Mission report

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Disclaimer

- The views and ideas expressed herein are those of the author and do not necessarily imply or reflect the opinion of the Swiss Agency for Development and Cooperation, Swiss Tropical and Public Health Institute or Health for All Project (HAP).
- Some of the text reflects the content of the previous report from 2021. Topics that I consider are still relevant are re-iterated, topics and recommendation that were realized or have shown not to be feasible were removed.

Table of Content

Abbreviations

AIMS	Assessment Instrument for Mental Health Systems
CMD	Common Mental Disorder
CGP	Clinical Guideline Protocol
CMHC	Community Mental Healthcare Center
FD	Family Doctor
FN	Family Nurse
HC	Health Centers
HIF	Health Insurance Fund
HO	Health Operators
LUHC	Local Units of Healthcare
MH	Mental Health
MHPSS	Mental Health and Psychosocial Support
MoHSP	Ministry of Health and Social Protection
OCD	Obsessive Compulsive Disorder
PG	Peer Group
PHC	Primary Health Care
PHQ-9	Patient Health Questionnaire - 9
PTSD	Posttraumatic Stress Disorder
SDC	Swiss Agency for Development and Cooperation
ToR	Terms of Reference
ToT	Training of Trainers
WHO	World Health Organization

Summary

Objective

To evaluate and provide recommendations for strengthening mental health integration in Albania's PHC system, focusing on services, competencies of health workers, tools, and sustainability.

Key Findings

1. Progress & Status

- Training of 136 PHC providers and integration of over 100 psychologists and social workers in PHCs has been conducted since 2023.
- Clinical Guideline Protocols (CGPs) for common MH conditions in PHC, developed with HAP support were approved by the MoHSP in 2022.
- The assessment tool PHQ-9, used for depression, is underused during annual checkup
- Integration of Mental Health (MH) services in PHC was rated 3 out of 5 by WHO. This means they are not yet fully functional.

2. Strengths

- Increased accessibility and awareness of MH care.
- The presence of psychologists at PHC level improves trust and care quality.
- Early diagnosis, reduced referrals, improved team collaboration.

3. Weaknesses & Threats

- Lack of supervision and role clarity for psychologists.
- Stigma, lack of communication with specialized services.
- No plan for post-HAP training or structural use of annual checkup data

4. Key Challenges

- Reimbursement restrictions by the Health Insurance Fund (HIF): psychotropic medication needs psychiatrist approval.
- Lack of job profiles for psychologists in PHC approved by MoHSP.
- No structured supervision system or formal intervision groups (peer support).

The integration of MH into PHC in Albania is on track, but needs structural reinforcement, role clarity, training continuity, and policy adjustments. A shift toward inter-professional collaboration, supported by national strategies and simplified procedures, is essential for long-term impact.

Introduction

Embedded into the SDC cooperation strategy 2018 to 2021 for Albania, the overall goal of the Health for All Project (HAP) is:

- The Albanian population benefits from better health thanks to improved primary health care services.

Expected outcomes are:

1. MoHSP and its regional entities manage more effectively and efficiently primary health care service. Citizens in target regions have access to and use effectively primary health care services of better quality.

The current 3rd phase of the project or the consolidation phase, has just finished its second year. Some of the mentioned activities related to MH were: training of 136 PHC providers on working with the MH Clinical Guideline Protocols (CGP's), approaching MH topics in 110 Peer Groups (PGs) with a total of 1076 participants in the 120 HCs (in 17 LUCH) that HAP has been supporting, integrating 100 social workers and psychologists in the Primary Socio-Health Centers and supporting the integration of health and psychosocial services.

