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APPLIED BEHAVIOURAL SCIENCE AND MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT



**SOCIAL +
BEHAVIOUR
CHANGE**

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On 3 June, displaced children engage in mental health and psychosocial support activities at a gathering centre in Madani.

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Preface

Who should use this document?

This chapter of the social and behaviour change (SBC) for mental health and psychosocial support (MHPSS) package is tailored to a global and diverse set of change-makers committed to improving mental health and psychosocial support, including but not limited to MHPSS practitioners, humanitarian aid workers, public health professionals, educators and policymakers. It serves as a valuable resource for those seeking to design, implement and evaluate applied behavioural science (ABS) interventions for SBC within MHPSS.

How should this document be used?

This chapter is designed to be evidence-based and practical. Readers are encouraged to make use of the guidance, case studies and resources provided that are relevant to their specific needs. The first section of the chapter covers the definition of applied behavioural science, its intersections with MHPSS specific entry points where behavioural science could build upon or improve existing interventions, and vice versa. The second part of the chapter outlines how practitioners might use UNICEF's DEPTHS (Define, Explore, Prototype, Test Hypotheses, Scale) framework to design and implement behaviourally informed MHPSS interventions.

How was this document developed?

This chapter is the result of a collaborative effort involving experts in the fields of MHPSS and SBC. Drawing from a diverse array of experiences, best practices and evidence-based approaches, this guidance document incorporates real-world insights and lessons learned.



INTRODUCTION: Applied Behavioural Science (ABS)

Applied Behavioural Science (ABS) is a multidisciplinary field of research and practice focused on understanding and influencing real-world behaviour. UNICEF positions ABS as both a Social and Behaviour Change (SBC) approach and a methodology. ABS is a broad field that combines theories from psychology, economics, sociology and other disciplines to understand how individuals, families and communities behave, make decisions, and enact policies.

At the heart of ABS is the understanding that people do not always act as they intend to. Knowledge and awareness alone are rarely enough to motivate and enable behaviour change. People are much more complex and context matters. Even though a mother may know she needs to take her child for a mental health appointment, a host of challenges may arise, such as the stigma of being seen at the appointment, attitudes surrounding mental health treatment, and social norms. ABS uses research insights to better understand why people do what they do and design evidence-based and behaviourally informed solutions.

These can be applied across mental health and psychosocial support (MHPSS) topics in different contexts. As both an approach and a methodology, ABS primarily applies evidence and methods such as behavioural insights. In a behavioural insights project, specific behaviours and outcomes – as well as how they will be measured – are identified. Information is gathered to understand the scientific literature on the identified behaviour. In addition, input is gathered from the community and hypotheses are generated.

Next, an intervention is designed and tested. Behavioural insights testing often involves studies that randomly assign participants to an experimental group, i.e., randomized controlled trials (or RCTs), to gauge whether a change has occurred and whether the intervention contributed to that change. Results are shared with the community and effective interventions are scaled.

UNICEF identifies four key principles for ABS: 1) recognizing the impact of context on behaviour, 2) acknowledging the gap between intentions and actions, 3) exploring the unpredictability of human decisions, and 4) emphasizing the potential of small contextual changes to drive substantial behaviour shifts. You can read more in UNICEF's

SBC guidance on ABS. UNICEF's SBC YouTube channel also has a variety of videos on ABS, behavioural insights and UN Behavioural Science Week.

KEY POINTS

- The fields of Applied Behavioural Science (ABS) and Mental Health and Psychosocial Support (MHPSS) have a shared history, overlap in goals, and are derived from similar theories and frameworks.
- While MHPSS has extensively developed services to help protect and promote psychosocial-wellbeing and/or prevent and treat mental health issues, behavioural science can help facilitate the uptake of those services.
- Both fields can also collaborate on conducting research in the under-researched regions that UNICEF operates to better understand the interaction between culture and mental health.

Intersection Between Behavioural Science and MHPSS

Applied Behavioural Science (ABS) and Mental Health and Psychosocial Support (MHPSS) both trace their roots back to the field of psychology. MHPSS was first introduced by the Inter Agency Standing Committee- (IASC) Reference Group for Mental Health and Psychosocial Support in Emergency Settings to bring together clinical and psychosocial approaches for working with distressed populations. In contrast, ABS developed from a wider branch of psychology concerned with exploring and understanding general human cognition and behaviour. This broader perspective of psychology eventually intersected with other similar disciplines like economics and sociology, leading to the evolution of the multifaceted field of behavioural science.

ABS seeks to understand how environmental, cognitive, and emotional factors influence decision-making and behaviour, and uses those insights to design interventions aimed at promoting behaviour change. ABS applies empirical research methods to analyse behavioural patterns, often employing controlled experiments and observational studies to test hypotheses, with the goal of using these insights to develop strategies and interventions grounded in a deeper understanding of human behaviour. The key purpose of ABS is, therefore, to predict, explain, and change behaviours.

Because the two fields share fundamental principles and approaches, this document therefore serves to recognise those commonalities while identifying opportunities where behavioural science can complement MHPSS programming.

