World Health Organization

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Abbreviations

DALYs	Disability-Adjusted Life Years
LMICs	Low-and Middle-Income Countries
IACAPAP	International Association for Child and Adolescent Psychiatry and Allied Professions
NTNU	Norwegian University of Science and Technology
mhGAP	Mental Health Gap Action Programme
mhGAP-IG	Mental Health Gap Action Programme Intervention Guide
MNS	Mental, Neurological and Substance Use
UN	United Nations
WHO	World Health Organization
WONCA	World Organization of Family Doctors
WPA	World Psychiatric Association

Executive summary

The current global mental health burden calls for an expansion of the mental health workforce, including for children and adolescents. The mental health Gap Action Programme Intervention Guide (mhGAP-IG) provides evidence-based guidance and tools for the assessment and integrated management of priority mental, neurological and substance use (MNS) disorders in non-specialized health settings.

This document was designed to inform educators and decision-makers, health and education authorities, professional societies, and students about enhancing the pre-service curriculum with mhGAP-IG materials, which can provide future professionals with the theoretical and clinical knowledge they need. Pre-service education is the learning that takes place in preparation for a future professional role, for example as a medical doctor, nurse or other health worker.

Integration within pre-service training has the potential to serve as a sustainable and cost-effective approach to workforce expansion by providing practical clinical skills to a variety of future professionals, including doctors, nurses, public health professionals, social workers and others, who can all then contribute to the administration of mental health care from their respective professional roles in their communities.

This document advises educators on why the enhancement of curricula with the mhGAP-IG is important and on how to approach implementation. It also provides an opportunity to provide helpful feedback on the use of mhGAP-IG materials in pre-service training.

The document emphasizes that the integration of mhGAP-IG materials within pre-service curricula is not intended to alter these curricula but rather to enhance what is already in place, with each institution approaching the process from an individualized perspective. It includes suggestions for how to integrate the materials, guiding readers through seven potential phases of implementing the mhGAP-IG in pre-service training curricula.

Where possible, educators should consider assessing both the knowledge of and skills in implementing the mhGAP-IG of all students in pre-service training as a requirement for completing their degree.

Introduction

Mental health

Globally, one-quarter of disability-adjusted life years (DALYs) are explained by mental, neurological and substance use (MNS) disorders.[1] Approximately half of all mental disorders emerge before 14 years of age, and 75 % by 25 years of age.[2,3] While scientific knowledge of mental health continues to grow, the world continues to experience a lack of qualified professionals to administer the necessary care. The prevalence of mental disorders shows no signs of diminishing,[4] and interest in mental health and mental health conditions has not been accompanied by an even remotely proportionate documented expansion in mental health services.[5,6]

The current high global demand for health care workers trained in mental health has created an urgent need for an immediate scale-up of academic programmes to qualify professionals to provide high-quality care for MNS disorders across the life course.[6,7]

Expansion of professional care services

Based on the extensive gaps in access to mental health care globally, the need for mental health services cannot and will not be met by specialists alone.[8,9] Therefore, expanding the workforce requires the expansion of training programmes not only in specialist care but also in primary health care, nursing and paediatrics. With the limited number of specialists available, including limited numbers of child and adolescent and old age psychiatry specialists, relative to the high need for their services, there is a clear demand for more trained staff to provide services. To achieve the Sustainable Development Goal (SDG) of ensuring healthy lives and promoting well-being for all at all ages, it is pertinent to equip the workforce with necessary mental health care skills. For this purpose, pre-service training on WHO's mental health Gap Action Programme Intervention Guide (mhGAP-IG) fits in the overall mental health care pathways, serving as a significant tool for training the required non-specialist workforce.

What is the aim of this document?

This document aims to outline principles and approaches for integrating the mhGAP-IG in the context of an academic institution's unique teaching processes for future health professionals.[10] It guides teaching staff, administrators and students through the implementation process and provides step-by-step advice on integration of the mhGAP-IG into pre-service training. It facilitates an approach in which a teaching institution takes ownership of the process and of the strengthened and enhanced curriculum and contributes to a country's overall mental health strategy.

For whom is this document intended?

This document has been prepared first for staff of educational institutions who:

- teach students about mental health, mental well-being and mental disorders and are responsible for teaching content;
- recognize the need to strengthen and enhance mental health teaching in their institution;
- are prepared to invest time and energy to improve the teaching process;
- are ready and willing to use the WHO evidence-based teaching materials available as part of the mhGAP-IG package.[10]

This document also targets the administration and leadership of educational institutions. Their support is very important in advancing the teaching process and enhancing the curriculum with mhGAP. The document is also aimed at current and former students. Students' feedback can and should contribute to improvement of the teaching process.

Finally, the document can be used by national health and educational authorities and by national and international professional societies to help them understand principles, processes and efforts required to strengthen pre-service education using the mhGAP-IG. Closer collaboration between the education and health sectors and professional societies should improve alignment between the education of health professionals and the realities of health service delivery.[11,12]

What are mhGAP and the mhGAP-IG?

The World Health Organization (WHO) is the technical authority for health within the United Nations system. WHO launched its Mental Health Gap Action Programme (mhGAP) in 2008, and the mhGAP Intervention Guide (mhGAP-IG) in 2010.[9,10] The mhGAP-IG provides evidence-based guidance and tools for assessment and integrated management of priority MNS disorders in non-specialized health settings.

