# mhGAP Action Programme: mhGAP Operations manual

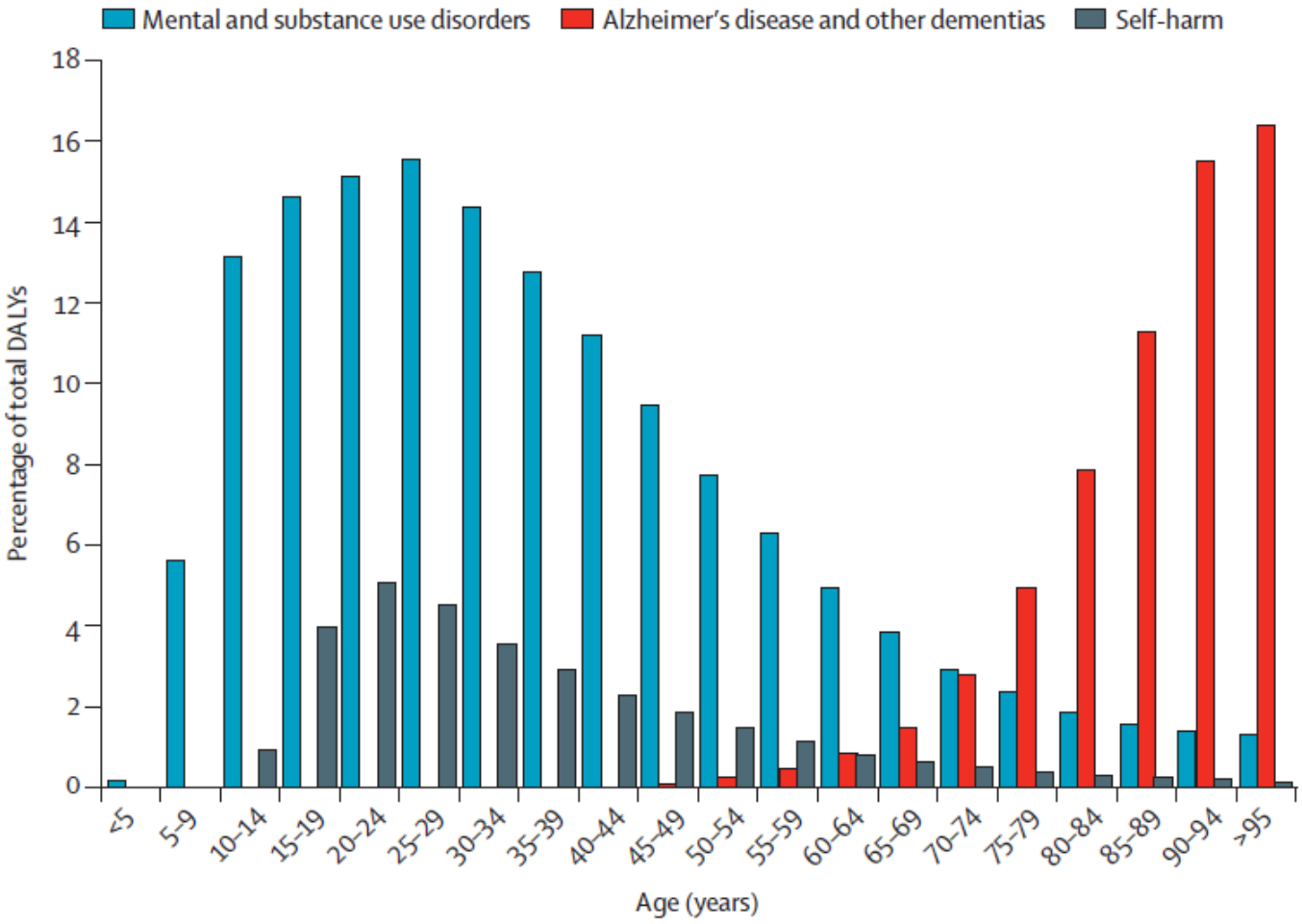
## Sierra Leone

Neerja Chowdhary

# Overview

1. **Why** do we need mhGAP? What is the context?
2. **What** is mhGAP? How is it designed and planned?
3. **How** can mhGAP be used and scaled-up?