The objectives of this consultancy are the following:

- In the light of experiences elsewhere and the observations/recommendations within the expert assignment in 2021, examine and analyse the approach of HAP to the following:
    a. Mental health services at PHC level including within home services addressing needs of vulnerable population groups.
    b. Capacities and experiences of PHC centers in the provision of mental health services to the patients and their families and interlinkages to psycho-social services.
    c. Experiences and potential of psychologist at PHC level for offering good quality mental health services.
- Communicate and work with representatives of MoHSP (Focal Point on mental health), Regional Health Operator, local health authorities (LUHCs and their mental health personnel) and PHC providers on approaches to mental health services to PHC patients and their family members, with a specific focus on elderly people.
- Ahead of the exit of HAP, examine the transfer of responsibilities of HAP in the areas of mental health namely in respect to continuation of training and overseeing the implementation of the mental health guidelines by the PHC teams, psychologists included.
- Summarize the findings and recommendations of the assignment through a synthetic summary report

Approach

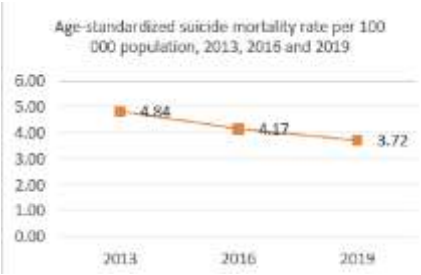
There were pre-mission email contacts about the ToR. Relevant preparatory documents were studied. The developed manuals for MH conditions in PHC and care for elderly patients were translated with google translate to understand the content. Relevant documents, as well as additional scientific literature were read and analyzed. They can be found in the literature chapter below. Full text version is available on request. In the period, June 17th till June 20th several meetings were held as summarized in Annex 1.

Preliminary findings and recommendations were discussed with the HAP team at the end of the mission on Friday 20 June. The report was finalized after additional input and feedback from HAP management. The realized approach is in line with the approach as described in the ToR.

Findings:

(Grey) Literature

The age standardized suicide rate, to be interpreted with caution, is 2.1 in Albania, placing it in the lowest WHO category (<5) (1, 2). The Standardized suicide rate has steadily decreased in the last years. This is in line with a global trend.



Standardized suicide rates (2021, both sexes):

Albania	Netherlands	Bosnia and Herzegovina	Switzerland
2.1	9.1	5.7	14.02

Albania is spending 3% of the GDP, or about 7% if private spending is included, on health (3). It is not known what percentage is spent on mental health. The WHO Assessment Instrument for Mental Health Systems (WHO-AIMS) is a comprehensive tool developed by the World Health Organization (WHO) to assess mental health systems, particularly in low- and middle-income countries. It aims to provide essential information for mental health planning and policy development. AIMS results for Albania show that the amount of psychiatrists in Albania 1.6 per 100.000 population is about average for a upper middle

income country. The amount of nurses working in mental health, is with 8.7 per 100.000 inhabitants higher than in 2014 (6.12). The benchmark is 10 per 100.000 (4).

Actually there is, as far as I could find in grey literature and the most recent AIMS results, neither a family member of patients Organisation or service users in Albania (4). The level of integration of Mental Health in Primary Healthcare, as mentioned in the AIMS results, is considered 3 on a likert scale 1-5, in which 4 or higher means functional integration (4).

The WHO MH atlas reference does not specify which of the criteria are met. The obervsations put are my impression. The used AIMS criteria are:

Criterium	**Observation**
Guidelines for MH into PHC are available and adopted at national level	Guidelines for MH into PHC are adopted at national level (MoHSP, order nr.417, July 7, 2022 and are published at https://fsdksh.gov.al/project/udhezues-per-menaxhimin-e-crregullimeve-te-shendetit-mendor-ne-kshp/ HAP has supported the fullfillment of this criterium by supporting CGP development and implementation.
Pharmacological interventions for MH conditions are available and provided at PHC level	A specialist psychiatric consultation appears to be needed for psychotropic HIF re-imbursement. This fact hinders integration.
Psychological interventions for MH conditions are available and provided at PHC level	MoHSP is posting psychologists and social workers in PHC. HAP is elaborating the Manual for psychologists working in PHC.
Healthcare workers at PHC level receive training on the management of MH conditions	HAP supports this criterium by offering ToT training and support for PG on this topic.
MH specialists are involved in the training and supervision of primary care providers.	MH specialists are the trainers in the ToTs “CGP of MH disorders in PHC” that are still being provided with HAP support.