KEY POINTS

- To process the thousands of inputs received daily and make decisions on them, human brains use mental shortcuts, or heuristics. These shortcuts are necessary and often reliable for processing information, but can also result in cognitive biases, which are predictable patterns of deviation from rational judgement and decisionmaking.
- Understanding cognitive biases is useful in behavioural science and mental health research because such biases can be leveraged to change behaviour. This may be particularly relevant for people suffering from mental health problems that may exacerbate cognitive biases or drive certain symptoms¹.
- Cognitive and behavioural insights from Behavioural Science and MHPSS can improve the design of interventions and services in both fields.

Cognitive biases are a much studied and important component of both behavioural science and mental health research. In the general population, they arise from the brain's attempt to simplify information processing and are influenced by a variety of factors, such as individual experiences, emotions, and social context. However, in clinical populations they tend to be methods of information processing that are congruent with their disorders. These biases often lead to perceptual distortion, inaccurate judgment, illogical interpretation, or what is broadly termed irrationality.

While there are clear overlaps between cognitive biases studied in mental health research and those studied in behavioural science, in each field there are distinct objectives for doing so.

Table 1 provides some examples of cognitive biases relevant to behavioural science and mental health. Annex 1 includes additional biases and behavior science concepts.

Behavioural science, when applied to intervention design, often can be used to identify these biases to either prevent them from occurring (e.g. getting people to invest for their future rather than spending money for their immediate pleasure), or to leverage them to achieve behaviour change.

This could include, for example, using commitment devices, such as setting up an automatic transfer to a savings account that work by leveraging status quo bias- a cognitive bias where individuals prefer the current state of affairs to encourage more financial savings. In mental health research, on the other hand, these cognitive biases are understood as either intensified in certain disorders or as a driver of symptoms¹.

Table 1 Examples of overlaps of cognitive biases in behavioural science and mental health

Cognitive bias	Definition	Relevant findings from Mental Health Research
Hyperbolic discounting	Tendency for people to increasingly prefer smaller, immediate rewards over larger, later rewards as the delay to the latter increases.	People experiencing depression are more impulsive and inconsistent in choices with consequences in multiple time periods ²
Attention Bias	Tendency to pay more attention to certain types of information while neglecting others, often influenced by emotional states.	Patients with anxiety, and to some extent depression, demonstrate faster engagement to and slower disengagement from threatening stimuli ³
Attribution bias	Tendency to misattribute causes and effects of certain behaviours or events.	Research suggests that persecutory (paranoid) delusions found amongst schizophrenic patients may derive from attribution bias ⁴
Pessimism Bias	Tendency to overestimate the likelihood of negative events, and the perception that negative events are persistent and pervasive.	Pessimism bias has been identified as a potential mediating variable between low socioeconomic status and mental health issues in children ⁵

Therefore, while **behavioural science can be used to identify how these cognitive biases may affect a target behaviour in order to design interventions to reduce the effect of that bias or to leverage them to drive behaviour change, mental health research has often focused on trying to reduce those biases in individuals as a path to mitigating symptoms**

Being able to identify and understand these biases as they occur in both clinical and general populations can help to inform the design of programmes to maximise impact. For instance, while much of UNICEF's MHPSS programming is focused on promoting positive coping skills in the general population, knowing how and in which populations certain biases manifest can help with tailoring programs accordingly. Here, behavioural science and MHPSS could share tools and methodologies to achieve this.

Leveraging ABS for Psychosocial Wellbeing

KEY POINTS

- ABS can have a positive impact on mental health by changing the context in which behaviours take place, preventing the behaviours that lead to mental health issues, or by encouraging specific behaviours to improve mental health.
- Where MHPSS is concerned, ABS can encourage engagement by
 - 1) generating demand,
 - 2) addressing stigma,
 - 3) improving access to services, promoting retention and adherence, and
 - 4) mitigating provider biases and stigma.
- Employing behavioural science theories, approaches, and insights may be a complementary way to strengthen existing MHPSS interventions, and vice versa.

In simple terms, mental health problems can occur either because of interactions between genes and the environment, or due to environmental factors (e.g. distressing events)⁸. Focusing on the environment is therefore a path to preventing mental health issues and is naturally a key component of MHPSS activities.

This is also an area in which ABS can complement those activities through its focus on regulating behaviours and reframing information. Case study #1 below provides an example of how using behavioural science to change the environment can lead to improved mental health-related outcomes. Furthermore, behavioural science has been applied to address issues of loneliness, and its impact on depression and even mortality⁹, through various mechanisms such as gratitude or volunteering activities^{10,11,12}.

Case Study #1: Changing the environment to reduce burnout and resignations

A field experiment in the US involving over 500 emergency services dispatchers (911) across nine U.S. cities found that weekly storytelling emails emphasising social connections significantly reduced burnout and halved resignations¹².

The study suggests that while the stressful nature of dispatch work cannot be fundamentally changed, fostering a sense of belonging and value within the workplace can meaningfully improve outcomes.

This is, of course, in line with the types of prevention activity that the MHPSS teams already engage in which focus on providing services (e.g. psychosocial education) that help them cope with or manage potential stressors.