# Global disease burden attributable to mental, neurological and substance use disorders




Source: GBD Results tool



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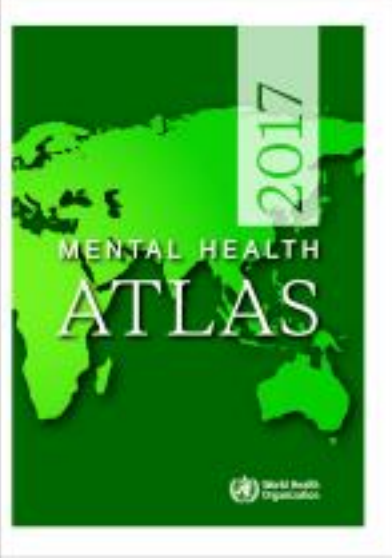
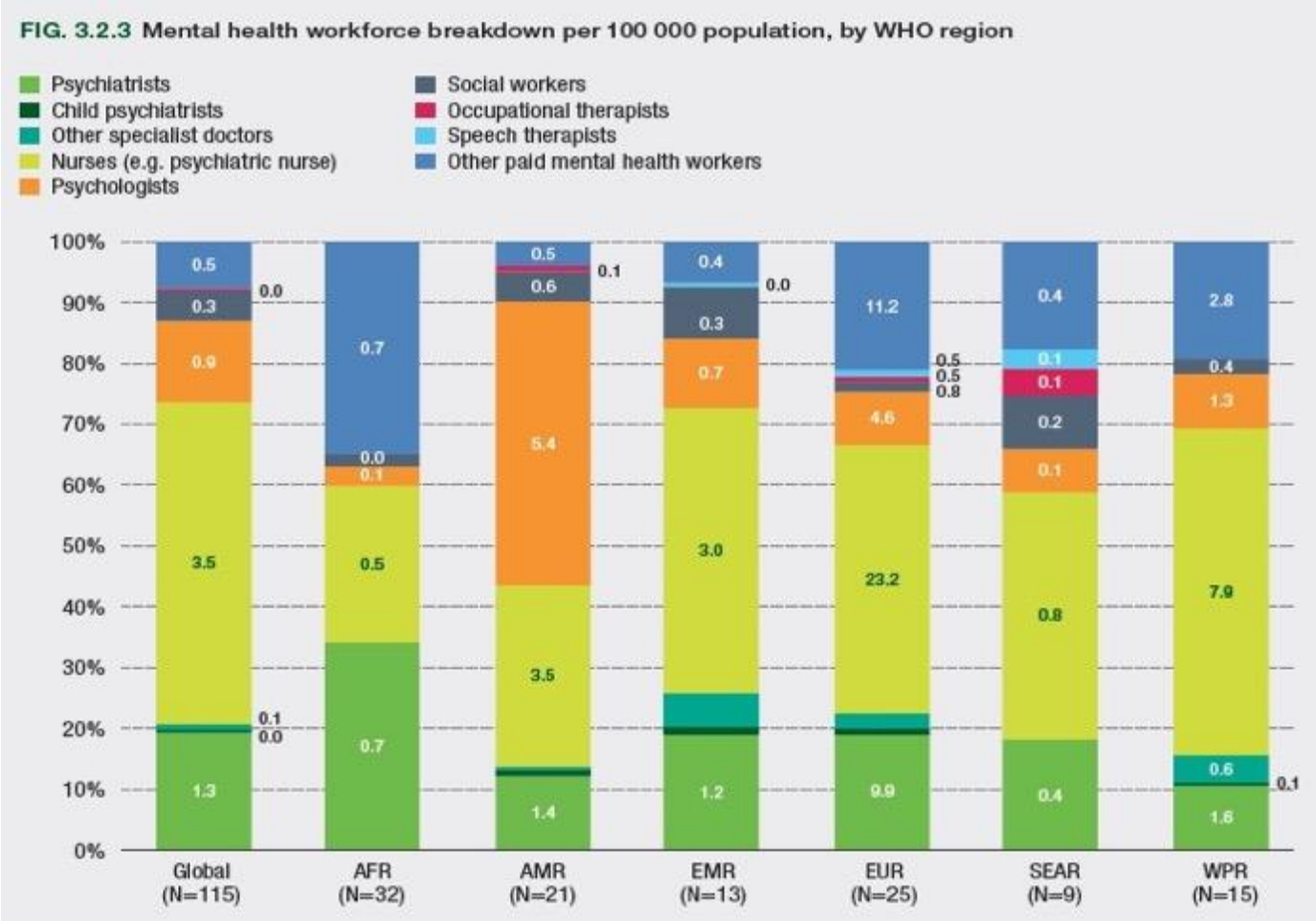
# The need for mhGAP is large




- Nearly half of the world's population lives in a country where there is less than one psychiatrist per 100 000 people

Source: Mental Health Atlas 2017



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# Mental Health ATLAS 2017 Member State Profile

## Sierra Leone

| | |
|---|---|
| Total population *(UN official estimate)* : [a] | 7,237,025 |
| WHO Region: | AFR |
| Income group: [b] | Low income |
| Total mental health expenditure per person (reported currency) | Not reported |
| Availability / status of mental health reporting | Mental health data (either in the public system, private system or both) have been compiled for general health statistics in the last two years, but not in a specific mental health report |