The mhGAP-IG is for use by non-specialist doctors, nurses and other health workers, as well as health planners and managers. It presents the integrated management of priority MNS conditions using clinical decision-making algorithms. The current (2016) version of the mhGAP-IG (version 2.0) includes information on essential care and practice, a master chart of common presentations of the priority conditions, and specific modules for depression, psychoses (including bipolar disorder), epilepsy, child and adolescent mental and behavioural disorders, dementia, disorders due to substance and alcohol use, self-harm/suicide and other significant mental health complaints. In addition to being used as a clinical care tool, it has to date been used by ministries, non-governmental organizations (NGOs) and academics for scale-up.[10]

The mhGAP-IG contributes towards achieving the targets of WHO's Comprehensive Mental Health Action Plan 2013–2020, which aims for universal health coverage (UHC) of MNS conditions through the provision of comprehensive, integrated and responsive mental health and social care services in community-based settings.[13]

The first version of the mhGAP-IG (version 1.0), which is available as a book and online, was used in over 100 countries and translated into more than 20 languages.[5] The second version – mhGAP-IG 2.0 – was released in 2016.[10] The mhGAP-IG 2.0 assessment and treatment algorithms are based on the 2015 mhGAP guidelines, which were developed according to WHO's guideline development process; this includes evidence review, synthesis and development of recommendations through the participation of an international panel of individual experts and institutions, including clinicians, researchers, programme managers, policy-makers and service users.[10]

For mhGAP-IG 2.0, WHO has made training manuals available for both the training of trainers and supervisors and the training of health care providers (see *www.who.int/mental_health/mhgap/training_manuals/en/*). The materials are competency-based and address knowledge, attitude and skills. These materials can be adapted for use with instructors and students respectively.

In addition to the mhGAP-IG being available in book format and available for free download online as a PDF (at *www.who.int/mental_health/mhgap/mhGAP_intervention_guide_02/en/*), WHO's mhGAP-IG 2.0 mobile app was launched in 2017. The app, which can be used on a tablet or smartphone, is now available for both iOS and Android free of charge. It provides non-specialized health care providers with access to comprehensive information to help them diagnose and treat a range of MNS disorders, including depression, epilepsy and dementia, via their tablets or mobile phones.

The mhGAP-IG is a model guide, and it is essential that it is adapted to the unique national or local situation. Users may select a subset of the priority conditions or interventions to adapt and implement, depending on the context.[10]

While the first mhGAP-IG was used in over 100 countries, mainly for in-service education, a recent systematic review of the mhGAP-IG highlighted that its implementation in pre-service education remains very limited.[5]

What is pre-service education?

Pre-service education is the learning that takes place in preparation for a future professional role, for example as a medical doctor, nurse or other health worker. This stage of professional education is vitally important as it lays the foundations for motivation to care for people with MNS disorders and seeks to ascertain, through rigorous assessments, that new health workers are competent. Pre-service education takes place in universities, colleges and professional schools (e.g. public health schools, nursing schools, etc.). It aims to provide a broad range of skills, knowledge, experiences and attitudes necessary for the future profession. This is distinct from in-service training, which typically provides brief training during employment. In-service training is expensive and requires staff to be removed from their daily duties.[14,15] All courses for graduates and undergraduates are "pre-service courses" if they provide the competence needed to perform new "services".[16]

Why is the mhGAP-IG important and relevant for pre-service education?

mhGAP-IG pre-service education refers to the introduction of mhGAP-IG materials, concepts and approaches in teaching programmes for health workers before they enter service roles. Good pre-service training is invaluable in inculcating basic professional knowledge and skills.[16] Pre-service training for health workers in many countries tends to focus more on theoretical aspects of psychiatry and severe mental disorders (e.g. schizophrenia), rather than on common mental health problems and disorders (e.g. depressive and anxiety disorders) and practical clinical skills. Quite often, specialized mental health clinics or psychiatric hospitals are used as teaching bases for medical and other students and provide limited training on the competencies needed at the primary care level. The majority of future graduates will be based in communities and not in tertiary centres, so it is imperative to provide suitable education geared towards these community settings.[11,12]

While mhGAP-IG in-service training is important in providing tools and frameworks for professionals in non-specialist health settings to identify and treat mental health conditions, pre-service mhGAP-IG training has additional long-term advantages:

- It benefits people with mental health conditions by introducing future providers, early in their careers, to evidence-based practical clinical tools. New graduates will therefore be better equipped to help people with mental health issues, will feel more confident in assessment and management and will need less time for in-service training.
- It involves a sustainable training model: unlike separate short courses, it is integrated into teaching curricula and does not require additional resources.
- It is likely to be more cost-effective as it reduces the need for relatively costly in-service training.
- It provides a common understanding among different categories of health workers about the assessment and management of mental, neurological and substance use disorders.
- It strengthens health systems in the long term.

Which health professions are most suitable for mhGAP-IG pre-service training?

mhGAP-IG pre-service training can be used in a number of educational settings; for example:

- Using the mhGAP-IG as a guide for students of medicine and nursing during clinical placements;
- Introducing the mhGAP-IG in public/mental health masters programmes.

Examples of mhGAP-IG implementation in pre-service training are provided in Box 1–5.