Encouraging Participation in MHPSS Activities Using ABS

Globally, seventy percent of people with some form of mental health situation do not receive any form of professional help¹². This is due to a broad range of barriers that discourage or prevent individuals from seeking help or accessing services.

Out of these, there are four barriers where behavioural science can potentially have the greatest impact including, generating demand through raising awareness and promoting help-seeking behaviour, reducing stigma as a major barrier to service access, overcoming general barriers to services, and finally ensuring retention to services or adherence to treatment.

Generating Demand: Awareness and help-seeking

It is vital to support people to better understand how they are feeling, how this may be impacting their lives negatively, and to identify ways to help them feel better. This can be achieved through awareness-raising activities.

Behavioural science can offer theory and evidence to improve communication campaigns. The three steps required here are, 1) making people aware of mental health issues and its symptoms, 2) promoting self-reflection and monitoring so people can assess whether they have been affected, and 3) encouraging people to seek help. While all three steps can be tackled with standard communication campaigns, behavioural science's contribution may be in the design and delivery of these campaigns that maximises uptake. For example, the theory of planned behaviour, a prominent theory in behavioural science that considers the perceived behavioural control, attitudes and subjective norm of a target behaviour, has been extensively used to better understand help-seeking behaviour¹³.

For example, rather than solely informing about the availability of psychosocial support services, a communication campaign informed by the theory of planned behaviour may harness the influence of friends or family members or aim to correct the perception that most others do not experience mental health issues. Qualitative research conducted by UNICEF Poland on Ukrainian refugees as part of an MHPSS project, for instance, found that parents play a crucial role in encouraging and supporting their adolescents in seeking psychological support. Such findings could be leveraged alongside other components of the theory of planned behaviour as part of a behaviourally informed intervention.

Overcoming stigma

Stigma towards mental health issues is a significant barrier to accessing MHPSS

services: approximately 40% of individuals experiencing depression avoid seeking help due to fear of discrimination¹⁴. Because stigma and discrimination operate on intrapersonal, interpersonal, organizational, and structural levels, interventions must be comprehensive, addressing multiple layers to be effective¹⁵.

There are already many types of interventions being employed to reduce stigma including campaigns to educate, raise awareness and debunk myths about mental health conditions,

or more interpersonal interventions such as contact between the public and individuals with a mental health condition aimed at reducing prejudice and discrimination¹⁶, however, the efficacy of these interventions, especially in the long term are unclear¹⁷. While there are not yet any interventions uniquely developed through behavioural science, the field's knowledge and experience in behaviour change could compliment these interventions. For example, while contact interventions, have been shown to be effective in reducing stigma, it is most successful when it involves equal-status interactions and cooperative activities between individuals with and without mental health conditions¹⁶.

For instance, in the field of HIV prevention, care and treatment, lay counsellors, who are often people living with HIV/AIDS themselves, have been effectively employed to implement psychosocial support activities with individuals newly diagnosed with HIV/AIDS^{18,19}. Evidence from research and practice suggests that personal contact, and receiving support from an individual with lived experience of one's condition may be helpful for overcoming various forms of HIV-related stigma. Furthermore, behavioural scientists have conducted extensive research into the role of the messenger in campaigns, which could help increase the effectiveness of advocacy campaigns¹⁷. This might entail, for example, involving opinion leaders or influential individuals in the delivery of messages, which may result in greater receptivity at the community level or a stronger signal of injunctive norms.

Improving access to services while activities aiming to raise awareness of mental health and reduce stigma are being implemented, it is crucial to simultaneously ensure individuals have easy access to services. The area of promoting the uptake of services is one where behavioural science has extensive experience.

For example, in Poland, the UNICEF country office developed a campaign called 'The Roof is in Your Hands' to promote the uptake of MHPSS amongst Ukrainian refugees see Case Study #2 below.

Case study #2: Using ABS to encourage uptake of mental health services in Poland

UNICEF colleagues applied behavioural science principles for a project on refugee mental health, with the goal of encouraging Ukrainian adolescents to make an appointment with a mental health provider. In-depth research was conducted to understand enablers and barriers to seeking help from providers.

The following behavioural map outlines barriers (in blue) and steps (in yellow) needed for adolescents to make a mental health appointment and inform others about the appointment (i.e., behaviours, in green). The resulting SBC solutions from this ABS project – called 'The Roof is in Your Hands' – were thus research based and behaviourally informed.

The name of the project itself comes from a Ukrainian metaphor about a roof protecting a house and how taking care of your mental health makes your life safer and healthier

Behaviourally-informed interventions may help increase service uptake and retention.

