



International
Medical Corps

CASE STUDY

Mental Health Integration in General Health Care: a Step-Wise Approach

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INTRODUCTION: WHY INTEGRATE MENTAL HEALTH INTO GENERAL HEALTH CARE?

Mental health is an important public health problem in humanitarian crises

Mental health problems affect one in five people globally. Depression alone was the third leading contributor to the global burden of disease (4.3%) in 2004 and is projected to reach first place in 2030¹. The risk for developing mental health problems is much higher in humanitarian emergencies, where populations affected by conflict and crises frequently suffer various severe and inter-related stressors such as being exposed to violence, losing their homes, livelihoods, material belongings, and community or social support systems and they may lose or become separated from loved ones. People with pre-existing mental disorders are especially vulnerable in humanitarian settings, often do not have access to necessary services and are at risk for violence and abuse. Mental disorders in humanitarian settings impair day to day functioning and can be key barriers to accessing needed basic services and support.

Access to appropriate mental health interventions remains a critical gap

World Health Organization (WHO) estimates that approximately 4 out of 5 people with mental health conditions do not receive care in low and middle income countries². There is already a shortage of qualified specialized mental health workers in those countries which is compounded during humanitarian crises, where health facilities may be damaged, the availability of health staff is often limited, and access to health facilities can be compromised. To close the gap between people who need mental health services and those who have access to them, WHO has been recommending the integration of mental health (MH) into general health care³ by training doctors and nurses in the frontline management of mental health priority conditions.

Global guidelines to train general health workers in mental health exist but there is a need to learn more about how they can be used in humanitarian settings

Global guidelines for the integration of mental health into general health care have already been developed by WHO with input from other agencies including International Medical Corps. The WHO released the *Mental Health Global Action Program Intervention Guide (mhGAP-IG)*⁴ for the management of mental health priority conditions by general health care providers in 2011 and WHO mhGAP-HIG guidelines specifically for humanitarian settings in 2015⁵. Aside from being cost-effective, offering services through existing general health care is an accessible, non-stigmatizing way to offer affected populations assistance. However, documentation of experiences and lessons learned is needed to better inform their use in humanitarian settings, which pose unique challenges.

The purpose of this report is to evaluate and document the integration of mental health into general health care using WHO mhGAP-IG Intervention Guidelines in three humanitarian settings (the Philippines, South Sudan and Central African Republic) and to share common steps as well as experiences and lessons learned with other organizations and agencies, which can further inform and improve similar programming globally.

1 The global burden of disease: 2004 update (2008) chapter Part 4: Burden of disease: DALYs http://www.who.int/healthinfo/global_burden_disease/en/index.html

2 WHO World Mental Health Consortium. Prevalence, severity and unmet need for treatment of mental disorders in the World Mental Health Organization world mental health surveys. *JAMA* 2004; 291: 2581–90.

3 World Health Organization. (2008). Scaling up care for mental, neurological and substance use disorders. Mental Health Gap Action Program. Geneva, Switzerland.

4 WHO (2011). Mental health Global action Program Intervention Guide (mhGAP-IG): http://www.who.int/mental_health/mhgap/evidence/en/index.html

THE COUNTRY CONTEXT: THREE HUMANITARIAN SETTINGS

The three settings that are the focus of this report are the Philippines, Central African Republic (CAR), and South Sudan, all sites where International Medical Corps is implementing mental health primary health care (PHC) integration programs for non-refugee populations affected by conflict or crises.

Two of the programs (South Sudan, CAR) are based in countries affected by prolonged conflict and embedded within International Medical Corps long-standing engagement, while one (Philippines) was initiated following a natural disaster in a country where International Medical Corps had not worked previously. While the Philippine model focused on capacity building of existing government staff, the South Sudan program involved both training and implementation within International Medical Corps run health facilities albeit focusing on national staff. The CAR program similarly focused on government facilities but provided both training as well as clinical interventions through government and International Medical Corps staff.





PHILIPPINES

The International Medical Corps mental health program began in January 2014 (and ended in March 2015) as an emergency response to the devastation wrought by Typhoon Yolanda in the Province of Leyte.



SOUTH SUDAN

The mental health program began in August 2014 (and is currently ongoing) in four States that were severely affected by the escalation of violence in December 2013 leading to millions of internally displaced people.



CENTRAL AFRICAN REPUBLIC

The mental health program is being implemented since February 2015 in Bria located in the northeastern prefecture of Haute-Kotto. Significant mental health needs have been identified due to the widespread exposure to violence that had worsened during end 2013.

METHODS OF DATA COLLECTION

A mixed methods approach of qualitative case study methodology as well as quantitative data collection was used to document activities in the 3 program sites (see Figure 1)⁶. Outcomes and successes of integration were analyzed through perspectives of service users, service providers and other relevant stakeholders (e.g. government representatives).

Tools and instruments: Data collection tools were adapted from WHO UNHCR (2012) assessment toolkit⁷, as well as International Medical Corps specific tools. Measures included facility level checklists (MH PHC Integration checklist), measures of knowledge and skills among trainees (Knowledge & Attitudes Questionnaire, On the job Supervision Checklist), and client measures (satisfaction with services, client functioning outcomes).

Process and timeline: Data was collected by in-country project coordinators supported by the global project manager at 3 different time points – December 2014-January 2015, March-April 2015, and June-July 2015.

End of project workshops: Country level workshops with key stakeholders to share findings and lessons learned and to discuss next steps for mental health integration were conducted in all three countries in November 2015 (Philippines), December 2015 (South Sudan), and January 2016 (CAR).