Box 1

Using the mhGAP-IG to teach medical students and master's-level students in child and adolescent mental health in Nigeria

Professor Olayinka Omigbodun of the Department of Psychiatry, College of Medicine, University of Ibadan and the Centre for Child and Adolescent Mental Health, also at the University of Ibadan, in Nigeria, reported that a new medical school curriculum introduced a few years ago includes a compulsory eight-week clerkship in psychiatry. The first four weeks of the clerkship are during medical students' fifth year. The medical students practise child psychiatry, adult psychiatry, geriatric psychiatry and one additional rotation of any one of these. The final four weeks of the clerkship are during the final sixth year, where students practise community psychiatry. The university has been using mhGAP-IG modules for child and adolescent mental and behavioural disorders, depression and dementia.[17] Professor Omigbodun expressed the view that using the mhGAP-IG modules brought life to the theory part of the teaching, enhancing the existing curriculum. The establishment of the new curriculum has allowed for the training of over 300 medical students who now practise in the community with an expertise in youth mental health services.

The additional area of integration of the mhGAP-IG in Nigeria has been through the establishment of a separate Master of Science Programme in Child and Adolescent Mental Health. The programme was established using a grant for capacity-building in sub-Saharan Africa funded by the MacArthur Foundation, and implemented through an 18-month multi-disciplinary and multi-professional programme with teaching, clinical, theoretical and leadership skills training. The students receive training from the mhGAP-IG child and adolescent module, which runs for four weeks.

Using the mhGAP-IG to teach nursing, physician assistant and midwifery students in Liberia

Dr Janice L. Cooper of the Carter Center Mental Health Initiative in Liberia reported that the country's mental health policy had proposed that all registered nurses, physician assistants and medical staff should be trained with mhGAP-IG materials in the period 2016–2021.[18] More importantly, the policy in place mandates that these materials should be implemented at a pre-service level, requiring graduating nurses and physician assistants and registered midwives to have received mhGAP-IG training prior to graduation.

The institutions that have implemented mhGAP-IG pre-service training include colleges, faith-based institutions, universities and nursing training programmes, with 90 % of all institutions in rural locations. So far, at the pre-service level 16 % of all nursing, midwifery and physician assistant students – a total of 1,251 students – have completed mhGAP training.[17]

Using the mhGAP-IG to teach junior doctors in rural Mexico

In Mexico, a mandatory year of social service following medical school, or pasantía (internship), is designed to provide a safety net for underserved segments of the population.[19]

Dr Silvia Ortiz Leon of the Department of Psychiatry and Mental Health, Universidad Nacional Autónoma de México (UNAM) and UNAM colleagues Dr Claudia Fouilloux and Dr José Javier Mendoza reported that they had developed a 20-hour course and that, to date, 50 pre-service doctors had been trained in mhGAP. They conducted an evaluation of mhGAP pre-service training and the response from students was positive: junior doctors have more knowledge about mental health and mental disorders.[20] UNAM has initiated mhGAP-IG pre-service training for third-year medical students within the subject of psychological medicine and communication. This is expected to increase the number of professionals addressing mental health in the country.[20]

Do current curricula need to be changed in order to introduce mhGAP materials into pre-service training?

A curriculum can be defined as the totality of learning activities that are designed to achieve specific educational outcomes. The term "curriculum" can refer to both a written document and to the actual practice of implementing an academic programme. Neither a written nor a practised curriculum is static; it must be flexible enough to incorporate changing health care needs and an emerging evidence base. Curriculum enhancement is built around existing general curricula.[21–23]

Curriculum modifications or changes involve combinations of altered content, conceptual difficulty and educational goals.[23] When a curriculum is modified rather than enhanced, there tend to be more educational practices involving student and lecturer interactions that differ from the original general curriculum.[23]

If the mhGAP-IG is used to enhance or strengthen an existing pre-service curriculum and not to change it, then there is no need to change the formal written curriculum. For example, medical students may be instructed to use the mhGAP-IG mobile app during clinical rotations to aid in clinical decision-making. Also, the mhGAP-IG may be used as part of small group learning activities or in lectures to strengthen existing learning. If there is no mental health component in the general curriculum, and the mhGAP-IG is introduced as a new curriculum component, then the formal written course curriculum should be changed. For example, a nursing curriculum that did not previously contain any training on child and adolescent mental health may be modified to include a week on this subject area based on the mhGAP-IG module on children.

How to plan pre-service education using mhGAP

The mhGAP-IG introduction process to strengthen or enhance a curriculum can be divided into seven phases. However, not all phases need to be followed in the order given and not all of them need to be included. Each teaching institution should have its own process, tailored to its resources and needs.

The seven phases are as follows:

- **Phase 1:** Create awareness and understanding
- **Phase 2:** Provide mhGAP-IG training for educational leaders
- **Phase 3:** Assemble a team and make an action plan
- **Phase 4:** Review the current curriculum
- **Phase 5:** Adapt the mhGAP-IG to the circumstances of the teaching institution
- **Phase 6:** Deliver a pilot curriculum
- **Phase 7:** Evaluate and revise the curriculum.

Phase 1: Create awareness and understanding

While the mhGAP-IG has been used to date in more than 100 countries, implementation in pre-service education is limited. Clinical educators and decision-makers need to be informed about mhGAP-IG pre-service benefits and impacts, and a mix of communication approaches should be used.

A personal approach – involving consultation with all relevant stakeholders – is often the most effective means of creating awareness.[24] Examples of personal communication might include presentations about mhGAP pre-service training at teaching institutions and at local, national and international conferences. In 2018, three consultation meetings on mhGAP-IG implementation in pre-service curricula took place (see Box 2, 3 and 4).

