Feature / Symptoms	Resource Person	Description of Risk Level	Resource Person	Checklist (standard tools/ questionnaire to be used)	MHPSS Action/ Response	Additional Action to Consider
To identify caller's risk level	**To identify caller's risk level**		**To provide consultation**			
• Suicidal ideation with no plan and/or history of suicidal ideation • Rapidly increasing symptoms of psychosis and/or severe mood disorder • High risk behavior associated with perceptual/thought disturbance, delirium, dementia, or impaired impulse control • Unable to care for self or dependents or perform activities of daily living • Known caller requiring intervention to prevent or contain relapse • Significant client distress associated with serious mental illness (including mood/anxiety disorder) but not suicidal	**First responders:** Trained Volunteers (Para Counsellors)	**Moderate risk:** Caller is in need of timely intervention due to inability to cope with current stressors. Risk of harm to self or others is not pressing at the time of contact due to the presence of other reliable support or due to lack of plan or intent.	**2nd Responders** (Designated Professionals): • Assistant Psychologists/ • Psychologists (Clinical, Counseling, Education)/ • Final year MD Psychiatry Students/ Psychiatrists	• Risk declaration checklist • Clinical supervision checklist • M&E checklist for service providers (already developed) • Caller satisfaction checklist • Data recording checklist • Referral indicators	• Forward to Designated Professional after identifying caller risk level (by 1st responder) • Designated professional to assess situation to determine immediate risk • In case of immediate risk call National Emergency Service (999) to respond • In case of 'no immediate risk' designated professional provides counseling/ treatment and monitoring of client behaviors • Designated professional devises crisis/ safety plan as part of counseling/ treatment	• Facilitate appointment with Professionals for further follow-ups • Follow-up phone contact as deemed necessary • Referral to Professionals as per referral indicators for continuous support • Recommend Social Work professionals for support
• Violent behavior/extreme agitation • Harmful objects readily available • Self-destructive • Acute suicidal ideations or risk for harming others with a clear plan and means and/or history of self-harm or aggression	**First responders:** Trained Volunteers (Para Counsellors)	**High risk:** • The individual (caller) is in need of immediate intervention due to significant risk to harm self or others. The individual is verbalizing, threatening, suicidal or homicidal thoughts and demonstrating furtherance of such thoughts.	**2nd Responders** (Designated Professionals): • Assistant Psychologists/ • Psychologists (Clinical, Counseling, Education)/ • Final year MD Psychiatry Students/ Psychiatrists	• Risk declaration checklist • Clinical supervision checklist • M&E checklist for service providers (already developed) • Caller satisfaction checklist • Data recording checklist • Referral indicators	• Forward to Designated Professional after identifying caller risk level (by 1st responder) and /or notify ambulance and/or police (999) • Designated Professional to notify ambulance and/or police (999) • In addition, Designated Professional (If needed) to assess situation and conduct a mental health assessment	• Facilitate appointment with Professionals for further follow-ups • Follow-up phone contact • Referral to Professionals as per referral indicators for continuous support • Recommend Social Work Professionals for support

Risk Declaration Checklist Presenting Feature / Symptoms	Resource Person	Description of Risk Level	Resource Person	Checklist (standard tools/ questionnaire to be used)	MHPSS Action/ Response	Additional Action to Consider
To identify caller's risk level	**To identify caller's risk level**		**To provide consultation**			
• Overdose • Possession of a harmful object and/or weapon • Suicide attempt/serious self-harm in progress • Other medical emergencies	**First responders:** Trained Volunteers (Para Counsellors)	**Severe risk:** The individual (caller or may not be the caller) is in need of immediate intervention, police are called to the scene or in route and ambulance service has been requested.	**2nd Responders** (Designated Professionals): • Assistant Psychologists/ • Psychologists (Clinical, Counseling, Education) • Final year MD Psychiatry Students/ Psychiatrists	• Risk declaration checklist • Clinical supervision checklist • M&E checklist for service providers (already developed) • Caller satisfaction checklist • Data recording checklist • Referral indicators	• Forward to Designated Professional after identifying caller risk level (by 1st responder) and /or notify ambulance and/or police (999) • Designated Professional to notify ambulance and/or police (999) • In addition, Designated Professional (If needed) to assess situation and conduct a mental health assessment	• Facilitate appointment with Professionals for further follow-ups • Follow-up phone contact • Referral to Professionals as per referral indicators for continuous support • Recommend Social Work professionals for support

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Level of services

Critical Considerations

While implementing the MHPSS call centers the following aspects must be considered critically and necessary actions should be taken accordingly:

i) Multilevel considerations to be taken in establishing MHPSS call center/helpline, i.e. ethical, legal, resource constraints (specifically dearth of professional and trained personnel) and social implications depending on the depth of services provided linked with urgency/emergency of the caller and the extend of coordination and preparedness of the emergency services providers (ambulance & fire service: 999), law-enforcement agencies and local bureaucratic administration. Gradual progression towards a developing a coordinated service may of be importance to sustain such an initiative in the long run. Number of protocols need to be in place as mentioned in the triage table below.