6 Cohen, A, Eaton, J., Radtke, B., de Menil, V., Chatterjee, S., De Silva, M. & Patel, V (2012). Case Study Methodology to Monitor & Evaluate Community Mental Health Programs in Low-Income Countries. CBM. <http://www.cbm.org/Community-Mental-Health-case-studies-manual-366724.php>

7 WHO/UNHCR (2012) Assessing Mental Health and Psychosocial Needs and Resources - Toolkit for Humanitarian Settings



Figure 1: Methods of data collection to document mental health PHC integration

RESULTS: STEPS OF MENTAL HEALTH INTEGRATION

In summary, mental health PHC integration in humanitarian settings can be conceptualized as occurring in several incremental steps:

1. Ensure stakeholder engagement and conduct baseline situational analysis
2. Build capacity of general healthcare staff to provide mental health care
3. Provide clinical and community level interventions for people with mental illness
4. Ensure holistic integration by strengthening referral mechanisms, adherence to treatments and medication supply
5. Engage in networking, coordination, and advocacy
6. Support sustainability of mental health services integrated into general health care

The following section describes each of these steps, challenges encountered and strategies used to overcome them.



1. ENSURE STAKEHOLDER INVOLVEMENT AND CONDUCT BASELINE SITUATIONAL ANALYSIS

Before setting up a mental health integration program, it is important to understand the context including existing national policies pertaining to mental health, staff capacities in country, what other actors are already providing as well as belief systems and care seeking around mental health in affected communities. This process involved

desktop reviews, semi-structured interviews and focus group discussions with key informants to obtain a comprehensive understanding of mental health and psychosocial needs of the community, information about mental health policies and legislation and mapping of mental health resources and services.

Table 1. Summary of situational analysis findings⁸

	PHILIPPINES	S SUDAN	CAR
POLICY AND LEGISLATION	<p>MH policy available</p> <p>MH Strategy available</p> <p>No MH Act</p>	<p>No separate MH policy</p> <p>Draft MH Strategy</p> <p>MH part of BPHS (Basic package of Health Services)</p>	<p>MH Policy developed but not implemented</p> <p>No MH Strategy</p> <p>MH Guidelines available</p>
HEALTH SYSTEM	<p>Infrastructure damage due to Typhoon</p> <p>Staff migration</p>	<p>Very poor health infrastructure outside Juba</p>	<p>Healthcare facilities heavily impacted by the crisis (e.g. Outside Bangui, more than half facilities non-functional)</p>
MENTAL HEALTH SERVICES	<p>6 psychiatrists for 1.8 million in Leyte</p> <p>2 inpatient facilities in Leyte</p> <p>No PHC staff trained so far in Leyte</p> <p>Psychotropics generally not available (Medicine Access Program not implemented)</p>	<p>2 psychiatrists in country</p> <p>1 psychiatric department in Juba</p> <p>No PHC staff trained</p> <p>Psychotropics inadequate and available only in Juba. Access only through private pharmacies</p>	<p>1 psychiatrist in country</p> <p>1 psychiatric department in Bangui</p> <p>No PHC staff trained</p> <p>Psychotropics inadequate and available only in Bangui. Access only through private pharmacies</p>
SOCIO-CULTURAL ATTITUDES TOWARDS MENTAL HEALTH	<p>Stigma</p> <p>Many restrained/caged</p> <p>Traditional healing sought for severe mental illnesses by faith healers (Tambalan) who provide potions to drink</p>	<p>Stigma and human rights abuses. People with severe mental illness sometimes locked up in prison</p> <p>Traditional faith healing for psychosis often involves sacrificing animals</p>	<p>Stigma and human rights abuses</p> <p>Traditional healers, religious leaders and village chiefs are very influential and are approached for advice/treatment for mental health problems</p>

⁸ Detailed Situational Analysis reports for each country are available from International Medical Corps, please email iweissbecker@internationalmedicalcorps.org if you would like to receive a copy

2. Build capacity of general health care staff to provide mental health care

2.1. Adaptation of the mhGAP-IG material to the local context

All sites used a combination of steps to iteratively adapt the mhGAP-IG and training material to the local setting. This included a needs assessment involving various stakeholders, drawing on experiences during the training, feedback from partic-

ipants and experience in the field during supervision visits. Examples of adaptations to the mhGAP training material are summarized below (Table 2).



Table 2. Summary of adaptations to the mhGAP-IG

ADAPTATIONS	EXAMPLES
<p>A) Simplification of material so that it is more accessible to PHC staff with limited skills and qualifications</p>	<p>Limiting the number of mental health priority conditions to those most relevant in each setting</p> <p>Restricting medication information to 1-2 drugs per priority condition in CAR</p> <p>Reduced emphasis on advanced psychological interventions in S Sudan and CAR</p>
<p>B) Addition of material based on identified needs in the community</p>	<p>Inclusion of stress and anxiety module in all 3 settings and greater emphasis on Post-traumatic stress disorder (PTSD) in CAR</p> <p>Addition of a module on insomnia in the Philippines given that it was a common complaint in the PHCs</p> <p>A session on record keeping and documentation as well as procedures to access medicines via the Medicines Access Program (MAP) in the Philippines</p> <p>Use of videos to demonstrate clinical phenomena such as seizures in the Philippines</p>
<p>C) Local contextual and cultural modifications</p>	<p>Use of local case examples from the participants' experiences</p> <p>In the alcohol and drug abuse module, details and alcohol content of local brew 'tuba' in the Philippines</p> <p>In the epilepsy module under safety risks, the phrase advising people "not to take bath or wash clothes inside rivers alone" was added in S Sudan</p>
<p>D) Duration and scheduling of training</p>	<p>Reduced number of training hours in S Sudan due to work pressures. Also, training was limited to the afternoon after clinical responsibilities were completed.</p>

2.2 Training and supervision of general health care staff

The mhGAP base course training and supervision for PHC staff was carried out in all sites by a specialist trainer psychiatrist (please see Table 3 for details). All training workshops included pre and post-tests and a training evaluation by the participants. Supervision consisted of on-the-job joint clinical consultations in which one of the trained PHC staff (either the doctor, clinical officer, mental health officer, nurse or nurse assistant and, sometimes more than one clinic staff, depending on the site)

would conduct the patient interview in its entirety, communicate all the relevant points, and arrive at the diagnosis and management on their own. This would be followed by a discussion about diagnosis and management with the specialist and examination of case records. Additionally, in the Philippines and South Sudan where there were multiple field sites, the specialist trainer would provide off-site (Skype, phone, email) consultations when needed.