Box 2

WHO Informal Consultation on mhGAP pre-service training in child and adolescent mental health – Prague, Czech Republic, July 2018

A WHO Informal Consultation on mhGAP pre-service training in child and adolescent mental health was held on 25 July 2018, during the International Association for Child and Adolescent Psychiatry and Allied Professions (IACAPAP) Congress in Prague, Czech Republic. The meeting was attended by 37 invited child and adolescent mental health educators representing Nigeria, China, Pakistan, Croatia, Qatar, Georgia, Serbia, Hong Kong, Singapore, Japan, Slovenia, Kazakhstan, Tunisia, Kyrgyzstan, Ukraine, Liberia, the United Arab Emirates, Lithuania, the USA and Norway (see Table 1 in the Appendix).

All those attending fell into one of the following professional categories: educators who had implemented the mhGAP-IG in pre-service training; educators who had not yet implemented the mhGAP-IG but who were looking for opportunities to improve their pre-service training programmes; experts in child and adolescent mental health education with or without previous experience with the mhGAP-IG; and representatives of the WHO Department of Mental Health and Substance Use, Geneva, Switzerland.

Key discussion points at this consultation:

- *In many countries, particularly in low- and middle-income countries, there is a huge treatment gap in mental health services. In-service mhGAP training can be one pillar in strengthening the health care workforce but if it is not accompanied by other measures, such as pre-service training, then the desired objective of bridging the gap will not be achieved.*
- *It is crucial to inform a broad range of academic stakeholders (i.e. universities and other teaching institutions) about the usefulness of mhGAP-IG modules and opportunities to enhance pre-service training with the mhGAP-IG.*
- *There is a need for training of trainers (ToT) on integrating the mhGAP-IG into pre-service training.*
- *The mhGAP-IG needs to be acknowledged as an enhancement tool to strengthen the implementation of existing curricula. Viewing the materials in this way will encourage more countries to integrate them and to promote capacity-building for mental health care across the life course.*
- *The integration of the mhGAP-IG into pre-service training needs to be acknowledged as a global approach to capacity-building that promotes evidence-based practice and high-quality clinical care. High-income countries may also benefit from integrating the mhGAP-IG into pre-service training.*

WHO Informal Consultation on mhGAP pre-service training in child and adolescent mental health in Prague, Czech Republic. July 2018

WHO Informal Consultation on mhGAP pre-service training in child and adolescent mental health in Prague, Czech Republic, July 2018

Box 3

WHO Informal Consultation on mhGAP pre-service training in general mental health including child and adolescent mental health – Mexico City, Mexico, September 2018

A WHO Informal Consultation on mhGAP pre-service training in general mental health including child and adolescent mental health took place on 29 September 2018 during the 18th World Psychiatric Association (WPA) World Congress of Psychiatry, held in Mexico City, Mexico. Altogether, 22 invited mental health educators attended, representing Argentina, Australia, Canada, Hong Kong, China, India, Indonesia, Japan, Lithuania, Mexico, Nigeria, Norway, Peru, Qatar, the United Kingdom and the USA (Table 2 in the Appendix).

The aim of this meeting was two-fold: to bring together professionals responsible for and involved in pre-service mental health training to update them on the mhGAP-IG and to explore future opportunities to use it; and to explore opportunities for collaboration between WHO and the WPA in the area of training, including mhGAP-IG pre-service training.

Key discussion points at this consultation:

- *Pre-service training is a sustainable and impactful method of capacity-building to provide care and services for people with mental health conditions.*
- *Staff turnover is an issue when it comes to in-service training; hence it is important to provide training when people are early in their careers and open to learning, which is the optimal situation.*
- *The WPA will work on how the mhGAP-IG can be incorporated into the WPA undergraduate curriculum and how it will be useful for medical students.*
- *There is a need to collect data and create documentation on what has been done in the implementation of mhGAP in pre-service training. There is a need to be thoughtful about what kind of data are to be collected and from whom they are collected, and the need to develop a feedback mechanism. The WHO mhGAP team and its implementing countries need to think about how to demonstrate that what they are implementing is actually reducing the treatment gap.*

WHO Informal Consultation on mhGAP pre-service training in general mental health including child and adolescent mental health in Mexico City, Mexico, September 2018

Box 4

Session on mhGAP-IG pre-service training, mhGAP Forum, WHO – Geneva, Switzerland, October 2018

The 2018 mhGAP Forum took place on 11–12 October 2018 and provided an opportunity for diverse stakeholders to discuss progress on WHO's Mental Health Action Plan 2013–2020. The theme for the forum was "Accelerating Country Action on Mental Health", which reflected the vision of WHO's 13th General Programme of Work.

This mhGAP forum hosted the mhGAP pre-service consultation meeting (as a small group discussion) on 12 October 2018. More than 20 experts attended, representing Armenia, Australia, Canada, India, Japan, Kazakhstan, Liberia, Norway, Qatar, Spain, Ukraine, the USA and WHO (see Table 3 in the Appendix).