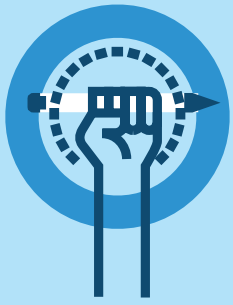
ii) This initiative entails identifying available resource pool. The resource pool will include trained (standardized training to be provided) non-professionals, para counsellors, assistant clinical psychologists, psychologists and psychiatrists. The qualifications and criteria for the personnel recruitment for the resource pool to be as per Bangladesh Rehabilitation Council Act, National Mental Health Strategic Plan 2020 -2030, BMDC criteria, approved criteria developed/used by all the departments of Psychology discipline of Public Universities (considering the private universities as well), Psychiatry Departments of Medical Universities and other affiliated organizations.

iii) Consultative session/s of a multi-stakeholder working group (working group composition should reflect the multi-stakeholder approach: service providers, emergency service providers, law enforcement agencies, local bureaucracy service seeker and funding agencies) is suggested to address input for the SOP in the following basic outline in terms of program and planning detailing at the onset of establishing the call center:

- Listing and development of procedure, protocols and checklist for all the levels of responders
- Development of call process (structure of call)
- Clinical supervision process and guideline
- Multi-inisterial coordination and preparedness for proper functioning of multi-stakeholder approach for the call center
- Monitoring & Evaluation process and guideline
- Service providers (resource person) classifications based on 1st responder and 2nd responder(professionals) and condition of the caller
- Qualifications and competencies of the service providers (resource person)
- Curriculum of such telepsychology: listing of requirement-based training of the service providers[5] ranging from orientation to clinical service including self-care of the responders
- Referral indicators & referral directory: specially for the high and severe risk level specific referral protocol to be in place for medication and follow-ups by the psychiatrists
- Categorization of target population(caller)
- Decision on multidisciplinary tele counseling group composition (i.e. psychiatrist, psychologist (broader term), counselor, Para counselor, volunteer, IT professionals etc.).

Expectations from the MHPSS service providers

1. Operate in line with the National MHPSS guideline to respond to provide telephonic MHPSS services, start with 8 hours services with plan to extend to 24 hours
2. Be staffed with well-trained para-counsellor / assistant psychologist / psychologists / MD psychiatry student/ psychiatrists (as mentioned in the table)/relevant personnel
3. Staffed with clinicians overseeing clinical triage
4. Coordinate with National Emergency Services (i.e. 999)
5. Refer/Connect individuals to facility-based care if required
6. Schedule outpatient appointments if required
7. Incorporate caller ID Functioning and implement GPS-enabling technology if possible, for smooth operation of the call-center
8. Confirmation on Ethical practices by trained professionals
9. Arrangement of Clinical supervision by MH professionals
10. Practice active engagement with callers and make effort to establish sufficient rapport so as to promote the caller's collaboration in securing his/her safety
11. Use the least invasive intervention and consider involuntary emergency intervention as a last resort, except for in circumstances as described below;
12. Initiate life-saving services for attempts in progress in accordance with guideline that do not require the individual's consent to initiate medically necessary rescue services;
13. Initiate active rescue to secure the immediate safety of the individual at risk if the caller remains unwilling and/or unable to take action to prevent his/her suicide and remains at imminent risk;
14. Practice active engagement with persons calling on behalf of someone else (third-party callers) towards determining the least invasive, most collaborative actions to best ensure the safety of the person at risk;
15. Have clinical supervisory staff available during all hour of operations for timely consultation in determining the most appropriate intervention for any individual who may at imminent risk of suicide and
16. Maintain caller ID or other method of identifying the caller's location that is readily accessible to staff.



Capacity Building of Resource Persons

Relevant training protocols and manuals on MHPSS to be developed or revised by NIMH, relevant departments of Dhaka University, Bangabandhu Sheikh Mujib Medical University (BSMMU), JHUCCP and Save the Children experts. This will entail standardization of training for non-professionals and professionals to ensure standardized MHPSS services. Training efficacy to be ensured with hand-on training with option for virtual training and using online resources.

Legal aspects

Necessary agreements with NIMH or the key point of online service providers and DGHS are required for future endeavors for maintaining quality of the MHPSS services. In addition to that official communication with other stakeholders (service providers, emergency service providers, law enforcement agencies, local bureaucracy, telecommunication authority and funding agencies) might be relevant to in relation to this initiative.