**Burden of mental disorders *(WHO official estimates)***

| | |
|---|---|
| Disability-adjusted life years (per 100,000 population) [c] | 2,370.09 |
| Suicide mortality rate (per 100,000 population) [d] | 9.7 |

**Mental health workforce (rate per 100'000 population)**

| | |
|---|---|
| Psychiatrists | 0.04 |
| Child psychiatrists | None or not reported |
| Other specialist doctors | None or not reported |
| Mental health nurses | 0.33 |
| Psychologists | 0.03 |
| Social workers | 0.03 |
| Occupational therapists | None or not reported |
| Speech therapists | None or not reported |
| Other paid mental health workers | 0.28 |

In case a mental health workforce appears as 0.0, it has either not been reported by the Member State or is zero.

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# mhGAP Journey….2008 to 2018


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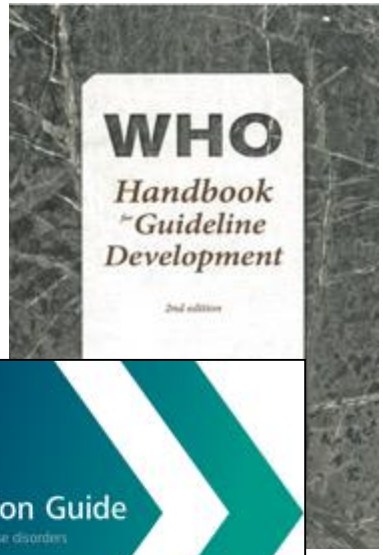
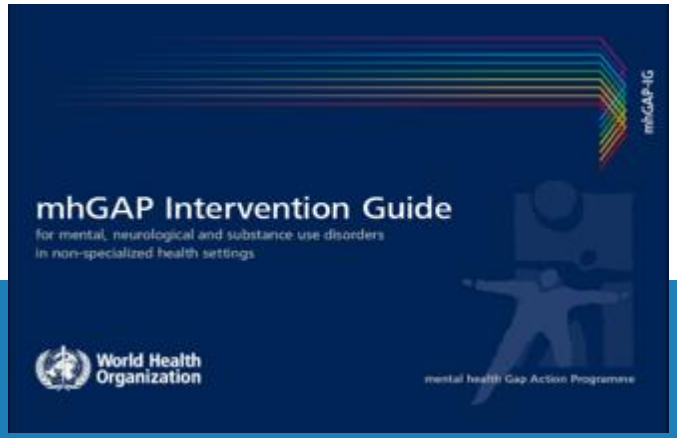
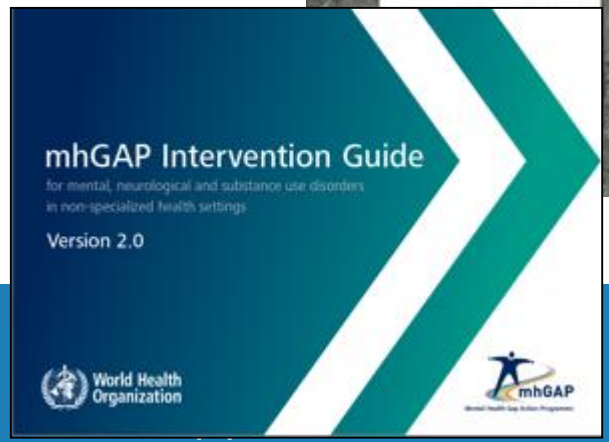
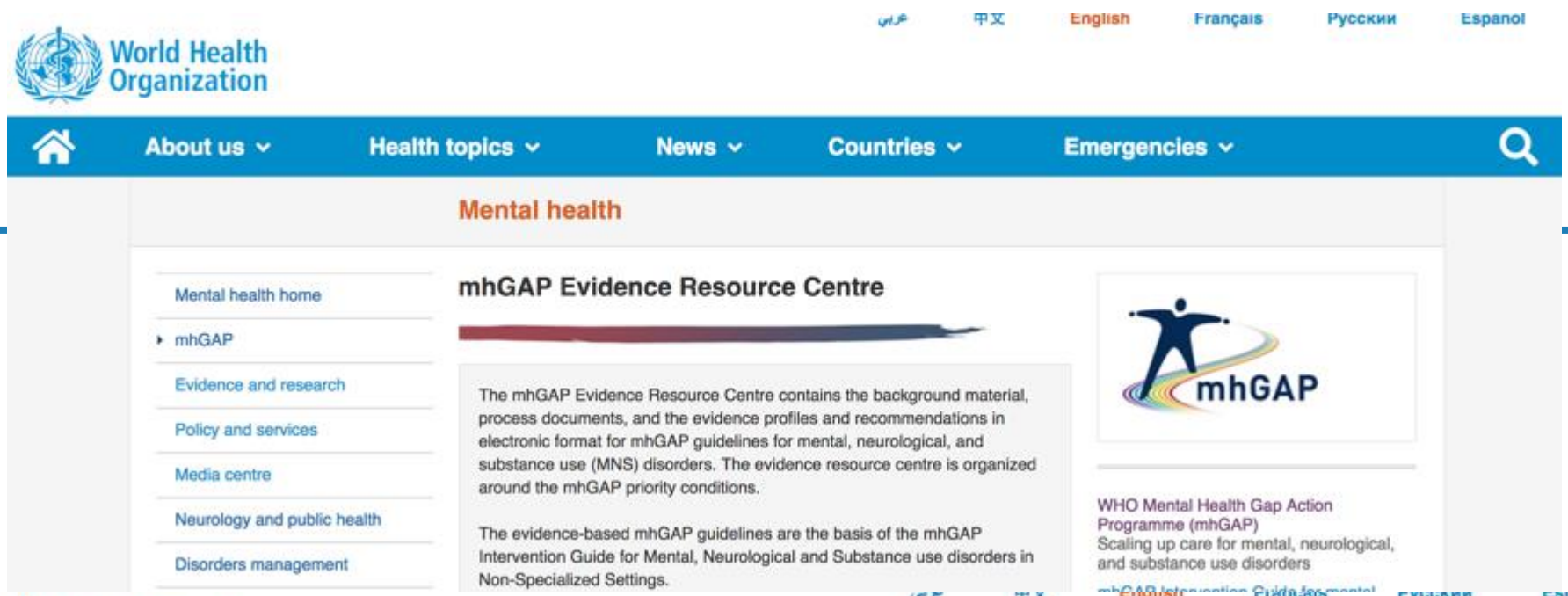
# Need for evidence-based Guidance