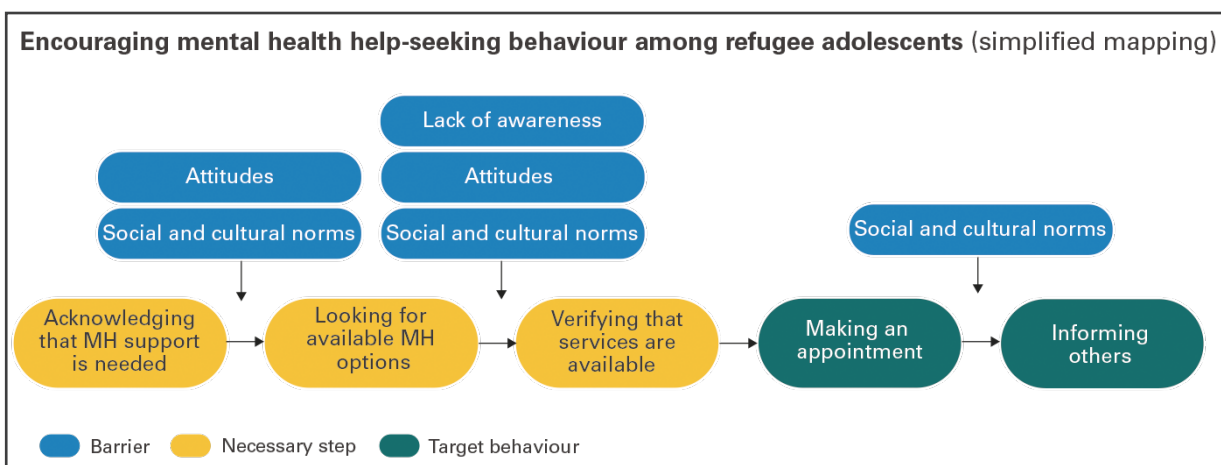
In another example, recognising the cognitive and motivational challenges of uptake of drug and alcohol misuse services by service users, researchers used behaviourally informed interventions to ensure the consistent uptake and retention of services²⁰.

These interventions included the development of treatment calendar and behaviourally informed reminder SMS, to reduce the cognitive burden of accessing services. Furthermore, experiments conducted by International Rescue Committee found that messaging focusing on the views of peers instead of professionals were more effective at promoting the uptake of services.

User experience research can help to tailor the program to the priority population.

The delivery of mobile-based health interventions (m-Health) has been seen as a very successful approach to MHPSS delivery because time, distance, and cost of travel, especially in LMIC contexts, are barriers to uptake of services²¹. Bringing the service to the individuals is therefore one of the easiest ways of reducing the friction to access but has the added benefit of avoiding public stigma.

Figure 1. A behavioural map for encouraging refugee adolescents to seek mental health support



Source: Adapted from 'Behaviour Science in Mental Health Refugee Response in Poland', UNICEF Refugee Response Office, Poland.

However, uptake and retention of mobile-based interventions can be low. One study about how to design effective m-Health, or mobile-based, interventions for mental health support found that a key factor for delivering a successful intervention to ensure the program components align with the needs and preferences of the priority population (e.g., that it fits into the user's daily routine, that prompts are sent at appropriate times)²². Here, methods from behavioural science that try to deeply understand people's experiences helps to identify different effective program components, develop and validate insights into how user interact with those components²³ through experimentation, and deliver a personalised experience that maximises uptake and retention.

Promoting retention and adherence

within psychotherapy, an estimated 19% of patients do not complete their treatment²⁴ resulting in poor use of resources and slower rates of recovery²⁵. Patients indicate that having a sense of autonomy and understanding the potential advantages of therapy encourages participation in community therapy groups, while insufficient knowledge about the available treatments hinders attendance²⁶.

With regards to autonomy, preference of treatment (i.e. patients having a choice of their treatment) itself has a 14% point increase in retention of MHPSS²⁷, however it is unclear whether preference of treatment leads to better clinical outcomes.

Here, behavioural science insights in choice architecture (the design of different ways in which choices can be presented can support the treatment decision-making process. For instance, presenting patients with a visual aid outlining the benefits of different treatment options – with the most selected choice highlighted for each case may increase their sense of autonomy and understanding of the benefits of therapy)

Case Study #3: Continuously engaging with patients to avoid dropout.

Many people might drop out of health systems due to long waits for services, especially within systems that have minimal resources and where service users are experiencing mental health or psychosocial problems.

Ongoing is key for those on the waiting list, which is why the Behavioural Insights team, working with the Improving Access to Psychological Therapies (IAPT) programme in the UK, developed an intervention that continually engaged with patients on the waiting list, reassuring them that they had not been forgotten and would be attended to.

Behavioural science techniques can help to increase retention in MHPSS activities.

For instance, commitment devices can encourage patients to stick to their treatment plans by having them set specific, actionable goals. Additionally, leveraging the foot-in-the-door technique, where therapists start by asking service users for a small commitment that gradually increases over time, can also improve retention.

This has been seen in therapies where initial sessions are kept short and less intensive, gradually leading to more in-depth treatment as the patient becomes more comfortable. Moreover, the principles of social proof and normative influence can be applied to encourage attendance. For example, informing patients that others with similar conditions have seen improvements with consistent attendance can motivate them to continue their treatment.

Behavioural science as it relates to the treatment of mental health.

Behavioural science can be applied to clinician decision-making to mitigate these biases and improve outcomes. Where the service side is concerned, MHPSS practitioners, clinicians, and other health care providers are susceptible to cognitive biases as much as the general population, which may influence their judgment and ability to provide quality care.