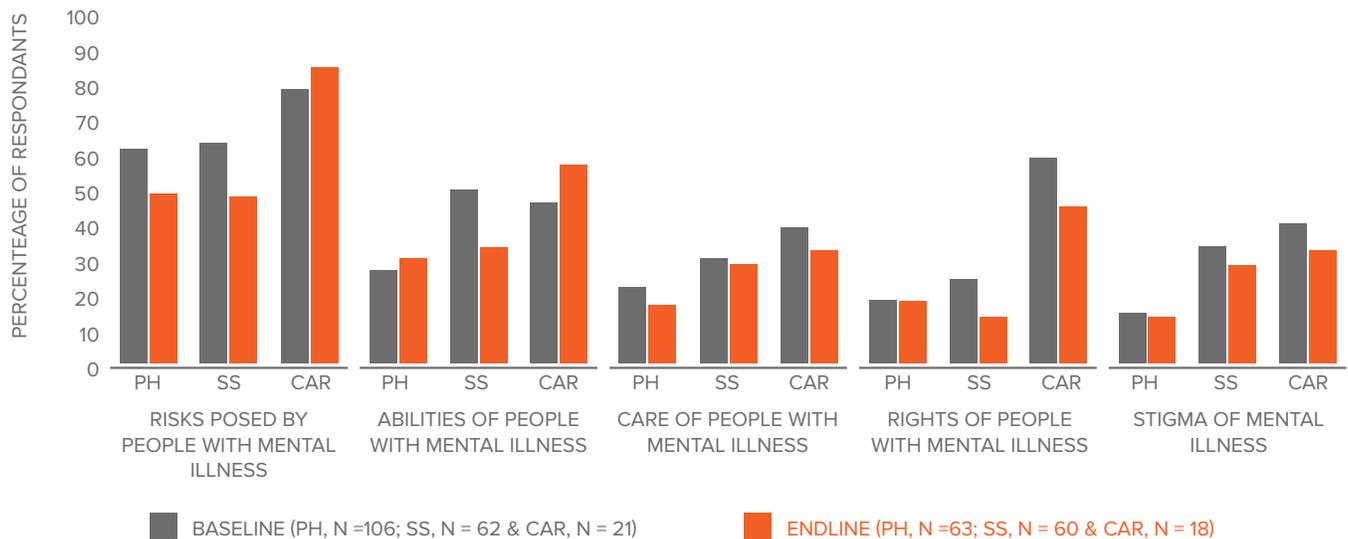
Table 3: Details of training and supervision

	PHILIPPINES	S SUDAN	CAR
Number of trainees out of total health staff in target facilities	213 out of 533 (40%)	49 out of 130 (38%)	58 out of 135 (43%)
Number of training days	average 3 days duration	average 4 days duration	average 4 days duration
Average pre test score	70	55	46
Average post test score	94	69	59
% trainees who found the training useful	80	88	100
Number of supervision sessions overall	132	30	8
Average no. of supervisions per trainee	3	4	2
% of trainees who received supervision	65%	12%	31%
% improvement in skills/ practice (Calculated based on scores in supervision checklist)	31%	17%	not done

Change in knowledge and skills: All trainees showed improved knowledge (pre post test) and skills (supervision checklist) with the high-test results in Philippines and lowest results in CAR (see Table 3).

Change in attitudes of PHC staff towards people with mental illness following the training: A questionnaire⁹ with statements reflecting negative attitudes towards people with mental illness and responses was administered to PHC providers at baseline and follow-up. The statements were organized in 5 domains (e.g. a statement included in the domain ‘Risks posed by people with mental illness’ was “People with mental illness are dangerous” and “People with mental illness are unpredictable”. Some of the staff in Philippines and South Sudan demonstrated reduced negative attitudes towards people with mental illness while this was inconsistent amongst the CAR staff (See graph 1 below). This may be a reflection of inadequate training as well as lack of sustained specialist support in CAR, where the psychiatry trainer was only deployed for three months.

Graph 1: Proportion of people who agreed or somewhat agreed with statements implying negative attitudes towards people with mental illness (before and after the training) measured in 5 different domains



⁹ A Knowledge and Attitudes questionnaire adapted from various sources including US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA, 2010) and other International Medical Corps program tools

Perceived competency of trained healthcare staff in providing care for people with mental illness:

Perceived competency was measured using a checklist of general competencies (e.g. knowledge about the effects of stress on mental health, ability to communicate with people with mental illness and their families and provide non-discriminatory care) and clinical competencies (e.g. the ability to conduct a detailed assessment, diagnose and provide appropriate interventions including medication, psychosocial interventions, and referral for people with mental illness). All the trainees surveyed reported improved competency post training (see Graph 2).

Qualitative data from follow-up discussions with trainees suggested that most trainees felt the training had helped them understand the different types of mental illness with their signs and symptoms and to gain some knowledge about psychotropic medication. Clinicians in the Philippines shared stories of their successes in treating patients with psychotic disorder who were caged for many years and never treated. One nurse in CAR explained that the training helped him learn that counseling and psychological support can help persons with mental illness to get better.

“I learnt about mental illness....that stress following a typhoon can cause mental health problems, because for me, I used to think ...it is quite absurd for one to become mentally ill after experiencing a typhoon”

— Midwife, Philippines

“Earlier I used to get angry with these patients...when the patient yells, I would yell back. Now I try to understand the patient and look for a solution to their problem”

— Nurse Assistant, CAR

“I used to think that mental illness was due to people’s own failures. Now I know they can still be useful – can be treated and go back to normal.....and contribute to the community”

— CHW, Juba, South Sudan

Key challenges and strategies used to overcome these:

“We have learnt a lot but there is still much to learn”

Almost all trainees in the three sites reported the need for further refresher training and ongoing clinical supervision which was challenging due to limited funding, specialist time constraints and security issues restricting travel to project sites. In addition, site-specific challenges were identified (Table 4).