Key points raised by participants:

- *Medical educators and decision-makers need to be informed about the mhGAP-IG and its potential use in pre-service training.*
- *Each country has a particular approach to education, with each teaching institution tailored to the professional resources available and the population's needs; the mhGAP-IG therefore has to be adapted.*
- *Countries interested in integrating the mhGAP-IG into pre-service education are encouraged to collaborate with other interested countries and with WHO to promote the sharing of evidence-based knowledge and any further development of the mhGAP-IG materials.*
- *There is potential for the implementation of mhGAP-IG materials in pre-service training, as the mhGAP-IG is an instrumental tool towards reaching UHC and the SDGs.*
- *mhGAP-IG pre-service training should not be seen as primarily an approach for low-income, low-resource settings but as having broad applicability. This understanding will enhance its acceptance.*

Common approaches to education in awareness-raising include ToT courses (for more details about mhGAP pre-service ToT courses, see Phase 2). Finally, advocacy and lobbying efforts are important in ensuring ongoing support from decision-makers. The early engagement of educational leaders and decision-makers in curriculum enhancement processes will stimulate interest, understanding, support, acceptance and commitment. Although decision-makers are unlikely to be involved in all curriculum enhancement phases, their input and support are critical.

Early engagement of educational leaders and decision makers in curriculum enhancement processes will stimulate interest, understanding, support, acceptance and commitment. Although decision-makers are unlikely to be involved in all curriculum enhancement phases, their input and support is critical.

Consultation on mhGAP-IG in pre-service training, WHO mhGAP forum at WHO head-quarters, Geneva, Switzerland

Phase 2: Provide mhGAP-IG training for educational leaders

mhGAP-IG training manuals follow the "cascade" model, with two levels of educators: 1) "master trainers" who train teaching faculty staff and 2) teaching faculty staff who then teach students. Training leading teaching faculties on the mhGAP-IG is of paramount importance. When key stakeholders have no previous training in using the mhGAP-IG, a longer workshop is needed so that participants can not only familiarize themselves with the mhGAP topics but also become trainers themselves. In any case, participants should be asked to read the mhGAP materials in advance. Training may best be conducted at one of the teaching institutions and led by an mhGAP-IG trainer from outside that institution. The training course will help participants to spot new opportunities to strengthen and enhance the teaching process with the mhGAP-IG and see challenges in current educational practices from a different perspective.

In addition to their clinical and teaching experience, personal qualities such as good rapport-building with learners, the creation of a learning environment that promotes self-reflection and collaboration, and motivation and interest in innovative teaching methods should be considered when selecting mhGAP master trainers and trainers or facilitators.

Box 5

WHO mhGAP-IG Pre-service Training of Trainers and Supervisors course in child and adolescent mental health – Kiev, Ukraine, November 2018

The first WHO mhGAP-IG Pre-service Training of Trainers and Supervisors course in child and adolescent mental health was held on 21–23 November 2018 in Kiev, Ukraine. This workshop was organized by the UNA Partnership with technical support from WHO (see Table 4 in the Appendix).

The aim of the workshop was to bring together decision-makers and clinical educators from postgraduate and undergraduate teaching institutions to discuss how the mhGAP-IG can be used to strengthen pre-service training and to provide training on the module on child and adolescent mental and behavioural disorders. The training course helped participants to identify challenges in the current curriculum and new opportunities to strengthen and enhance the teaching process with the mhGAP-IG.

Specific objectives for this training course were: 1) to provide an overview of the mhGAP-IG and to discuss its application in pre-service training; 2) to discuss principles and approaches of mhGAP- IG integration in the context of an academic institution's unique teaching process; 3) to develop provisional plans for the use of the mhGAP-IG for pre-service training in participants' teaching institutions; and 4) to train a cadre of clinical educators who could be future mhGAP-IG trainers. The participants left the course not only with new knowledge but also with concrete ideas on how to strengthen and enhance their teaching programmes with the mhGAP-IG and how to ensure that accreditation requirements and guidelines were optimally met, with components of the mhGAP-IG implemented, and future ideas about projects on mhGAP in pre-service training.

WHO mhGAP-IG Pre-service ToT and Supervisors course in child and adolescent mental health – Kiev, Ukraine, November 2018

WHO mhGAP-IG Pre-service ToT and Supervisors course in child and adolescent mental health – Kiev, Ukraine, November 2018

Phase 3: Assemble a team and make a work plan

One person alone cannot enhance and strengthen a curriculum: there is a need for a committed group of individuals. Finding suitable partners with well-established educational networks is important, and this should already have been explored when creating awareness about mhGAP pre-service training (Phase 1). There are three suggested steps in assembling an mhGAP-IG pre-service team:

1. An educational leader who has participated in an mhGAP-IG ToT course should recruit energetic, committed and interested staff members into the curriculum strengthening process. It will be helpful if the team includes both mental health specialists and non-specialists. The team should have staff members responsible for didactic teaching about mental health and clinical placements. The educational leader will have to take responsibility for the curriculum enhancement process. The team members will be responsible for assessing needs, enhancing and strengthening the curriculum and successfully integrating mhGAP.
2. To effectively review and enhance the existing curriculum with mhGAP-IG materials, team members must be trained on the mhGAP-IG. The leader should provide mhGAP-IG training for his/her team.
3. The team leader, together with the team, should set up a plan for the adaptation, implementation and evaluation of the enhanced curriculum. The plan should describe individual responsibilities and the timeline.

All educational staff, especially those who do not belong to the curriculum team, should be informed about the process and involved from the beginning. Leaving faculty staff out of the curriculum revision process invites resistance to the proposed enhancements.

Students and graduate students should also be invited to join the curriculum strengthening process and to provide feedback. Student involvement also creates the opportunity for faculty staff to explain the enhancement process and its benefits.