For instance, research consistently shows that healthcare providers often hold pessimistic beliefs about the likelihood of recovery, which is experienced as a source of stigma and a barrier to recovery for people seeking help for mental illnesses²⁹. Another study among trauma-focused cognitive behavioural therapy (TF-CBT) clinicians in the US found that biases such as choice overload, which makes it more difficult to make decisions amid many options, and decision fatigue, which leads to poorer decision-making, led them to only complete Trauma Narrative (TN), a core component of TF-CBT, with half of their patients. Behavioural insights such as these were used to identify interventions to increase its completion³⁰. These included, for example, the use of a decision aid (such as checklists, trauma hierarchy, or flowsheet), which uses the patient’s clinical characteristics to guide TN priorities.

What ABS Can Learn from MHPSS

Certain elements of the MHPSS approach and the focus on promoting well-being and improving coping among the broader population can inspire behavioural science. For example, one of the criticisms, of the latter, is the tendency to emphasize individual attributes and characteristics when related to decision-making when structural or social barriers are often to blame. Conversely, MHPSS interventions utilize integrated support systems and multi-layered support structures while recognizing the strengths and roles of different individuals. For example, in Liberia, researchers found that providing cognitive behavioural therapy (CBT) training to young men engaged in crime showed a large and persistent effect in reducing criminal and violent behaviour³¹. This effect was even more pronounced when the CBT training was paired with a direct cash transfer.

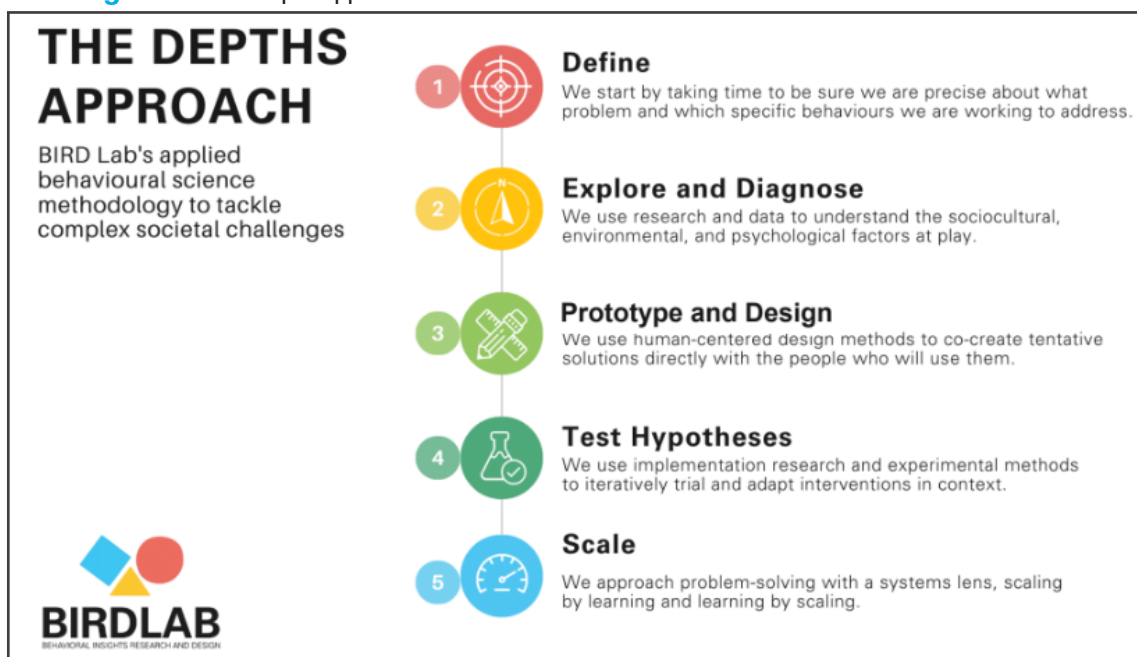
MHPSS can also play a critical role in improving the application of behavioural science by addressing the potential negative by-products of its interventions. Behavioural science interventions, while effective can sometimes lead to a reduction in well-being. For example, interventions that highlight the nutritional value of snacks, while effective, have been shown to reduce an individual’s well-being in response³². Similarly, behavioural interventions designed to promote pro-environmental behaviours may lead to negative welfare effects^{33,34}. For example, they often fail to consider the financial costs consumers incur to generate energy savings (e.g., to install improved insulation) or the time costs devoted to turning off lights or adjusting thermostats. Therefore, insights from

MHPSS interventions could be considered and integrated when designing behavioural interventions to take into consideration its downstream effects.

Designing an MHPSS Intervention with ABS Principles



Figure 2: The Depth approach



Behavioural Science Process

To explore avenues in which behavioural science can collaborate with MHPSS, it might be helpful to highlight the process of a behavioural science project. At UNICEF, the DEPTHS approach is used.

The DEPTHS approach offers a systematic and evidence-based framework for designing, implementing, and evaluating interventions that improve child and family mental health and psychosocial wellbeing. The five steps of the DEPTHS approach (each of which starts with a letter in the DEPTHS acronym) strongly emphasize research and iterative prototyping, while also addressing adaptation and scaling.