Graph 2: Perceived competency of trained PHC staff

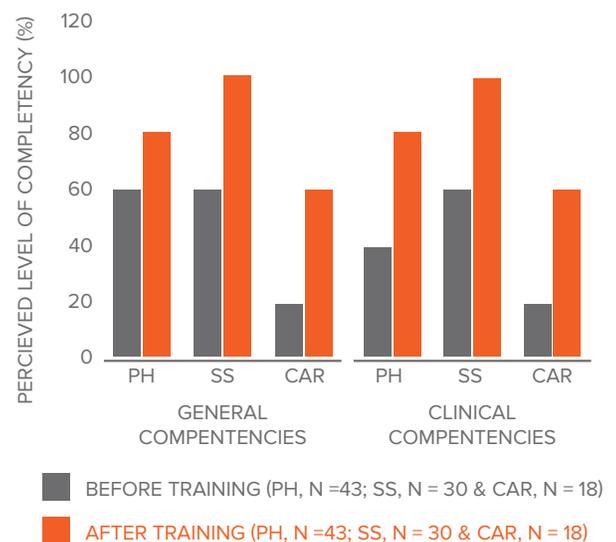


Table 4. Challenges to capacity building and strategies to overcome them

COUNTRY	CHALLENGES
<p>PHILIPPINES</p>	<p>Staff had difficulty in scheduling the mhGAP training due to numerous trainings organized by MoH and partners in the post typhoon emergency period and conflicting work pressures, climate conditions (2 typhoons in Dec 2015) and cultural events taking place at the same time (e.g. Christmas season and the Pope’s visit to Tacloban). Engagement and close collaboration with local administration were useful in ensuring participation of health care staff in training. Flexible training schedules (e.g. training in afternoons/evenings) were another method to overcome barriers.</p>
<p>SOUTH SUDAN</p>	<p>Security constraints, staff work pressures and a large number of sites meant that the training duration had to be shortened and training conducted in a staggered manner. High staff turnover necessitated training for new staff and varying staff qualifications meant that the training level had to be simplified so that all the staff could benefit from the training. Staff work pressures and time constraints were addressed by addition of local paraprofessional staff who were trained by IMC to serve as mental health case managers to ensure continued support and follow-up of patients.</p>
<p>CAR</p>	<p>Apart from security constraints and very low staff skills and qualifications, the biggest challenge was recruitment of a qualified (French speaking) psychiatrist specialist trainer and his continued engagement. After a delayed start, the donor funds were insufficient to support a psychiatrist beyond 3 months. This has made it necessary for the team to identify alternate sources of funding to enable recruitment of specialist to provide support and supervision to the PHC team as well as refresher training and building capacity of national staff to take on the training/supervision role over time.</p>

3. Provide clinical and community level interventions for people with mental illness

All three programs adapted a comprehensive approach of interventions and activities for people with mental illness and their families in line with

International Medical Corps and global standards and recommendations. This consisted of:

Facility level interventions

Interventions provided by the trained PHC staff in all facilities consisted of:

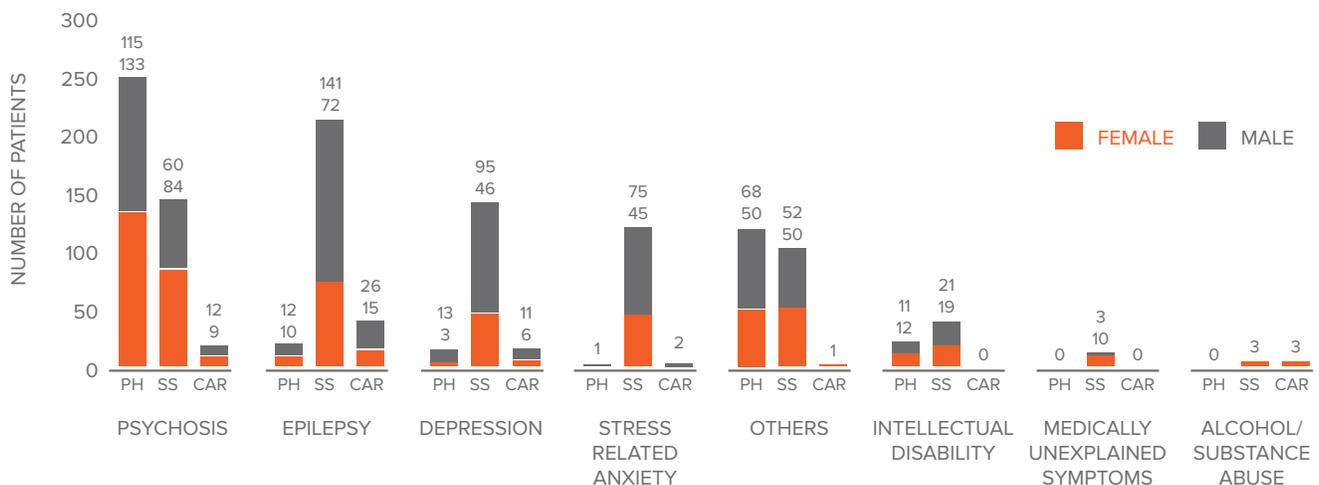
- > Assessment and diagnosis
- > Psychoeducation to patient and family members
- > Psychotropic medication, if needed

Community level interventions

In addition to PHC-based interventions, psychosocial interventions at the community level were very important in engaging communities, people with mental illness and their families. Examples of such interventions were: activities to address social isolation (eg: small social gatherings with music, singing, talking); activity groups for children (eg: games

and fun activities for children under 12); community awareness/education (eg: modeling appropriate interaction with people with mental illness) and individual supportive counseling conducted by the mental health officers/case managers under supervision of the specialists.