- Initially developed in 2009-2010, literature updates in 2012 and **second edition of guidelines** published in 2016
- Collaborative process involving large number of multi-disciplinary experts
- Using the best available evidence

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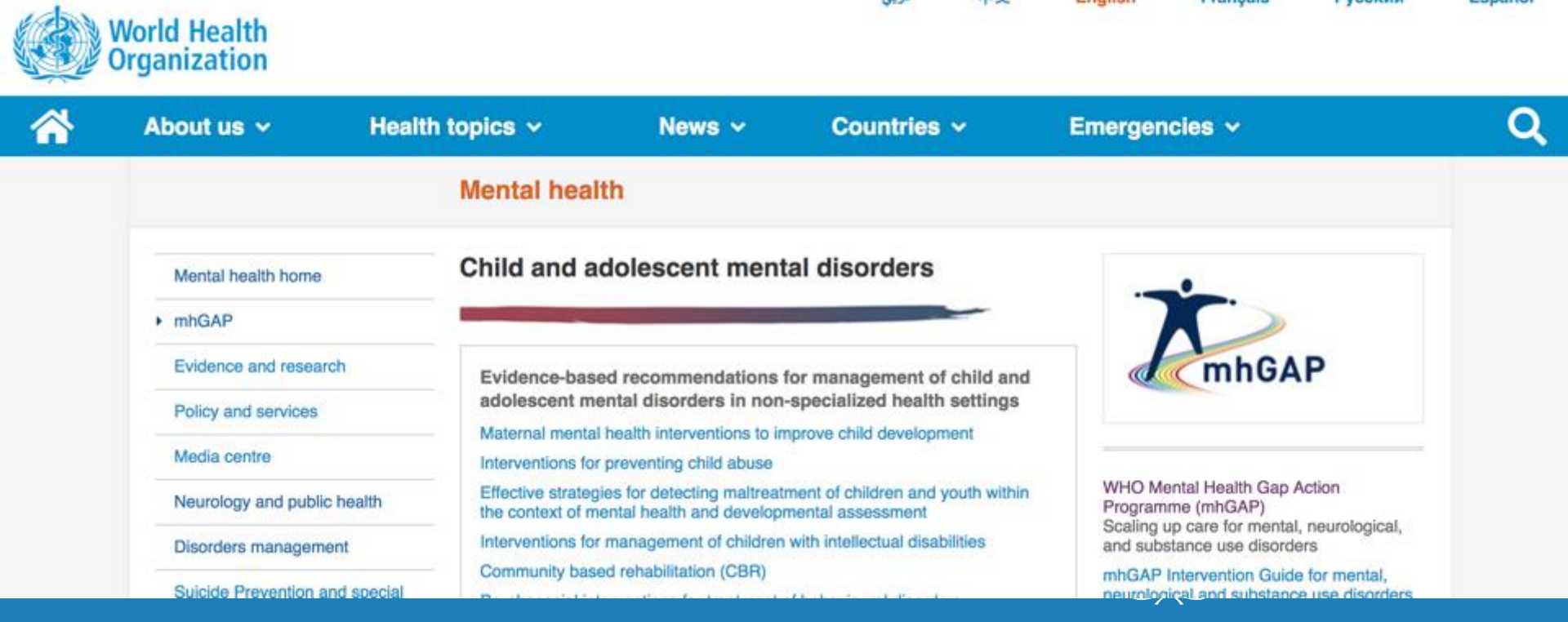
mhGAP Evidence Resource Centre
The mhGAP Evidence Resource Centre contains the background material, process documents, and the evidence profiles and recommendations in electronic format for mhGAP guidelines for mental, neurological, and substance use (MNS) disorders. The evidence resource centre is organized around the mhGAP priority conditions.
The evidence-based mhGAP guidelines are the basis of the mhGAP Intervention Guide for Mental, Neurological and Substance use disorders in Non-Specialized Settings.
mhGAP
WHO Mental Health Gap Action Programme (mhGAP)