Step 1. Define

In the first step, MHPSS practitioners should be specific about which behaviours they would like to address for specific groups at different levels of the socio-ecological model (depending on the level(s) where they intend to intervene). To this end, programme planners may choose to hold a project inception workshop to define objectives, select the project focus, and begin to identify priority behaviours. Where feasible, this process should include an intersectional lens to examine issues related to equity, diversity, inclusion, and accessibility and include these considerations from the outset of the project. The UNICEF Ethics Toolkit's Behavioral Goal Tool also provides guidance to consider when selecting behaviours to change.

To provide an example, a specific MHPSS behaviour to address at the policy level would be to encourage policymakers to include life skills education in schools to promote mental health for children and adolescents and to mitigate drug and alcohol use.



Step 2. Explore and diagnose

In the second step of an ABS project, MHPSS practitioners should use existing data and research to understand the complex factors surrounding target behaviours. Activities could include desk research, primary data collection, and behavioural mapping (a research tool used to observe and record behaviours in a particular setting at a time). Programme planners may choose to use to carry out participatory activities, such as developing personal profiles and mapping out the user journey toward successfully performing the target MHPSS behaviours. Such activities (among others) help identify the enablers and barriers at the individual, interpersonal, community, and societal levels that may be present at each stage of a person's journey.



Step 3. Prototype and design

In the third step, MHPSS practitioners should incorporate the behavioural insights related to the behaviours of interest and use human-centred design principles to co-design contextually appropriate prototypes (interventions) for each behaviour. This can be achieved through activities such as participatory ideation workshops that meaningfully engage participants from the community. Prototypes should be tested to assess their feasibility, effectiveness, and acceptability in real-world settings. For example, practitioners can hold focus group discussions to test materials and gather reactions.

Feedback collected from practitioners, community members, and other key stakeholders can be used to further refine interventions and ensure they meet the needs of the priority population. Ethical considerations related to project design should be incorporated at this stage. More information is available in [The UNICEF Ethics Toolkit for ABS](#).

ABS can also be employed in policy and decision-making by using choice architecture. Remember, the aim is to facilitate better decision-making, not to coerce or manipulate. Some points to consider for prototyping and designing MHPSS policy interventions include:

- Understand the decision context and underlying biases: Begin by comprehensively understanding the context in which policymakers operate. Identify the specific policy area, the stakeholders involved and the key objectives. Recognize the cognitive biases that may be influencing policymakers' decisions. For instance, confirmation bias, i.e., when a person searches for information that supports their beliefs, may be prevalent. A policymaker that does not believe in the importance of MHPSS programs may take the absence of local studies about the effectiveness of such interventions as "proof" that they are not worthy of investment.

- **Frame choices thoughtfully:** Present policy options in a way that highlights their benefits and aligns with policymakers' goals. Use language and framing techniques that resonate with their values and priorities.
- **Limit decision overload:** Avoid overwhelming policymakers with too many options. In decision paralysis, people often go for the easiest choice, which is often no choice at all. Inaction or ignoring MHPSS topics is too often the norm. Provide a manageable set of well-defined choices to prevent decision paralysis
- **Use defaults strategically:** Designate a default option that aligns with the desired policy outcome. Defaults tend to have a significant impact on decision-making. For example, embedding an MHPSS intervention within a popular policy that is likely to be approved may result in it being supported by default.
- **Provide timely information:** Ensure that policymakers have access to relevant and timely information. This may involve summarizing key data, research findings and expert opinions.



Step 4. Test hypotheses

In the fourth step, MHPSS practitioners should employ behavioural metrics and well-being indicators to track intervention effectiveness. While the behaviours that MHPSS programs promote may be difficult to observe and measure, they should be considered carefully from the beginning of any ABS project. Monitoring and evaluation are key to ABS. Testing interventions, learning and adapting are important components of any ABS approach and should be applied iteratively. Data should be collected in a systematic way that takes communities and local context into account, while also linking to standard indicators across settings. Findings should be discussed with the community to obtain real-time feedback on what worked to change behaviour, and how to improve or adapt the intervention.

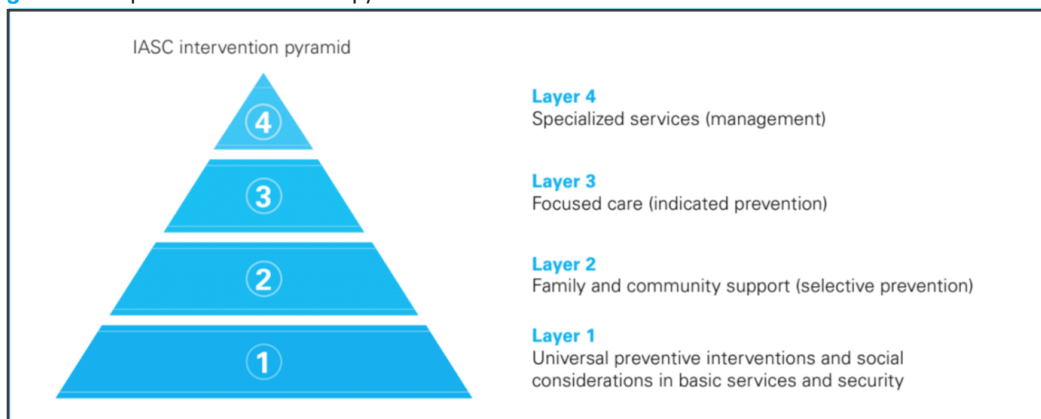
If feasible, consider evaluating the final pilot using experimental methods and implementation research to generate more robust evidence on which interventions worked and in which contexts. Quasi-experimental designs (i.e., studies that do not use randomization) may be employed when trials are not feasible, and mixed methods designs that include qualitative tools to illustrate “why” and “how” a program worked are encouraged.