Phase 4: Review the current curriculum

Once the mhGAP-IG pre-service team is established, the existing curriculum must be reviewed to help decide how currently employed teaching materials can be matched with mhGAP-IG materials. While reviewing the curriculum, it is helpful to raise and discuss the following questions:

1. Where are we now? What are the strengths and the weaknesses of the current curriculum? Why do we need to enhance and strengthen the teaching process and teaching curriculum?
2. Where do we want to be? What does the "ideal" curriculum look like?
3. How can mhGAP-IG materials help us to get there, and how can the mhGAP-IG be adapted?

While discussing these questions, it is important to consider the extent to which the existing curriculum contains issues of mental health, updated information on common mental health problems across the life course and systematic approaches and strategies to the promotion, prevention, management and referral of those problems, and whether teaching and learning materials and approaches include sufficient practice.

Phase 5: Adapt the mhGAP-IG to the circumstances of the teaching institution

There is no best way to carry out mhGAP-IG adaption; there are as many different types of procedure as there are teaching institutions. However, it is important to refer to other mhGAP resources e.g. the mhGAP Operations Manual, which provides detailed guidelines on adaptations.[25] Additionally, there are a number of universal questions that are helpful to address when adapting the mhGAP-IG:

1. How extensive does the adaptation have to be?
2. Which modules should be implemented?
3. How should mhGAP-IG materials be introduced into the current curriculum?

Adapting mhGAP materials involves tailoring mhGAP to the local health system, aligning materials with relevant national treatment guidelines and policies and, where necessary, making sure that the materials are acceptable in the local socio-cultural context and take into account local cultural practices.

Adaptation could be as simple as changing the names of people in case studies to names that are more common in the communities where mhGAP will be implemented; or the changes might be complex, such as acknowledging locally relevant beliefs and concepts of healing in the management of MNS conditions.[12]

mhGAP-IG 2.0 is currently available in English, French, Italian, Marathi, Russian and Spanish. Official translations into other languages are pending, meaning that in many cases adaptation will also include translation into the local language. The translation should be carried out as early as possible, especially if not all curriculum team members are fluent in one of the languages in which mhGAP-IG 2.0 is currently available.

Phase 6: Deliver a pilot curriculum

Once mhGAP-IG materials are incorporated into a curriculum and all teaching staff have been trained and/or oriented, the enhanced curriculum is ready to be piloted. It is important to ensure the availability of materials that are needed to support delivery of the pilot, ideally at the start of the academic year. Materials that are useful for delivering a pilot curriculum include: a printed version of the mhGAP-IG; the training package provided with presentations, videos and role-plays; and custom-made teaching tools created by faculty staff (e.g. handouts, presentations, lectures). Similarly, the mhGAP-IG materials can be taught during classroom lectures, small group learning activities or during the clinical placement as a clinical tool. Where possible, both knowledge of and skills in the mhGAP-IG should be assessed for students in pre-service training to receive their degree.

Phase 7: Evaluate and revise the curriculum

Evaluation can begin at the same time as delivery of the pilot curriculum. The aim of this phase is to identify challenges and achievements with the enhanced curriculum. Both teaching staff and students should be surveyed using quantitative and qualitative methods. While evaluation specifics (i.e. implementation specifics) should be tailored to local needs and resources, overall, data should be collected on the following:

1. Experience with the enhanced curriculum (i.e. Do students find the new knowledge and skills useful and applicable? Do new materials meet the intended learning objectives?);
2. Support for the enhanced curriculum (i.e. Do the administrators, educational staff and staff at clinical placements support the new teaching? Are necessary resources and teaching materials available for teaching?);
3. Educational processes involving the mhGAP-IG (i.e. How many students benefited from mhGAP materials? What resources are used to teach mhGAP? How many classroom hours were spent on the new content?);
4. Teaching results (i.e. How do students perform during examinations?).

Evaluation results should be shared with all stakeholders, including WHO, and can be used to shape the next revision of the curriculum.

Final comments

Strengthening and enhancing pre-service training with mhGAP is a very individualized process. This document is not prescriptive, but rather provides the main principles and approaches for strengthening and enhancing pre-service curricula with the mhGAP-IG. The document encourages the teaching institution's ownership of an individualized curriculum enhancement process.

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Table 1: WHO mhGAP-IG informal consultation meeting on pre-service training in child and adolescent mental health, Prague, Czech Republic, July 24, 2018 – participants list