Graph 3. Number of people with mental illness seen by trained PHC staff following mhGAP training Philippines: 38 facilities over 8 months, S Sudan: 9 facilities over 6 months, CAR: 7 facilities over 4 months



Mental health prevention & promotion activities consisted of:

- > Weekly health education sessions: conducted in the health facilities waiting area in S Sudan and CAR
- > House-to-house visits: to deliver mental health messages and identify people with mental illness and link with services by Community Health Workers (CHWs) in all sites
- > Radio shows: Live radio talk shows on mental health issues in S Sudan and Philippines
- > Distribution of Information Education and Communication (IEC) materials - IEC materials (e.g. drug and alcohol abuse prevention, mental health disorders and appropriate interventions, maternal health and postpartum depression, bullying and loss and grief) were translated in two local languages in the Philippines and distributed to the municipalities through social welfare offices. T-shirts with mental health messages e.g. “No Health without Mental Health” were distributed to trainees at the mhGAP training in South Sudan.
- > Community awareness raising sessions were conducted in the Philippines with high school and college students, parents and other family members, community leaders, teachers and guidance counselors, and day care workers. Topics included Understanding Mental Illnesses, Stigmatization, Bullying, Drug and Alcohol Use, Dementia.

Mental health service provision data

Data was collected systematically in all sites on types of mental health problems disaggregated by gender. The most common diagnosis seen across all sites were psychotic disorders followed by epilepsy and depression (see Graph 3).

Patient outcomes were measured using a 5-point Likert scale at each follow-up visit and represent the perception of the PHC service provider of patient functioning and symptom severity based on patient/family report and assessment of symptoms. The scale was developed for the purpose of this project and incorporated in the clinical assessment forms.

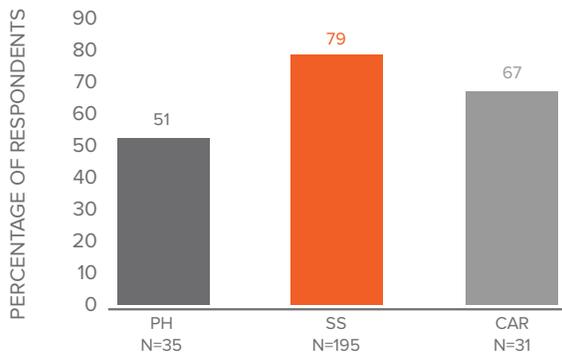
Satisfaction was measured using the International Medical Corps Patient Satisfaction Question-

naire and is an aggregate of responses (those who agreed/somewhat agreed) to 13 statements covering several domains (e.g. staff accessibility, confidentiality, information provided about health condition and treatment, etc). The satisfaction questionnaire was filled either by the patient or family member.

The majority of patients and family members in all 3 sites reported satisfaction with services (Graph 4) and improved functioning (Graph 5).

The PHC staffed reported various challenges to delivery of mental health interventions and strategies they had found useful to overcome these (Table 5).

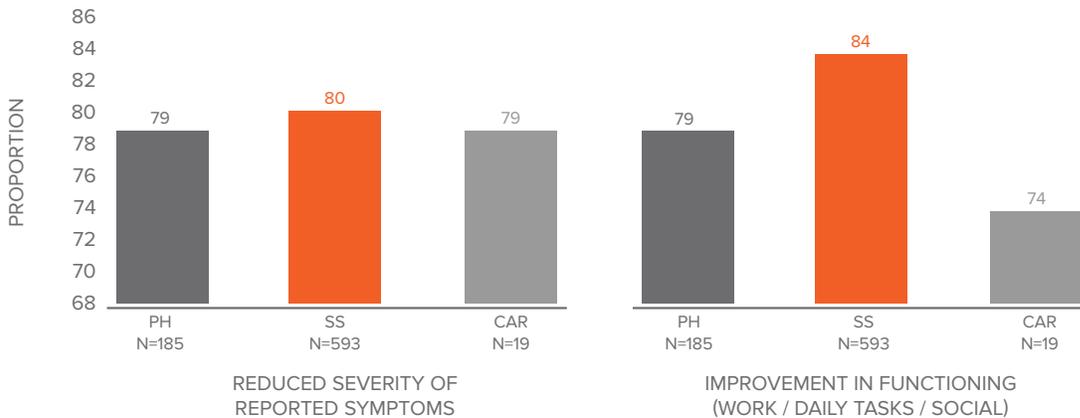
Graph 4. Percentage of patients/families members reporting that they were satisfied/somewhat satisfied with services



“I can go to work now as my child is better- her fits are under control”

— Mother of a child with epilepsy, Bria, CAR

Graph 5. Percentage of patients reporting improvement in symptoms and/or functioning following the treatment



“I can now cook for my children, bring water from the river, go to the forest to collect wood...Earlier I never used to do this...when I was sick. I had thoughts about killing my children....”

— Woman with depression, on treatment since 4 months, Akobo, South Sudan.

“There were so many patients in cages and in their homes who had no attention. There was no advocacy for them and we were the first one to address it through this program”

— Program Staff, Philippines

Table 5. Challenges in intervention delivery and strategies used to overcome these

CHALLENGES	SOLUTIONS
<p>Mental health services not accessed due to community stigma</p>	<p>Community awareness raising activities targeting various stakeholder groups</p> <p>Involving community leaders to encourage patients to seek help</p> <p>Including traditional healers in awareness activities</p>
<p>Failure to identify patients with depression and anxiety at the PHC (who may not directly seek MH care but present with symptoms such as problems sleeping). Help sought chiefly for psychosis and epilepsy (which have a more definite and easily recognizable symptom presentation).</p>	<p>Refresher trainings to enhance staff skills to detect depression and anxiety</p> <p>Management of epilepsy and psychosis used as a “gateway” for encouraging help seeking and raise awareness for other mental disorders as dramatic symptom improvement with treatment enhances patient satisfaction and increases acceptance of the mental health program</p>
<p>Difficulty in implementing psychosocial programs due to inadequate resources (time and personnel)</p>	<p>Coordination between different IMC programs (i.e. Nutrition, GBV, Protection programs) to share staff resources</p> <p>Staggered integration, first focusing on PHC based services and then expanding to community based psychosocial care</p>
<p>Disruption in services due to security issues such as looting, etc</p>	<p>Meeting with community leaders to discuss implications of these for IMC supported services and garnering community support</p>