Scaling up care for mental, neurological, and substance use disorders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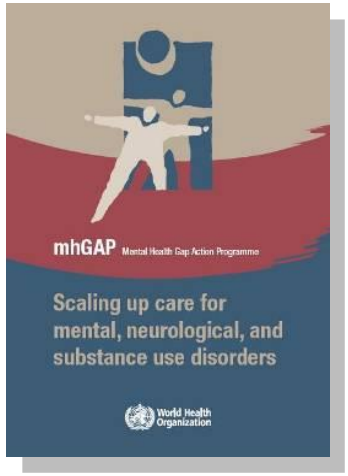
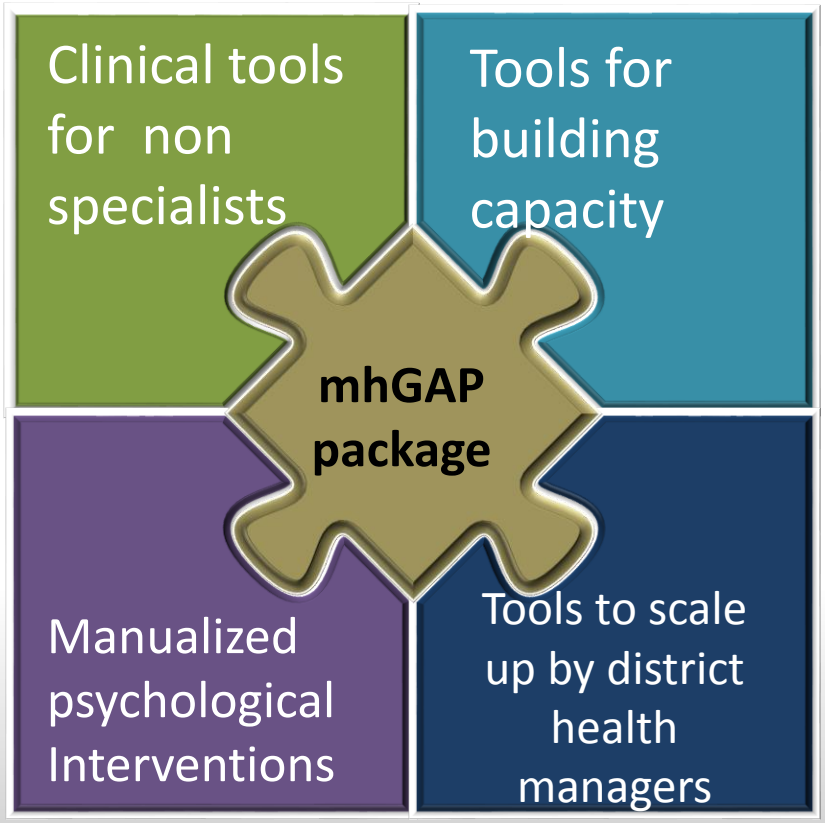
Suicide Prevention and special
Child and adolescent mental disorders
Evidence-based recommendations for management of child and adolescent mental disorders in non-specialized health settings
Maternal mental health interventions to improve child development
Interventions for preventing child abuse
Effective strategies for detecting maltreatment of children and youth within the context of mental health and developmental assessment
Interventions for management of children with intellectual disabilities
Community based rehabilitation (CBR)
mhGAP
WHO Mental Health Gap Action Programme (mhGAP)
Scaling up care for mental, neurological, and substance use disorders
mhGAP Intervention Guide for mental, neurological and substance use disorders