No.	Name and Surname	Affiliation	Country
1.	Dr Ammar Albanna	Chair, Department of Child and Adolescent Psychiatry, Al Jalila Children's Specialty Hospital	United Arab Emirates
2.	Dr Bella-Awusah	Child and Adolescent Psychiatrist, University of Ibadan	Nigeria
3.	Professor Muhammad Waqar Azeem	Chair, Department of Psychiatry, Weill Cornell Medical College	Qatar
4.	Professor Myron Belfer	Professor, Harvard Medical School	USA
5.	Dr Phyllis Kwok-ling Chan	Vice President of Education, Hong Kong College of Psychiatrists	Hong Kong (PRC)
6.	Dr Fatma Charfi	Department of Child and Adolescent Psychiatry, Tunis	Tunisia
7.	Ms Ashmita Chaulagain	Research Assistant, Norwegian University of Science and Technology	Norway
8.	Dr Wenhong Cheng	Chair, Department of Child and Adolescent Psychiatry, Medical School of Shanghai, Jiaotong University	China
9.	Dr Eka Chkonia	Chair, Department of Psychiatry, Tbilisi State Medical University	Georgia
10.	Dr Neerja Chowdhary	Technical Officer, WHO HQ	Switzerland
11.	Ms Carolyn Clausen	Norwegian University of Science and Technology	Norway
12.	Dr John Wong CM	Associate Professor, Head of Department of Psychology, National University of Singapore	Singapore
13.	Dr Janice L. Cooper	Leader, the Carter Center Mental Health Initiative	Liberia
14.	Ms Lucia Babiano Espinosa	PhD Student, RKBU, Norwegian University of Science and Technology	Norway
15.	Dr Daniel Fung	Chairman, Medical Board, Institute of Mental Health	Singapore
16.	Dr Naoufel Gaddour	Associate Professor in Child and Adolescent Psychiatry,	Tunisia
17.	Professor Anthony Guerrero	Chair, Department of Psychiatry at the University of Hawaii at Mānoa's John A. Burns School of Medicine	USA
18.	Dr Takachika Inagaki	Assistant Professor, Shiga University of Medical Science	Japan
19.	Professor Konrad Juszkiewicz	Professor, Kazakh National Medical University	Kazakhstan
20.	Dr Yukiko Kano	Chair, Department of Child and Adolescent Psychiatry, Tokyo University	Japan
21.	Dr Hojka Kumperščak	Chair, Department of Child and Adolescent Psychiatry, Maribor	Slovenia
22.	Dr Alisa Ladyk	National Professional Officer on Mental Health, WHO	Ukraine
23.	Dr Natasa Ljubomirovic	Associate Professor, Serbian Institute of Mental Health	Serbia
24.	Dr Salma Malik	Training Director, Department of Psychiatry, Weill Cornell Medical College	Qatar
25.	Dr Vlatka Boričević Maršanić	Head, Children Mental Health Hospital	Croatia
26.	Dr Ayesha Mian	Chair of Psychiatry, Aga Khan University	Pakistan
27.	Dr Kerim Munir	Associate Professor of Child and Adolescent Psychiatry, Harvard Medical School	USA
28.	Professor Olayinka Omigbodun	Chair, Department of Psychiatry, University of Ibadan	Nigeria
29.	Dr Say How Ong	Chief, Department of Child and Adolescent Psychiatry, Institute of Mental Health	Singapore
30.	Dr Laura Pacione	Lecturer, Department of Psychiatry, University of Toronto; Consultant, WHO	Canada
31.	Dr Lilya Panteleeva	Associate Professor, Kyrgyz-Russian Slavic University	Kyrgyzstan

32.	Professor Olena Petryayeva	Vice Dean, Donetsk Medical National University	Ukraine
33.	Professor Irina Pinchuk	Director, Ukrainian Research Institute of Social and Forensic Psychiatry and Drug Abuse	Ukraine
34.	Professor Dainius Puras	Chair, Department of Child and Adolescent Psychiatry, Vilnius University; UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health	Lithuania/UN
35.	Professor Norbert Skokauskas	Research Chair, RKBU, Norwegian University of Science and Technology	Norway
36.	Dr Xirui Wang	Medical Doctor, Shanghai Mental Health Centre	China
37.	Dr Li Yan	Medical Doctor, Shanghai Mental Health Centre	China

Table 2: WHO mhGAP-IG informal consultation meeting on pre-service training, Mexico City, Mexico, September 29, 2018 – participants list

No.	Name and Surname	Affiliation	Country
1.	Professor Tsuyoshi Akiyama	Tokyo University	Japan
2.	Professor Renato D. Alarcon	Universidad Cayetano Heredia	Peru
3.	Dr Chawanun Charnsil	Chiang Mai University and President of the Psychiatric Association of Thailand	Thailand
4.	Ms Ashmita Chaulagain	Research Assistant, Norwegian University of Science and Technology	Norway
5.	Dr Tarun Dua	Medical Officer, WHO HQ	Switzerland
6.	Dr Claudia Fouilloux	Teaching Coordinator, Universidad Nacional Autónoma de México	Mexico
7.	Dr Suhaila Ghuloum	Department of Psychiatry Rumailah Hospital and Weill Cornell Medical College	Qatar
8.	Dr Sara Haack	Assistant Professor of Psychiatry, University of Hawaii	USA
9.	Professor Helen Herrman	President of the World Psychiatric Association	Australia
10.	Professor Christina Hoven	Professor of Clinical Epidemiology (in Psychiatry), University of Columbia	USA
11.	Dr Afzal Javed	President-elect, World Psychiatric Association	United Kingdom
12.	Dr Fransiska Kaligis	Senior Lecturer, University of Indonesia	Indonesia
13.	Dr Joan Marsh	Senior Editor, Lancet Psychiatry	United Kingdom
14.	Dr José Javier Mendoza	Research Coordinator, Universidad Nacional Autónoma de	Mexico
15.	Dr Roger Man Kin NG	Secretary for Education, World Psychiatric Association	Hong Kong (PRC)
16.	Professor Olayinka Omigbodun	Chair, Department of Psychiatry, University of Ibadan	Nigeria
17.	Professor Graciela Onofrio	Hospital Italiano de Buenos Aires University	Argentina
18.	Dr Silvia Ortiz	Chair, Department of Psychiatry and Mental Health, Universidad Nacional Autónoma de México	Mexico
19.	Dr Laura Pacione	Lecturer, Department of Psychiatry, University of Toronto; Consultant, WHO	Canada
20.	Professor Dainius Puras	Chair, Department of Child and Adolescent Psychiatry, Vilnius University; UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health	Lithuania/UN
21.	Professor M.S.V.K. Raju	President of the Indian Psychiatric Society, Consultant in Psychiatry, Prashanti Clinic, Mohammadwadi, Pune, Maharashtra	India
22.	Professor Norbert Skokauskas	Research Chair, RKBU, Norwegian University of Science and Technology	Norway