“Usually patients only go to traditional healers. After the training, we raised public awareness about mental illness. The village chief also helped. Earlier they didn’t know about drug availability. Now they know they are wasting time by going to the traditional healer – so they come to the PHC”

— Nurse assistant, Bria, CAR

4. Ensure holistic integration of mental health by strengthening referral mechanisms, adherence to treatment and medication supply

4.1 Strengthening patient referral pathways:

Options for referring patients with more complex and severe mental health problems to more specialized mental health care providers (e.g. psychiatrists, psychiatric hospitals) varied among sites. In CAR there were no specialist referral options in Bria and patients had to travel to Bangui which was expensive and impractical. In the Philippines, specialist services were available in two in-patient facilities in the region and in S Sudan, referrals were chiefly to the International Medical Corps program specialists. Referral options for other needed services (e.g. financial support, protection, education, psychosocial activities) also varied. In addition, in the Philippines, the Department of Social Work and Development (DSWD) provided support (such as financial assistance to travel to hospital) to patients in need. In South Sudan, partner organizations were the main avenue for psychosocial support (e.g. protection, education) while in Bria, and CAR, there were barely any local options available.

Referrals to the PHCs were made most often by community health workers, community members and by organizations providing different services as well as by staff from other International Medical Corps programs (e.g. nutrition, GBV/protection).

Efforts to strengthen referrals to and from the PHCs were made by conducting workshops involving different services providers such as NGO partners, government staff and community care providers (e.g. school guidance counselors) as well as community leaders, in all sites and streamlining the process by using structured mechanisms and standardized forms.

The most useful method of ensuring referrals were successful was often direct personal contact by the clinic staff by a telephone call (rather than just a note) or by accompanying the patient to the referral agency/person.

4.2 Ensuring patient follow-up:

Methods used to ensure patient follow up in all sites consisted of:

- Providing psychoeducation and emphasizing the importance of continuing treatment, encouraging support of family members
- Tracking patients scheduled appointments using the clinic register
- CHWs assisting in tracking patients, visiting them in their homes and encouraging follow up in the PHC
- Link with community chiefs and traditional healers who encourage patients to continue treatment
- Clinic staff making home visits when possible.

4.3. Ensuring medication supply in the PHCs:

The programs supported medication usage and availability by:

- > Meeting with the mental health specialists in the Philippines (both government and private practice) to rationalize psychotropic prescribing practices so that they prescribed the easily available medicines that were part of the essential drug list
- > Working with government officials, WHO and other partners in the Philippines to strengthen the government Medicine Access Program (MAP) request and distribution scheme which functions to make essential medicines available in the PHCs at no cost to patients. IMC provided information about MAP during mhGAP training, supported staff in filling in requests for medicines, facilitated of supply of first batch of medicines through MAP and supported distribution of essential medicine supplies to each of the health facilities in the IMC coverage area in the Philippines.
- > In South Sudan, additional funding sources were identified to fulfill supply needs and procedures were established to streamline the medication utilization reporting as well as distribution from central warehouse to program sites. Procedures to obtain permits for import of restricted medicines (such as diazepam, phenobarbital) were initiated.

4.4 Documentation and reporting

Clinical forms were specifically developed for each program using International Medical Corps templates and MoH formats, including clinical record form, follow up form, registers, and supervision forms. In addition, in CAR and South Sudan weekly and monthly reporting forms were developed to capture the indicators important for program supervisors and for reporting to the donors and MoH. The M&E system for South Sudan was the most streamlined and well integrated into the Health Monitoring and Information System (HMIS) due a dedicated M&E coordinator from the start of the program. In Philippines, the mental health data was collected from the program staff by the program officer (who was not specifically trained in M&E). The clinic staff were trained in recording data in the forms but the quality and consistency were variable and largely depended on support from the International Medical Corps specialist. In CAR, mental health data was collected separately

from other clinic data and efforts are underway to have this integrated into the clinic reporting system. Rationalizing paperwork needed to document clinical encounters was important to reduce burden on clinic staff, for example, by using clinic assessment forms consisting of checklists rather than narrative details.

In order to assess facility level integration including those described in this section, IMC utilized the MH PHC integration checklist. In all sites, enhanced integration of mental health in general health services particularly in the domains of social indicators (e.g. respecting privacy during consultations, ensuring confidentiality), number of trained staff in health facilities, staff roles and team work in mental health care, knowledge about referral options and availability of psychotropic medication was noted.

5. Engage in networking, coordination and advocacy

Networking, coordination and advocacy activities were conducted to ensure discussion of program activities, relevant input from different stakeholders and joined planning at every level:

National level: National level activities by IMC included active and regular participation at the National level MHPSS subcluster meetings and contribution towards development of national mental

health guidelines (CAR), strengthening the mental health component of the health policy (South Sudan) and participating in the drafting of a comprehensive mental health bill (Philippines).

Regional level: In CAR, IMC developed and monitored activities with the health district management teams in Bria, in particular the medecin chef de district and with the hospital management to support their efforts in MH integration. For example, IMC was able to share important information about the priority mental health conditions being seen at the PHCs, the ways in which community health workers could be involved in increasing mental health awareness and mobilizing community/family support for people with mental illness.

locality and to serve as coordination group . For example, at one meeting a guidance counselor described the case of an adolescent student with psychosis who came to school with a knife and threatened to stab another child. The student had not received any prior medical or social service attention. The meeting allowed the team to come up with a plan of action to work with the family to ensure the student was seen by the PHC doctor who formulated a treatment plan.

The Philippines IMC teams participated in MH sub cluster meetings and in the Regional Mental Health Technical Working Group. At the municipal level, IMC convened mental health teams to provide avenues for discussing mental health issues in the

In Sudan Sudan, while mental health sub-cluster meetings do not take place outside of Juba, the team attends health and protection cluster meetings to share information and discuss linkages with other organizations.

Community level: Workshops with community leaders (including religious leaders) and community members in all sites were conducted to increase mental health literacy and address stigma and violation of human rights of people with mental illness. This improved the identification of people with severe mental illness who had been restrained/caged for prolonged periods of time and made it possible for them to receive treatment for their condition.