The included disorders in the CGPs of the management on MH problems in PHC, as developed with HAP’s support are:

- Acute Stress
- Grief
- Depression
- Psychosis
- Epilepsy

- Intellectual Disability
- Harmful use of Alcohol and Substances
- Suicide
- Other significant mental health problems
    - Various physical symptoms without physical causes
    - Changes in mood and behavior that cause distress
    - Complaints related to mild depressive disorder
    - Behavioral problems in adolescents

It is not clear why Acute Stress and Grief were included. They appear in the mhGAP-HIG (humanitarian intervention guide) and not in the mhGAP Intervention Guide, because of their increased burden on society in acute humanitarian situations. The actual situation in Albania is not considered a humanitarian situation.

The included pathologies in the described clinical cases, seem relevant to me and are:

- Depression
- Depression with somatic morbidity (diabetes)
- Generalized Anxiety Disorder
- Management of a young adolescent with schizophrenia
- Suicidal Tendencies with alcohol use and possible PTSD, OCD or personality problems
- Alcohol use
- Depression in elderly patients

MH CGP's that are included in the geriatric management guidelines are:

- Depression
- Dementia

The ToR of the ToT on CGP for mental health disorders in PHC and ToR of the local consultant in charge of developing the manual for psychologists were studied and seemed in line with the projects objectives and scope.

Site visits and meetings

During the **initial meeting** at HAP's office several items were discussed with Besim Nuri, Ehadu Mersini and Sajmira Aderaj.
The Swiss Embassy respectively SDC has respectively is supported 2 other projects that interlink with the HAP:

- Program on health education promotion (Schools for Health Project), executed by Safe the Children, including school based programs

- Emergency Response in PHC (Projekti “SOLIDAR- Bashkë në emergjencat mjekësore”), executed by GFA

The FD residency program has been on stand-by for a couple of years because of a lack of interest. There has been a successful restart with about 20 students. The Msc Program in Healthcare management, supported by HAP in its initial phase, is running well. The. Professional Master program of Family Nursing at the Faculty of Nursing has been suspended due to a lack of students and commitment and it is at risk of losing its accreditation soon.

A total amount of 12 job profiles have been developed and were approved by MoHSP, with HAPs support. The job profile of the psychologist in PHC is still lacking.
The MH CGP’s on mental health were developed by a local consultant and finished in July 2022. Subsequently a series of 2 days training on management of MH problems were realized using the ToT principle. After the ToT sessions and PGs at PHC level, no follow up supervision was realized. About 28% (102 Socio-Health Centers out of 365 HCs now have employed a social worker or a psychologist). This represents approximately 50–60 psychologists at PHC level at this moment. Their integration in services has proven challenging. This was one of the reasons to develop an additional Manual for psychologists operating in PHC.

The **meeting with MoHSP** Emanuella Tollozhina (ET) was conducted at the premises of MoHSP. The MoHSP is now working on the new National MH strategy plan 2026-2030. Since November 2024 the department on mental health was added to the MoHSP organigram.

The existing MH action plan 2023-2026 is under the umbrella of the health system strategy. A multi-sectorial national plan of suicide prevention 2025-2030 is going to be launched in September 2025 with support of a EU subsidy.

ET raised the concern that the PHQ-9 is underused if compared to other parts of the annual checkup/check-up. PHQ-9 is used as a self-report questionnaire, but it remains unclear if patient does not fill it in or the FNs don’t insist or support by clarifying questions.

102 HCs have included psychosocial staff in their organigram (psychologist or social worker) and are therefore considered socio-health centers. There’s not any specific plan on how to train healthcare providers in PHC centers after HAP project has finished.