# Towards integrated services: Mental Health GAP Action Programme




**mhGAP Guidelines**
**mhGAP IG**
**mhGAP HIG**
**E-mhGAP**




**mhGAP IG &**
**mhGAP HIG**
**Training materials**

**PM+**
**Thinking Healthy**
**Group IPT**
**CST**

**mhGAP**
**Operations**
**Manual**

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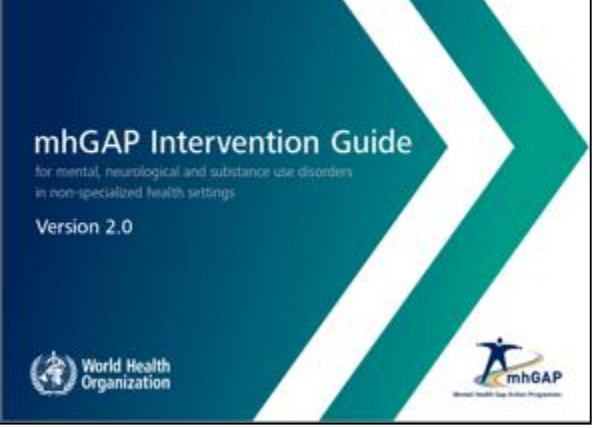
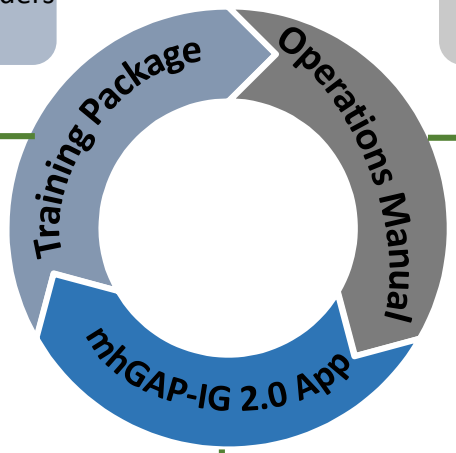



# mhGAP products

To build capacity of non-specialized health care providers in using mhGAP-IG

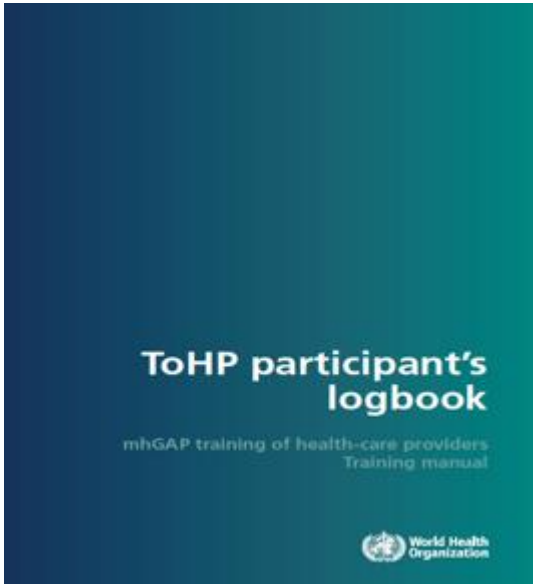

To be used by district health managers in rolling out mhGAP products


For non specialized providers in clinical settings to use mhGAP IG

mhGAP

# mhGAP training manuals





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## Mental health

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- mhGAP
- Evidence and research
- Policy and services
- Media centre
- Neurology and public health
- Disorders management
- Suicide Prevention and special programmes
- Mental health in emergencies
- Mental Health Publications

# mhGAP Operations Manual

**Authors:**
World Health Organization


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**Downloads**

– English

**Overview**

The WHO Mental Health Gap Action Programme (mhGAP) aims at scaling up mental health

# mhGAP planning, preparation and provision

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# mhGAP Operations Manual

The mhGAP operations manual is designed to provide **practical**, **step-by-step guidance** for implementation of the Mental Health Gap Action Programme. It includes the tools necessary for preparing, implementing, monitoring and evaluating the mhGAP.

**Target audience:**

- **District Health Managers :**in administrative units who are responsible for managing public health and mental health services.
- **Other stakeholders/potential members of mhGAP operations team:** e.g. Governmental Agencies, Non Governmental Organizations and Community Based Organizations.

# Phase I: PLAN

- Implementation is an iterative process, involving formative planning and modifications


- Assemble an mhGAP operations team
- Conduct a situational analysis
- Develop an mhGAP operations plan and budget
- Advocate for mental health.

PLAN

## Forming a team of key mental health stakeholders: The Mental Health Coalition – Sierra Leone

In Sierra Leone, mental health services are limited and outdated, despite a pressing need for MNS care in view of the weak health infrastructure, a decade-long civil war, the Ebola virus disease outbreak and devastating landslides. People with MNS conditions are often excluded from their communities, and human rights violations are common.

The Mental Health Coalition – Sierra Leone was established as a collective voice to advocate for better access to MNS care, promote the rights of people with MNS conditions and lead mental health services and programmes. Team members in the Coalition include individuals from the Ministry of Health and Sanitation, the psychiatric hospital, Government mental health services, the teaching hospital, the private sector, local and international NGOs, religious leaders, traditional healers, people with MNS conditions and their families.