Conducted community awareness raising activities with over 10,000 community members in the Philippines who were then informed how to access services within their municipalities.

10 The Government of Southern Sudan (2006) "Prevention and Treatment Guidelines for Primary Health Care Centers and Hospitals Clinical book"

Stakeholder Workshops

Workshops were held at the national level in all three countries towards the end of this project to share experiences using the mhGAP-IG for integrating mental health into general healthcare, discuss the many challenges faced as well as successes. A total of 88 representatives of funding organizations and international organizations, government agencies, and non-government orga-

nizations, academe, private and non-government organizations participated in the workshops (33 in the Philippines, 38 in South Sudan and 17 in CAR). Group discussions were held with participants to learn about their perceptions and ideas, provide the opportunity to share and learn best practices in mental health programming and brainstorming solutions for sustainable integration.

Four key challenges were pre-identified for discussion by the IMC team based on the initial findings:

1. Community stigma hindering access to services and care seeking for mental health
2. Coordination between implementers (government and non-government organizations) and policy makers at different levels (clinical & community)
3. Sustainability of programs in the longer term
4. Ensuring quality of clinical & community-based mental health services

The following key points and suggestions for ways forward emerged:

CAR: The Ministry of Health (MoH) in collaboration with WHO and other key partners is now in the process of organizing large scale training of trainers in mhGAP. MoH indicated that the IMC workshop report would be shared with partners and coordination group members to act as a template for further discussion in understanding how to address the challenges in PHC integration. The coordination group, led by the MoH also plans to focus on public awareness through mass media and organize large scale sensitization in the community on mental health topics.

Philippines: The Department of Health (DoH) plans to prepare a national registry of mhGAP trained personnel so that they could then be involved in further training and quality assurance measures. Efforts would also be made by DoH to organize a general assembly of organizations who have conducted the mhGAP training in Leyte (e.g. CBM, WHO, Save the Children and International Medical Corps) so that they can share experiences and strategies. In addition, efforts are planned by Department of Health (DoH) and partners to integrate tele-psychiatry in mental health programming, improve information sharing and coordination with the DoH not just at the regional/district level but also at the national level.

South Sudan: Representatives from partner organizations noted that the MHPSS coordination group would work on updating the mental health curriculum in teaching institutions in collaboration with the Director of Mental Health in the Ministry and update the country's national mental health guidelines¹⁰ to include experiences of using mhGAP and include guidance on community involvement (e.g. for reducing patient drop out etc). The MoH representative considered it important to continue extending the services to the other conflict affected areas in addition to locations where IMC is working. The participants renewed their commitment to attend meetings, share information, join coordination groups and to be involved in advocacy efforts and donor engagement.

In the words of one of the participants,

“The presentation was informative, the group work helped look into areas not dealt with in the presentation. It was an eye opener, meeting with the various actors was another new experience which is helpful in future coordination of activities”.

6. Support sustainability of mental health services integrated in general health care

Although it is essential to meet immediate mental health needs in humanitarian crises, it is also important to not set up services in isolation but to have a clear focus on medium and long term development of sustained and integrated mental health services. Sustainability of programs is best ensured through continuous involvement of the government and local organizations from the start, which is also something that all three programs have done.



Table 6. Specific methods to ensure sustainability in the three sites:

PHILIPPINES	S SUDAN	CAR
<p>Encouraging the multidisciplinary Mental Health Teams to develop TORs and obtain Mayors' ordinances</p>	<p>Integrating services with the local and national infrastructure e.g. Akobo County Hospital</p>	<p>Building the local capacity of MoH staff through formal training and on-the-job supervision</p>
<p>Supporting the creation of the Regional Technical Working Group</p>	<p>Recruitment of large number of national staff from the local community and providing them with training and supervision to build skills and competencies</p>	<p>Building the capacity of health management committees (COGES) and village health committees establishing a strong level of understanding among the local community regarding early recognition of mental illness and appropriate help seeking behavior early interventions.</p>
<p>Strengthening referral systems to and from RHUs</p>	<p>Working closely with local communities, local organizations and MoH</p>	<p>Supporting the documentation and reporting of key mental health indicators to inform service provision including medication supply</p>
<p>Supporting documentation and reporting</p>	<p>Contributing to development of a curriculum for a module on mental health for midwifery students to provide care for mental health disorders that impact women during and after pregnancy</p>	<p>Supporting the MoH in developing National policies and legislation for mental health</p>
<p>Supporting medicine access through MAP</p>		
<p>Involving national psychiatrists in the training programs to build their capacity</p>		

Recommendations and lessons learned

Closely following and collecting data from 3 countries over the course of 15 months has helped us further consolidate and describe the different steps involved in mental health PHC integration in humanitarian settings. There are also several key points and lessons learned that emerged:

Training and capacity building:

Adapt training methods and content over time: mhGAP is useful in MH PHC integration and requires varying degree of adaptation in both content and method of delivery of training. Adaptations are rarely a once off activity and need to be done iteratively through the course of the program, drawing from experiences during implementation.

Discuss the bigger context and rationale for integrating mental health with trainees and stakeholders: It is important to orient all stakeholders including program managers, specialist trainers, and PHC staff about the philosophy and objectives of mental health integration from a broader public health perspective and in a way that is relevant to them. Some health staff (e.g. in CAR) may see such training as an additional burden. It is important to communicate reasons for integration (e.g. increased access, public health burden of mental illness) and that such programming is not only about training staff to treat people with mental illness but it is an attempt to provide mental health and physical health care seamlessly in the same setting where members of the health care team share responsibility for patient care.

Ensure continued supervision and build capacity of national level specialist trainers: Given lack of country capacity for specialized mental health care, specialist trainers are often expatriate psychiatrists, who need to stay in country for an extended period of time (e.g. 6 months and more) to ensure follow-up supervision and skills building. However, where possible it is important to also develop a cadre of national trainer/s to share responsibilities and ensure sustained support of the PHC team as well as consultation and referral if needed is important. This gap has been noted in the CAR program where, in the absence of the expatriate psychiatrist after three months, the capacity to provide optimum continued support to the PHC staff is very limited.