Monitoring and Evaluation (M&E) Plan:

The entire activity will be monitored through two ways, namely, process monitoring and outcome monitoring. A list of indicators will be defined for the process monitoring and will be reported periodically. The M&E plan to be developed based on the content of the training program and the process of the call structure designed for the the call center. (Reference M&E Tools to be considered are WHO mhGAP M&E Tool, International Federation of Red Cross & Red Crescent Societies (IFRC), Inter – Agency Standing Committee (IASC)

For the purpose of monitoring, usually few checklists will be developed and will be used. Below can be a possible list of checklists for process monitoring:

- Facility checklist
- Individual checklist: for the service provider and caller
- Documentation checklist
- Follow up to provide feedback: for the service provider and caller
- Learning checklist for the service provider

Notes:

1. The list of stakeholders will be added in Appendix 3.
2. All the stakeholders will convene over a workshop to review the SOP, and the reviewed SOP will be validated over different consultative meeting with all the stakeholders.
3. Resource persons mentioned in this document will provide advice that aligns with the National Mental Health Strategic Plan 2020 -2030, Bangladesh Rehabilitation Council Act, and any other relevant approved documents.
4. Qualifications and other credentials for the resource persons to be listed per the schedule by the respective authorities
5. Consider training on Psychological 1st Aid, Tele-counseling Specific training, mhGAP, CBT (Cognitive Behavioral Therapy) etc.

References

1. https://www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf
2. WHO: mhGAP Humanitarian Intervention Guide
3. Bangladesh Rehabilitation Council Act 2018
4. National Mental Strategic Plan: 2020-2030
5. https://www.apa.org/practice/guidelines/telepsychology

Appendix

Appendix 1

A sub-committee has been formed under the Line Director, Non-communicable Disease Control (NCDC) of Directorate General of Health Services (DGHS) in June 2020, with the focus of directing MHPSS in an intergraded/coordinated manner. This has warranted a critical look at what is available, in reference to MHPSS, in the government, non-government and private sector for the period of the pandemic as one of the necessary agendas for the sub-committee. The National Institute of Mental Health, Bangladesh (NIMH) may be the pivotal force in coordinating the pool of service providers (professionals/non-professionals/organizations through a process of registration and tiered credentialing) under the umbrella of this sub-committee. The sub-committee has agreed in principle to support MHPSS and has initiated a search of resource persons with appropriate qualifications from government and reputed, government-approved institutions/organizations.

Appendix 2

An Example of De-escalation (Sands et al. 2013b)

Telephone-Based De-escalation Approaches for Managing Psychiatric Emergency

- Communication styles
- Adopt a calming, non-threatening tone of voice.
- Listen carefully to the caller
- Communicate respect and empathy for the caller's situation through verbal responses and acknowledgements
- Communicate encouragement to facilitate rapport and engagement, for example, "I know this is hard for you, but you are doing well. Can you tell me a bit more about your mood and your thoughts lately?"
- Use clear and simple language.

- Avoid vague terms and metaphors
- Avoid arguing with and/or challenging the caller unnecessarily
- Use non-judgmental and non-discriminative attitudes and communication
- Show a positive attitude toward the caller's own resources and potentiality

Practical Strategies

- Offer tearful, distressed callers some time to recover. For example, let them know that 'it's ok, take a minute to catch your breath" or "take the time you need, I'm here listening"
- Offer tearful, distressed callers" time", for example," its ok, take a minute to catch your breath", or "take the time you need, I'm here listening"
- Use the caller's (preferred) name with some frequency, this was noted to have a calming effect on the caller
- Rephrase questions that callers do not understand, simplify the expression and content, and only ask one question at a time
- Provide step-by-step guidance to assist the caller to achieve a calmer state, for example, "put the phone down for a minute and go get a glass of water/tissue/ your medication box and come back to the phone" or "let me help you to regain control of your breathing a bit before we go on. Take a few deep breaths"
- Pay attention to caller details such as tone of voice and thought content, form, and flow as key indications of changes in mental state and fluctuating risk level
- Be flexible. Collaborate with the caller as much as possible, and compromise where reasonable. Flexibility of approach was noted to increase caller engagement
- Always assess the potential for community-based assessment and treatment by determining the availability and appropriateness of social support.

Other considerations

- To prevent harm, in some cases it may be necessary to keep the caller on the line while instigating and/or awaiting a police, ambulance or crisis intervention team response
- Involve caregivers/significant others in the crisis planning and care. This may involve maintaining telephone contact and assisting the family to navigate the crisis and keep the person safe until services arrive or arrangements for further assessment and/or treatment are made
- Provide secondary consultation to other healthcare agencies or service providers to assist in safely and effectively managing psychiatric emergencies in the community.

Appendix 3

Contributors to approve SOP:

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