Its members participated in preparing a national mental health policy and hosting annual international conferences. Stakeholder engagement and shared leadership in the Coalition resulted in the establishment of subcommittees, such as one for coordinating the emergency response for mental health and psychosocial support during the Ebola virus disease outbreak and another for research capacity-building.

In coordination with district health managers, the Coalition established district mental health centres and trained nurses and other providers in use of the mhGAP-IG *(8),* the QualityRights Toolkit *(10)* and psychological first aid (PFA) *(18)*.

The Coalition has established itself as an important reference for mental health activities in the country and is represented on the national steering committee for mental health in the Ministry of Health and Sanitation. Good organization by a dedicated team of leaders resulted in a body that is recognized as having an essential role in national mental health service reform. Clear, time-bound funding from the European Union allowed the team to plan their own fund-raising and has ensured long-term financial sustainability.

*Sources:*

- Mental Health Innovation Network (http://www.mhinnovation.net/innovations/mental-health-coalition-%E2%80%93-sierra-leone).
- The Mental Health Coalition – Sierra Leone https://mentalhealthcoalitionsl.com).

# Phase II: PREPARE

- Preparation of the health system and building capacity of the workforce to deliver services


- Adapt components of the mhGAP package
- Train health care providers and others in the health system
- Prepare for clinical and administrative supervision
- Strengthen care pathways
- Improve access to psychotropic medicines
- Improve access to psychological interventions

# Phase III: PROVIDE

- Integration into different levels of service provision, including facilities & community care


- Provide services at facility level
- Provide treatment and care in the community
- Support of delivery of prevention and promotion interventions
- Raise awareness of MNS conditions and the services available

# What is included in each section?

- Potential **barriers and solutions** to mhGAP operations
- An **overview** of the topic
- **Steps** for district health managers
- **Practical tips**
- Proposed **mhGAP operations indicators**
- **Lessons learnt** from experience in the field
- Additional **resources and tools** for implementation

# Step-by-step guidance & practical tips

PREPARE

## Role of the mhGAP operations team in improving access to psychotropic medicines

**Step 1.** Review the results of the situation analysis (Annex 2) on the selection, availability, affordability and appropriate use of psychotropic medicines in the district.

**Step 2.** Build the capacity of nonspecialist health care providers in facilities in which the mhGAP will be implemented.

- This includes training in use of mhGAP-IG 2.0 for prescribing and continued education and referral pathways for providers who assess, treat and manage people with MNS conditions.

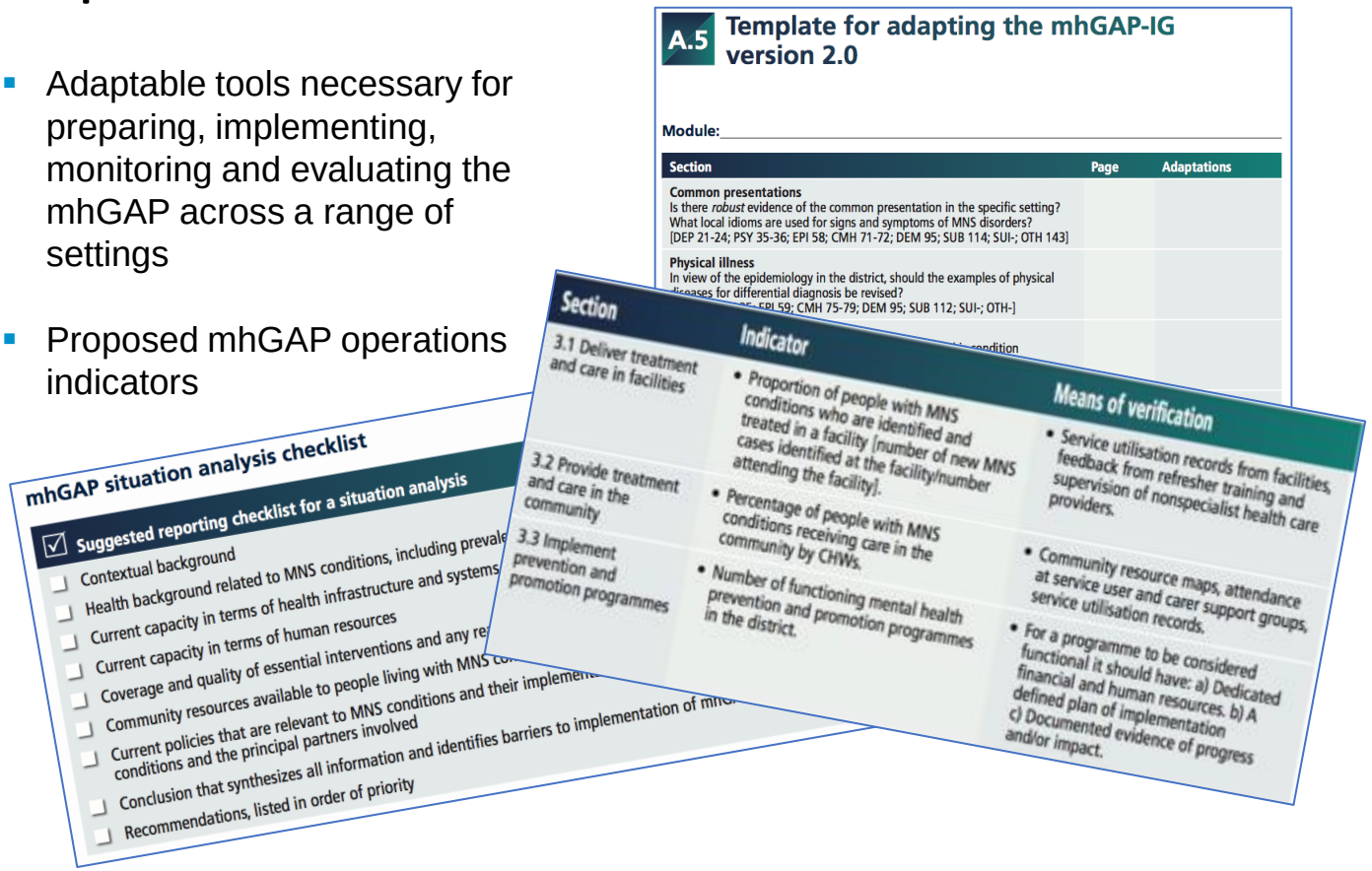
**Step 3.** Provide information for users on the acceptability of MNS care, including medicines for MNS conditions, to ensure appropriate perceptions, attitudes and expectations. This should improve help-seeking and stimulate demand.