Step 5. Scale

In the fifth step, MHPSS projects should be scaled up across all layers of the Inter-Agency Standing Committee (IASC) intervention pyramid. Scaling up should take place at each level independently; however, at each level needs increase in service provision to ensure comprehensive support across any country MHPSS eco-system. Continuously adapt interventions based on real-world feedback, emerging barriers and changing contexts. Factors to consider when scaling up include whether the MHPSS intervention was validated by stakeholders and evaluated, how it worked, the challenges encountered, and the conditions needed to ensure success and replicability.

Figure 3. Adapted IASC intervention pyramid



Source: UNICEF Global Multisectoral Operational Framework for MHPSS.

Contextualizing ABS Interventions to MHPSS

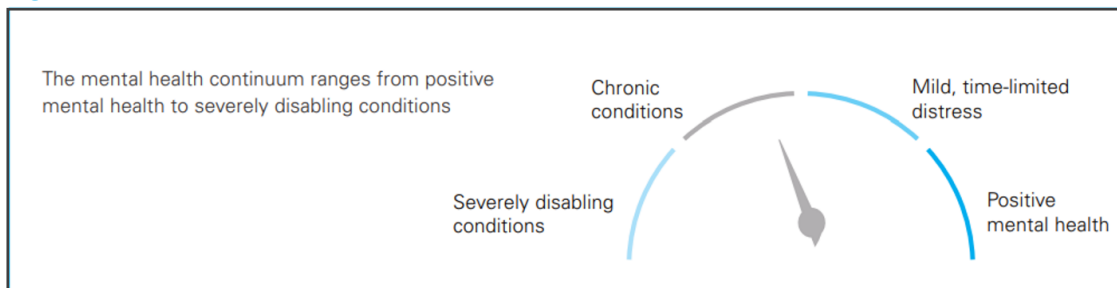
BS emphasizes preventive strategies along the mental health continuum by identifying factors that contribute to the development of mental health conditions and to enable rehabilitation. This aligns with identifying barriers and enablers for early intervention efforts and the promotion of behaviours that prevent deterioration.

These behaviours could include normalizing conversations around mental health and promoting self-care, including early help-seeking and meaningfully addressing faith and spirituality as part of a person's mental well-being.

ABS can also address key life transitions that impact mental health, offering insights into the barriers and enablers of healthy behaviour changes during adolescence, parenthood and aging. By understanding the unique journeys of target participants, ABS can help to design interventions that consider gender norms, disabilities and inclusivity to address these barriers, encourage positive behaviours and promote equal access to MHPSS.

An example of human-centred design in MHPSS can be found
[in this case study for mental health screening in Kenya.](#)

Figure 4. The mental health continuum



Source: UNICEF Global Multisectoral Operational Framework for MHPSS.

Collaboration and a multisectoral approach: ABS principles can be applied across different sectors, including health, protection, nutrition and education, and in various settings, including humanitarian crises, to promote collaborative and integrated approaches to MHPSS. Collaborate with target participants, stakeholders, community leaders and multisectoral experts in MHPSS, communication, and behavioural science to ensure holistic, comprehensive and effective interventions.

Resources for incorporating ABS in MHPSS

The following key resources provide more information for incorporating ABS in MHPSS:

1. [Applied Behavioural Science: Shaping contexts and designing processes and products to enable behaviour change \(UNICEF article\)](#)
2. [Behavioural Insights Research and Design \(BIRD\) Lab \(UNICEF\)](#)
3. [Choice Posture, Architecture and Infrastructure: Systemic behavioural design for public health policy \(journal article\)](#)
4. [Everybody Wants to Belong: A practical guide to tackling and leveraging social norms in behaviour change programming](#)
5. [Global Multisectoral Operational Framework for Mental Health and Psychosocial Support of Children, Adolescents and Caregivers across Settings \(UNICEF\)](#)
6. [Introduction to Behavioural Insights \(UNICEF e-course\)](#)
7. [Mental Health and Psychosocial Support \(UNICEF\)](#)
8. [Mental Health and Psychosocial Support Network](#)
9. [MHPSS Theory of Change Narrative](#)
10. [Social and Behaviour Change at UNICEF](#)
11. [Social and Behaviour Change Theory and Practice \(UNICEF e-course\)](#)
12. [Social and Behaviour Change \(UNICEF\)](#)
13. [Tools and Ethics for Applied Behavioural Insights: The basic toolkit \(OECD\)](#)
14. [United Nations Practitioner's Guide to Getting Started with Behavioural Science](#)
15. [UNICEF Mental Health and Psychosocial Technical Note](#)
16. [UNICEF's Behavioural Drivers Model](#)
17. [Young People's Participation and Mental Health: A protocol for practitioners](#)



ABS for MHPSS Behaviours in action

Imagine you are asked to consider applying ABS to MHPSS where you work. How might you answer the following questions?