There’s future about increasing financial funds for the 1) increase of the payment for caregivers for mentally ill patients in need of continuous support and 2) establishment of 3 new Community Mental Healthcare Centers (CMHCs). ET raised the concern about the capacity of the LUHC to monitor mental health services in PHC.

During the **meeting with Artemis Shehu** (Local Consultant mobilized by HAP for the development of the Manual of Psychologists working in PHC) we discussed the development of the manual for psychologists working in PHC. A degree in clinical psychology is obtained after 3 years of Bsc- and 2 years of Msc program. In 2016 the professional Order of

Psychologists was established, strengthening the position of psychologists around the country (5). Some of the mentioned challenges of the psychologists working in PHC can be summarized as followed: there's a lack of questionnaires and simple therapeutic tools, positioning of the psychologist in the multi-disciplinary PHC team, which conditions to attend and for what amount of sessions, what kind of standardized questionnaires can be added to the manual for the psychologists to use.

During the **roundtable discussion** with a group of 3 Family Doctors, 3 Nurses and 4 Psychologists working in HCs supported by HAP, there was active participation of all participants. After a general introduction, the implementation of MH in PHC was discussed. The group gave the impression that the integration went well in general and that there were no fundamental discussions in the HCs on whether to integrate MH in PHC. A SWOT analysis was performed on the integration of MH in PHC and some recommendations were made for the manual for psychologists (6).

Strengths	**Opportunities**
Improved accessibility to MH care Easier follow up on MH cases More trust (bidirectional) in PHC service We work with a broader view from the holistic perspective Improved collaboration in PHC teams Early Diagnosis and Treatment of MH conditions Less referrals needed to MH services More active and passive case finding of MH	The presence of Psychologist in Socio-Health Centers: More multi-disciplinary collaboration We can use the PG approach to learn about MH conditions The experience with HAP: HAP is expected to conclude its support so LUHC will mobilize their own resources to provide support for the integration of MH into PHC Big number of nurses in HC: More effective engagement of nurses
Weaknesses	**Threats**
Lack of time Poor physical infrastructure of HCs, lack of space hindering the privacy and confidentiality of the consultation included Lack of training and expertise Positioning of psychologists in PHC teams Lack of motivation	Stigma related to MH conditions Not a good two-way communication between HC and specialized MH Services, namely Community Mental Health Centers: Lack of social workers and psychologists in basic Health Centers (not Socio-Health Center) HAP is expected to conclude its support to PHC

Several suggestions were done on the development of the manual for psychologists:

- Give psychologist a role in supporting the mental health of PHC professionals
- Include small tools and simple techniques as not yet included in the MH CGP
- Give the psychologist a prominent role in multi-disciplinary communication between the colleagues

- Psychologists can play an active role in case finding
- Active attitude when transfer of more severe cases
- Give the psychologists a role in training the rest of the PHC team on MH issues

There was a **roundtable discussion** with 2 specialists from Tirana Central Health Operator and 6 MH specialists from LUHC Elbasan (2), Shkodra (2) and Kavaja (2). Another SWOT analyses was done on the integration of MH in PHC which led to a lively discussion. The results were like the previous discussion which I think is very positive.

Strengths	**Opportunities**
Improved accessibility to MH care Presence of psychologists improves the quality of care More trust (bidirectional) in PHC service Existence and expansion of MH residential services Consultation possibilities from MH specialist Expansion of number of CMHCs MH training improves quality of care More awareness about MH in general	More MH promotion activities More socio-health centers Presence of HAP Integration of psychologists/social workers in PHC Job description of psychologists Psychologist can receive the referrals from CMHCs
Weaknesses	**Threats**
Absence of child psychiatrists outside Tirana Lack of time Patients go directly to psychiatrists, not via PHC	Stigma related to MH conditions Nurses are not engaged

The topic of annual checkups was also discussed. Knowledge about the mental health related aspect/instrument (PHQ-9) of annual checkup was low, the checkup appears not to be integrated in other services and there appears to be no structural feedback on individual or aggregated level. Aggregated data, it was said, may go to the private company that provides this service. The only information that is provided to HO is the number of checkups. Tobacco, drugs and alcohol use are part of a lifestyle questionnaire administered during annual checkup. The annual checkup, although, it has great potential, it does not seem part of a quality cycle and is not embedded comprehensively in PHC and other services.