Table 3: Parallel session on mhGAP-IG and pre-service training, mhGAP Forum, WHO, Geneva, Switzerland, 12th October, 2018 – contributors list

No.	Name and Surname	Affiliation	Country
1.	Dr José Luis Ayuso-Mateos	Chairman and Director of the Department of Psychiatry, Medical School, Universidad Autonoma de Madrid	Spain
2.	Professor Myron Belfer	Professor, Harvard Medical School	USA
3.	Ms Ashmita Chaulagain	Research Assistant, Norwegian University of Science and Technology	Norway
4.	Dr Janice L. Cooper	Leader, the Carter Center Mental Health Initiative	Liberia
5.	Dr Maya Fuji	Medical Doctor, Faculty of Medicine, Tottori University	Japan
6.	Dr Khachatur Gasparyn	Chair, Department of Medical Psychology, Yerevan State Medical University	Armenia
7.	Dr Fahmy Hanna	Technical Officer, WHO HQ	Switzerland
8.	Professor Konrad Juszkiewicz	Professor, Kazakh National Medical University	Kazakhstan
9.	Dr Ahsan Nazeer	Chief, Division of Child and Adolescent Psychiatry, Deartment of Psychiatry, Weill Cornell Medical College	Qatar
10.	Professor Irina Pinchuk	Director, Ukrainian Research Institute of Social and Forensic Psychiatry and Drug Abuse	Ukraine
11.	Dr Khalid Saeed	Regional Advisor Mental Health and Substance Abuse, WHO/ EMRO	Egypt
12.	Professor Norbert Skokauskas	Research Chair, RKBU, Norwegian University of Science and Technology	Norway

Table 4: The first mhGAP-IG pre-service Training of Trainers and Supervisors course in child and adolescent mental health, 21–23 November 2018, Kiev, Ukraine – participants list

No.	Name and Surname	Affiliation	Country
1.	Dr Sagat Altynbekov	Acting Director, Teaching Methodological Unit, Kazakh National University	Kazakhstan
2.	Professor Gulnara Altynbekova	Professor, Kazakh National Medical University	Kazakhstan
3.	Dr Kristine Avetisyan	Associate Professor, Department of Medical Psychology, Yerevan State Medical University	Armenia
4.	Dr Tamara Bavykina	Chief, Department of Postgraduate Education, Kharkov Regional Medical College	Ukraine
5.	Dr Oksana Boiko	Associate Professor, School of Social Work, National University of Kyiv-Mohyla Academy	Ukraine
6.	Dr Vira Chaykovska	Director, Centre for Continuing Professional Education	Ukraine
7.	Ms Ashmita Chaulagain	Research Assistant, Norwegian University of Science and Technology	Norway
8.	Dr Dan Chisholm	Programme Manager for Mental Health, WHO Regional Office Europe	Denmark
9.	Dr Neerja Chowdhary	Technical Officer, WHO HQ	Switzerland
10.	Dr Stanislav Chumak	Assistant Professor, Department of Psychiatry, Psychotherapy and Medical Psychology, P.L. Shupyk National Medical Academy of Postgraduate Education	Ukraine
11.	Dr Gayane Ghazaryan	Associate Professor, Department of Medical Psychology, Yerevan State Medical University	Armenia
12.	Prof Boris Ivnev		
13.	Dr Nadiia Kabachenko	Associate Professor, School of Social Work, National University of Kyiv-Mohyla Academy	Ukraine
14.	Dr Alisa Ladyk	National Professional Officer on Mental Health, WHO Country Office	Ukraine
15.	Professor Valentyna Lavska	Chief Nurse, Kharkov Regional Medical College	Ukraine
16.	Professor Oksana Kopchak	Head of the Department of Neurology and Psychiatry, Kyiv Medical University	Ukraine
17.	Dr Svetlana Marusechko	Head of the Children's Specialized Clinic Slavansk, Health Department of Donetsk Regional State Administration	Ukraine
18.	Dr Svitlana Moskalyk	Assistant, Centre for Continuing Professional Education	Ukraine
19.	Dr Jarkyn Omorova	Head of Family Medicine, Postgraduate Medical University	Kyrgyzstan
20.	Dr Lilya Panteleeva	Associate Professor, Department of Psychiatry of the Kyrgyz Russian Slavic University	Kyrgyzstan
21.	Professor Olena Petryayeva	Vice-Rector, Medical University Kramatorsk	Ukraine
22.	Professor Irina Pinchuk	Director, Ukrainian Research Institute of Social and Forensic Psychiatry and Drug Abuse	Ukraine
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24.	Professor Alexandr Tolstanov	Vice-Rector, Medical Academy Postgraduate Education Shupika	Ukraine
25.	Dr Vadim Tolstik	Coordinator, Centre for Continuing Professional Education	Ukraine
26.	Dr Anatoly Tsarenko	Department of Palliative and Hospice Medicine, Medical Academy Postgraduate Education Shupika	Ukraine
27.	Dr Tatiana Vialykh	Senior Researcher, Center for Continuing Professional Education	Ukraine
28.	Dr Yulia Yachnik	Assistant, Ukrainian Research Institute of Social and Forensic Psychiatry and Drug Abuse	Ukraine
29.	Dr Antonina Zamaziy	Head of Practical Training, Kharkov Regional Medical College	Ukraine

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