- *What is the specific MHPSS problem?*
- *Which specific MHPSS behaviours would you want to address?*
- *How might you conduct research to understand the factors surrounding these behaviours?*
- *What types of solutions might be best suited for this problem?*
- *How would you co-create solutions with people who will use them?*
- *Which methods would you use to monitor and evaluate your programme?*
- *How could this programme be scaled?*

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Annex 1

Term	Definition	Application to MHPSS
Status quo bias	This describes the tendency of individuals to prefer the current state of affairs, resulting in resistance to change. This bias can lead people to avoid personal or institutional changes, even if these could lead to improvement.	A senior manager with many years of experience managing a program may insist on rolling out MHPSS programs as usual, despite newer evidence indicating the need for a shift in strategy.
Commitment bias	Also known as the escalation of commitment, commitment bias describes the tendency of individuals to remain committed to past behaviors, particularly those exhibited publicly, even if they do not have desirable outcomes.	Similar to status quo bias, after making a public announcement about a particular program, a manager may advocate for continuing its implementation despite indication that it is not working as well as planned due to a pressure to behave consistently with that commitment.
Commitment devices	Commitment devices are a way to overcome the tendency of individuals to focus on short-term preferences in favor of longer-term benefits. In other words, they are a way for self-aware people to modify their incentives or set of possible choices to help to overcome impatience or impulsive behavior.	Uptake and retention of mental health support services may be increased by harnessing existing social groups within the community (so that there is a social cost to missing sessions) and requesting enrolment in sessions upfront (as opposed to drop-in formats).
Social desirability bias	This bias is the tendency to underreport socially undesirable attitudes and behaviors and to over report more desirable attributes.	A caregiver experiencing difficulties with parenting a child with disabilities may report to the manager of an MHPSS program that they are coping better than they are in order to "save face."
Temptation bundling	Temptation bundling—pairing a pleasurable indulgence with a behavior that provides delayed rewards—combats present bias by making behaviors with delayed benefits more instantly-gratifying. Simply providing an audiobook to exercise program participants suggests they should temptation bundle.	Pairing a culturally appropriate activity that is enjoyable to the priority population, such as knitting or football, with psychosocial support activities may encourage greater uptake of the latter compared with offering this service by itself.
Behavioural mapping	A research tool used to observe and record behaviours in a particular setting at a particular time. Behavioral mapping can be either place-based or individual-based, depending on whether the focus of observation is to identify locational or temporal patterns of behaviors.	Engaging in a desired behavior, such as seeking psychosocial support, is often a multi-step process that requires practitioners to understand the barriers and enablers at each step, as well as contextual factors. For example, there may be some initial confusion about where to go and how to get there (step 1), followed by some hesitation about disclosing mental health conditions to the health care provider due to previous negative experiences (step 2).

Choice triad	The choice triad is a model that considers the intrapersonal, contextual, and structural factors that shape and affect individual decision-making	An individual’s decision to access psychosocial support services depends on intrapersonal factors, such as his or her knowledge of where to go, self-efficacy, and motivation, contextual factors, such as the socio-normative environment and whether it is acceptable to travel alone, and structural factors, such as the existence of accessible, culturally-appropriate services.
Pledge	Pledges are used to signal the intention to act in a socially desirable way. It is based on the theory that publicly declaring one’s intention to act increases likelihood of follow-through.	During a community meeting, asking adolescents committed to talking about mental health and well-being to pledge that they will serve as a resource for others may increase the chances that will continue to do so.
Social proof	This describes a psychological and social phenomenon where individuals tend to imitate the actions of those around them to try and conform to a behavior appropriate to the situation.	Providing influential messengers such as adolescents with visible cues (such as phone key rings) indicating their commitment to being mental health champions may help to normalize help-seeking behaviors in the community.
Messenger effect	The messenger effect is a cognitive bias that causes individuals to judge the validity or relevance of information based on its source. Rather than objectively analyzing the message's content, individuals interpret the information based on their judgement of the person delivering it.	Seeking out opinion leaders and influential messengers to deliver important messaging can be helpful for engaging others.
Call to action	A call-to-action (CTA) is the simple act of requesting an individual to act, while also providing the rationale and motivation needed.	A call-to-action can reflect the community’s values and priorities vis-à-vis MHPSS activities, and can serve as a unifying force, especially if developed in an inclusive and participatory manner.
Bystander approach	A bystander-based approach calls on third party individuals or witnesses to call out transgressions of social norms or uphold newer, more desirable social norms.	Employing a bystander approach could entail developing a campaign that encourages others to gently remind friends or neighbors about the importance of desired behaviors.