The **meeting with the ToT trainers of the MH CGP** was held at HAP office. In terms of the referral mechanisms between PHC and psychiatric services there was not much to synthesize or recommend that fits within the scope and duration of the HAP project. The role of psychologist in 1) promoting emotional selfcare in teams and 2) moderation of PG on MH, were discussed. The trainers see potential there which also appears to be feasible.

A group of about 20 **residents in Family Medicine** were met at the Medical Faculty. Most had extensive experience in PHC before entering the residency program (9 years average). None of them worked in a socio- health centers with social workers or psychologists. No structural consultation by psychiatrists in PHC was in place, but the possible scenario on how to organize this was welcomed positively. There was a general impression mentioned by the group that the PHQ-9 as part of check-up was underused or not valid. There was no aggregated data feedback to HC on the annual checkup. I do consider one of the administrative scenarios as a threat for successful implementation of the MH CGPs in PHC. The group mentioned that about 90% of the prescribed drugs are re-imbursed by the HIF. But for a drug to be re-imbursed by the HIF there's a consultation needed by a specialist. So, for example: if a depressive disorder is diagnosed in primary care and treatment is accepted and prescribed by the FD, there's still a consultation by a psychiatrist needed for reimbursement, leading to more expensive and less accessible care. If this mechanism is to change, it will probably have to be discussed with MoHSP and the HIF.

Other Findings

The CGPs on MH were based on the mhGAP Intervention Guide and adapted to local Albanian reality during the second phase of the HAP project. Experiences from the HAP project and recent evidence on implementing MH programs in PHC stress the importance of continuous supervision (7, 8). During my field trip to PHC centers in 2021 I understood that outpatient consultations of specialists was part of PHC services in Tirana. In 2025, the MoHSP representative confirmed that there's a reasonable number of psychiatrists available in the country. The mental health atlas 2020 shows the total number of 46 psychiatrists in Albania with 1.6 psychiatrist/100.000 inhabitants. The global average of psychiatrists is about 1/100.000 inhabitants and with 1.6 Albania the number of psychiatrists per 100.000 inhabitants is about average for an upper middle-income country.

When implementing new strategies, like implementing MH service provision in PHC, make use of the Diffusion of Innovations strategy as described by Orr (9). PHC or LUHC employees can be divided between Innovators (2.5%), early adopters (13.5%), early majority (34%), late majority (34%) and laggards (16%). Each group needs different information and approach in the subsequent steps of change. These principles can be used in several contexts.

Since the lifestyle questionnaire in the annual checkup provides information on drug/alcohol/Tobacco use this opens the way to implement the methodology of "Very Brief Advice" for smoking cessation. It has proven effective, acceptable and feasible and saves lives, since quitting nicotine use is one of the best lifestyle health decision someone can make. It is described in the literature and was recently evaluated in Greece (10, 11). This intervention is very simple. It can be performed by any professional like FN, FD and psychologist. In line with adding extra "tools" to the CGP for psychologists this one can be added to the manual.

Recommendations:

1) General

- Provide continuous education to PHC personnel on how to deal with MH conditions in PHC (MH department in MoHSP should plan, support and monitor the implementation of them through MH Departments or PHC department of LUHC (where the separate department on MH does not exist). The CGPs in MH and the manual for psychologists, as developed by HAP, should be used.
- Develop and let MoHSP approve the psychologist job description for use in PHC (MH department in MoHSP should draft and follow-up the endorsement)
- Adapt the PG approach to develop an additional role beside classical training with external facilitators. Make the PGs intervision groups. By bringing in own cases a process of collective learning will develop. This should be done by the LUHC in collaboration with HAP. See ANNEX 2.
- Promote patient follow up and counseling as recommended in the CGPs developed by HAP. Done by LUHC and PHC professionals.
- For HAP: Include small tools and simple techniques in the Manual for psychologists operating in PHC as far as not yet included in the MH CGP (listed in the next recommendation paragraph and ANNEX like black dog, very brief advice, traffic light method, analysis of PROs and CONs)
- Active attitude of FD while transferring the most severe cases towards specialized MH services or receiving them (live handover or with a call). The LUHC should stimulate and supervise this.
- Remove the condition that, for psychotropics to be reimbursed, a consultation by a psychiatrist is needed. This appears to be a responsibility for MoHSP with HIF.
- Organize formal PHC supervision by a psychiatrist, in which, for example, once a month during morning the PHC professionals consult the psychiatrist for advice and, if needed, see the patient together. This model guarantees continuous learning and empowerment of PHC professionals. Organized by the LUCH and supported by HAP.
- The HCs should organize and implement regular health promotion activities on drugs, tobacco and alcohol with individuals who score positive on this items in the annual checkup and their families. Organized by the LUCH.
- The HCs should organize and perform regular health promotion activities on depression and other CMDs. Invite those patients who score >4 on the PHQ-9 and their families. Organized by the LUCH. HAP considers including it in the manual for psychologists.
- Monitor if the “IfightDepression” platform is going to be used on a larger scale in PHC and, if so, include a link to the online intervention tool in the updated CGPs. See also my 2021 report (12). Find out with MH department of the MoHSP. Update CGPs by HAP and by department of MH of the MoHSP after the projects ends.

- Explore the possibilities of structural feedback from aggregated data on disease prevalence to PHC professionals, in collaboration with MoHSP and the Department of public health from the University.
- Include 1 working day to the international consultant to give feedback on the manual for psychologists (either by mail of zoom) or ToT trainers if needed.

2) Manual for psychologists

Should give the psychologists the following roles, in:

- training the rest of the PHC team on MH issues
- facilitating PG meetings on MH in a semi-structured, confident and emotionally safe way..
- playing an active role in case finding through the annual checkup

Include in the manual the following tools/procedures to foster their use in routine clinical care:

- the tool: Watching the WHO black dog film on depression with (automatically generated) Albanian Subtitles, and after reflecting with the patient on what is seen and can be done: https://www.youtube.com/watch?v=XiCrniLQGYc
- the tool: Provide Very Brief Advice for people that score positive on Tobacco use in the annual checkup (10, 11) (see ANNEX 3)
- Performing an analysis of Pros and Cons for at least alcohol-, drugs and tobacco use, consider performing it in other health related behavioral problems (example: not doing sports, not complying with prescribed somatic treatment). The methodology has been described by Mann & Prochaska as a small and simple part of motivational interviewing (13) (14). The tool is recommended to use in the presence of the patient and his/her family. (see ANNEX 4)
- Psycho-education and monitoring for patients with dementia including their families, since the emotional toll is high for family members. Refer to the existing steps in the HAP CGP for elderly patients.
- The procedure: Check the PHQ-9 from the annual checkup and invite the patient for follow up if the score is 5 or higher (5-9 can indicate moderate depression)
- The procedure:Check the PHQ-9 from the annual checkup and invite the patient for follow together with the FD is the score is 10.
- The procedure: The Questionnaire Core-OM since it can give a good overview of psychological functioning and it has been translated and validated in Albania (15). It is mentioned in the CGP on care for elderly people. In this way, the psychologist can be a reference point in the PHC team concerning this questionnaire.
- the questionnaires: MMSE and MOCA since they are mentioned in the CGP on care for elderly people. They are advised to use to further investigate a patient after scoring positive on the mini-COG.
- the questionnaires:PHQ-9 since its part of the annual checkup and appears to be underused.