Engage a broad array of health staff and community workers: Focusing only on PHC staff is not effective as noted in the Philippines program where lack of trained community health workers made it difficult to ensure patient followup. It is necessary to actively involve the community workers who can play a key role in case identification and referral and in organizing more structured awareness raising activities and community-based psychosocial activities, as done in CAR and South Sudan.

Ensure documentation is reinforced and built into the program: An important component of providing mental health services is patient tracking, documentation and reporting as well as obtaining and using information about available referral pathways and best methods to access these. M&E systems are best initiated right from the start of the program rather than as add-ons. It is also important to address staff attitudes towards documentation so that they understand that it is not important to only document successes. It is equally important to document what is not working so that corrective steps can be initiated early.

Program Planning:

Plan for longer term engagement: It is important for organizations implementing mental health programming plan for prolonged engagement especially when working in a region where preexisting services barely exist. Otherwise, it is difficult to sustain emergency services, for example, in Tacloban in the Philippines. In such settings, the emergency can act as an entry point for mental health programs and identifying this during the rapid assessment is important to then tailor proposals for longer term funding. It is also important for donors to recognize that mental health programs started during short term funding cycles in humanitarian crises, need longer term follow-up.

Manual and toolkit for mhGAP: It would be useful to develop an operations manual and a toolkit for mental health PHC integration in humanitarian settings that can be used as a resource for program planning and implementation. Some very useful tools are already available for this purpose such as WHO tools associated with mhGAP-IG and the mhGAP HIG¹¹ that provides advice to program planners. However, it would be useful to have practical and comprehensive materials specifically for humanitarian settings which include budget considerations as well as simple tools (e.g. to track indicators for successful integration, to record clinical data and patient notes) which can be used across sites with minimum adaptation.

Ensure to budget separately for specialist trainers and program managers: It is important to consider giving specialist mental health trainers adequate time and resources to focus on the technical aspect of the program which include developing and adapting training materials, carrying out training and supervision and assisting with systems level integration. Tasking this same person with additional program management tasks makes this role challenging. It is therefore recommended to budget for mental health program managers as well as specialist trainers which ensures complementary roles of different team members and adequate human resources to meet program goals.

Prepare an exit strategy: Where limited funding becomes a barrier to sustained involvement, it is important to prepare an 'exit' strategy and have discussions with relevant stakeholders and organizations about lessons learned from the project, follow up with health facilities and staff and any handover (if applicable).

¹¹ World Health Organization and United Nations High Commissioner for Refugees. mhGAP Humanitarian Intervention Guide (mhGAP-HIG): Clinical management of mental, neurological and substance use conditions in humanitarian emergencies. Geneva: WHO, 2015.

Ensuring holistic integration

Consider additional staffing to complement PHC staff: While existing PHC staff are ideally expected to deliver mental health interventions, IMCs experience has shown that clients with mental illness often experience multiple and complex problems and need access to other services (e.g. protection, shelter, education). The addition of paraprofessional case managers (such as the Mental Health Officers in South Sudan) who perform very basic mental health “social work” functions can be useful in many contexts and may provide greater chances that integration will be successful. Apart from providing additional support to the PHC team by focusing specifically on mental health, a case manager conducts a detailed assessment, provides psychosocial support to patients and families, encourages adherence, ensures linking with other services and supports/trains community health workers.

Ensure to plan for and strengthen patient follow-up: Active steps to encourage follow up are often necessary since many mental health problems such as psychotic disorders, epilepsy and depression may relapse if their treatment is discontinued. Patient follow up can be encouraged through a combination of different methods such as CHW involvement, text messages through cellphones, involvement of community leaders, and home visits.

Strengthen referral systems: Identification and strengthening of referral systems are important to ensure PHC staff are able to provide comprehensive care to people with mental illness and their families and are supported by specialists and other agencies who meet diverse patient needs. Mapping of services and referral workshops (as done in all three countries) are a key way of strengthening referral networks and processes.

Ensure coordination with other organizations. Coordination of mental health services with programs within an organization (e.g nutrition and protection programs) requires as much attention as coordination with other partners. Coordination enables sharing of resources such as training and human resources, identify gaps and ensure comprehensive patient care and cross-referrals.

Carefully plan for selection and supply of psychotropic medication. Medication supply needs to be ensured with adequate budget allocations, early understanding of import/export restrictions specific to the setting, and strengthening of utilization tracking as well as in-country delivery mechanisms. It is also often necessary to closely work with governments, regional authorities and health facilities (e.g. as done in the Philippines) to support longer term availability and supply of psychotropic medication at general health facilities.



A mother with post-partum psychotic depression in the Protection of Civilians site, Juba, South Sudan

A mother who delivered a premature infant (birth weight=1.3kg) was seen by the midwife who noticed that she was neglecting her baby, saying: “why has God given me this child who cannot survive? I do not want this child”. The baby girl was poorly responsive to anything that was going on around her. Evaluation by the clinic staff revealed that the mother was severely depressed and was also experiencing some psychotic symptoms. She reported having had two previous psychotic episodes for which she was admitted to the psychiatric hospitals in Khartoum, Sudan and Kampala, Uganda where she was treated with Electroconvulsive Therapy (ECT) and discharged. Her husband is living in a refugee camp in Uganda and her sister was the only supportive family member. Following discussion with the specialist, the mother was provided medication and seen regularly by the mental health officer. The mother was also seen by the nutrition team who provided additional nutritional supplementation. After 10 days of treatment, the mother showed dramatic clinical response and began to hold her baby and smile and croon to her. After a month, both mother and baby were in good condition. The baby weighed 2.8 kilograms and the mother was fully engaged in caring for her with minimal support from other family members. Efforts were also under way to link her with her husband through the phone. Regular home visits by the IMC counselor and nutrition assistant continued and she has been doing well.



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