- the questionnaires: Geriatric Depression Scale(16). It is mentioned in the CGP on care for elderly people. It can help the PHC professionals to further evaluate the possible existence of a depression. In this way, the psychologist can be a reference point in the PHC team concerning this questionnaire.
- the procedure: play a prominent role in supporting the mental health of PHC professionals by 1) advocating for the importance of professional's own mental health 2) implementing the "traffic light methodology" in the teams and 3) implementing "sharing successes" (see ANNEX 5)
- procedure: Psychologists play an active role in case finding through 1) findings from annual checkup 2) checkup of relatives from patients affected with severe MH conditions.

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ANNEXES

1) Supervision and intervision

The PGs are functional and, although mentioned in the project risks in the Yearly Progress Report, are of great potential. To improve its quality a Peer Group Supervision, also called intervision, could be introduced. Intervision is peer-based, informal and less structured than official supervision or training on a certain topic. Some of the main differences between supervision and intervision are mentioned here and can be further read in the book chapter of Tuomola from 2024 (17). Adding intervision to the PGs can improve quality of services because it stimulates collective learning and autonomous problem solving. Several colleagues suggested that the psychologists could play a prominent role in enhancing open communication in PHC teams. So, it's logical to train them on intervision and let them chair the meetings.

Feature	**Supervision**	**Intervision**
Structure	Hierarchical, formal	Peer-based, semi-structured or informal
Relationship	Supervisor-supervisee	Peer-to-peer
Focus	Individual development and performance	Collective learning and problem-solving
Authority	Supervisor has authority	No formal authority

2) Very Brief Advice

The concept of "Very Brief Advice" can be summarized as follows. Specialist support be follow up by any of the PHC professionals (FN, FD, psychologist)

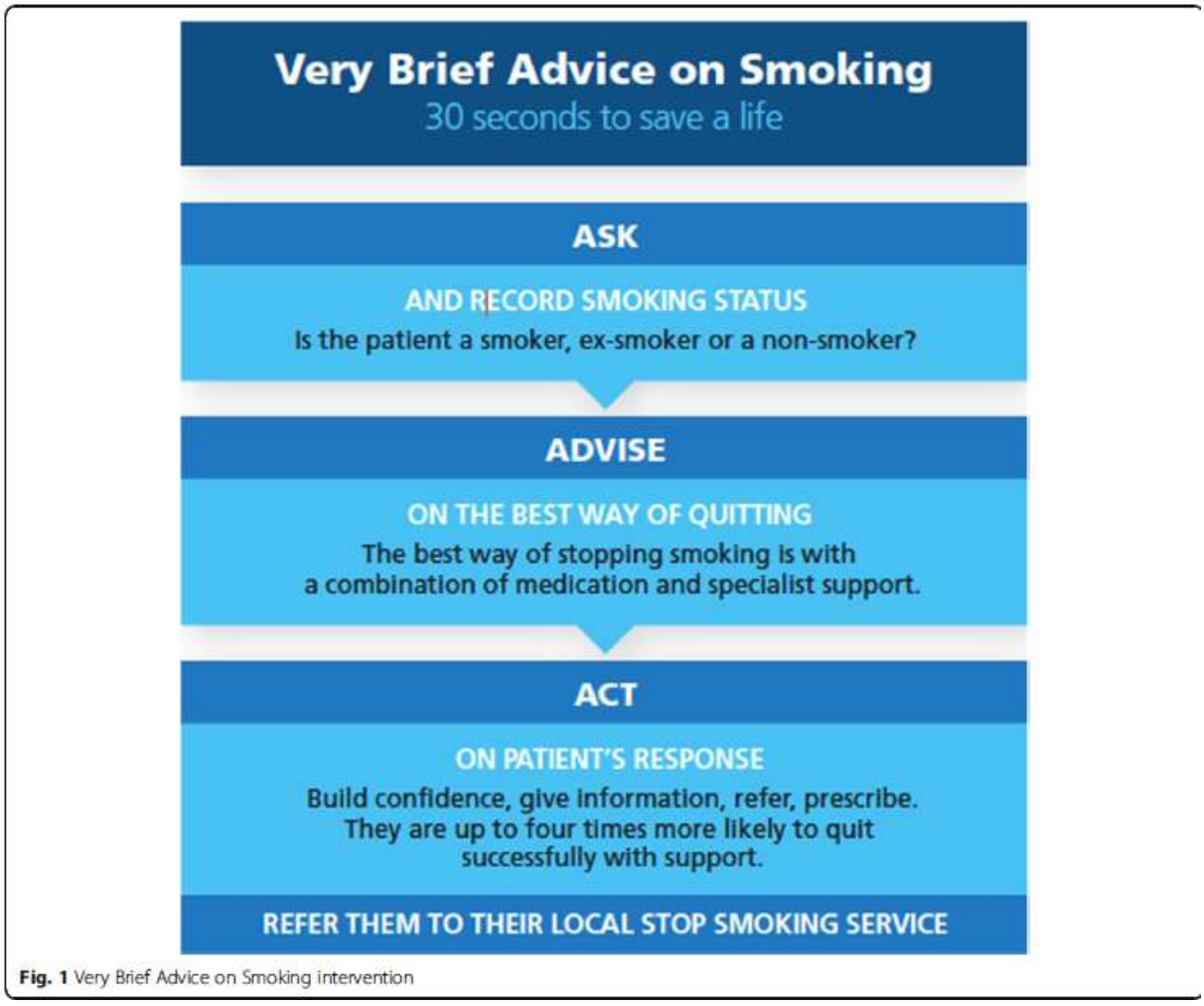

Fig. 1 Very Brief Advice on Smoking intervention

3) Analysis of Pros and Cons

1) Set the Stage
- Ask permission to explore together:
"Would it be okay if we look together at the pros and cons of this decision?"

2) Draw a Simple Table
| Pros (Advantages | Cons (Disadvantages) |

|----------|----------|
|
What are the benefits of change? What are the downsides of change?

3. Ask Open Questions
- "What are the good things about making this change?"
- "What might be difficult about it?"
- "What do you like about the current situation?"
- "What are the downsides of staying the same?"
4. Explore Ambivalence
- "What stands out most to you?"
- "Which side feels more important right now?"

5. Summarize and Support Autonomy
- "It's your choice. I'm here to support you either way."

Tips:
- Use neutral language.
- Allow silence.

4) Using visual management in self care

The method is used by a group of peers of colleagues that work together on a regular or daily basis, it is used at the beginning of a day or a meeting. The moderator or chair of the meeting takes the initiative to start the traffic light method and makes sure that everybody speaks and that it does not take too long. As an introduction is said:

- What the different colors mean
- The problems bothering can be professional or personal
- The colleague is NOT obliged to go into details about the problem
- That the exercise will not take more than 5 minutes

The introduction will be known by colleagues when the method is used in daily practice, but still it's recommended to mention it. If colleagues start asking questions about the mentioned problems bothering: that's OK but make sure the colleague is at ease to answer and manage time. The idea is that teams the apply this method learn that: it's OK to have problems and still come to work, it's OK to share your problems. The peer group of colleagues will often start to help the "red" colleague by, for example, supporting the colleague with a specific task that day or asking again how somebody is doing later that afternoon. That is a good result.

The meaning of the colors.

Red: I am not OK. There's a professional or personal problem bothering me severely. I am here but I don't really feel like working, I would like the working day to be finished as soon as possible.

Orange: I am reasonably well. There's a professional or personal problem bothering me. I feel like working but I will not be able to function as I would normally do.

Green: I am fine. I feel energetic and relaxed at the same time. I am looking forward to my day and confident that we will be able to confront the challenges that come up.

The start of the meeting or day with the traffic light method can be finalized with the invitation of a colleague to share a “success”. Something that went very well and can make the colleague and the team feel proud. The method can result in cultural change concerning empowerment and self-care if applied as a routine and short activity in which team leaders/directors give an example.