### Practical tips

- Refer to national and international (e.g. WHO) lists of essential psychotropic medicines, and in particular those recommended in mhGAP-IG 2.0.
- An insufficient supply of psychotropic medicines may delay initiation of mental health services.
- Costly medicines are not necessarily more effective than cheaper ones. For example, second-generation antipsychotics (with the exception of clozapine) may be considered for individuals with psychoses only if their availability can be assured and cost is not a constraint. Seek advice from district pharmacists, if available.

# Tools for mhGAP operations

- Adaptable tools necessary for preparing, implementing, monitoring and evaluating the mhGAP across a range of settings
- Proposed mhGAP operations indicators



**A.5 Template for adapting the mhGAP-IG version 2.0**

Module: _____

| Section | Page | Adaptations |
|---|---|---|
| **Common presentations**<br>Is there *robust* evidence of the common presentation in the specific setting?<br>What local idioms are used for signs and symptoms of MNS disorders?<br>[DEP 21-24; PSY 35-36; EPI 58; CMH 71-72; DEM 95; SUB 114; SUI-; OTH 143] | | |
| **Physical illness**<br>In view of the epidemiology in the district, should the examples of physical diseases for differential diagnosis be revised?<br>[DEP 21-24; EPI 59; CMH 75-79; DEM 95; SUB 112; SUI-; OTH-] | | |

**mhGAP situation analysis checklist**

**Suggested reporting checklist for a situation analysis**

- ☐ Contextual background
- ☐ Health background related to MNS conditions, including prevale
- ☐ Current capacity in terms of health infrastructure and systems
- ☐ Current capacity in terms of human resources
- ☐ Coverage and quality of essential interventions and any re
- ☐ Community resources available to people living with MNS co
- ☐ Current policies that are relevant to MNS conditions and their implemen conditions and the principal partners involved
- ☐ Conclusion that synthesizes all information and identifies barriers to implementation of mh
- ☐ Recommendations, listed in order of priority

| Section | Indicator | Means of verification |
|---|---|---|
| 3.1 Deliver treatment and care in facilities | • Proportion of people with MNS conditions who are identified and treated in a facility [number of new MNS cases identified at the facility/number attending the facility]. | • Service utilisation records from facilities, feedback from refresher training and supervision of nonspecialist health care providers. |
| 3.2 Provide treatment and care in the community | • Percentage of people with MNS conditions receiving care in the community by CHWs. | • Community resource maps, attendance at service user and carer support groups, service utilisation records. |
| 3.3 Implement prevention and promotion programmes | • Number of functioning mental health prevention and promotion programmes in the district. | • For a programme to be considered functional it should have: a) Dedicated financial and human resources. b) A defined plan of implementation c) Documented evidence of progress and/or impact. |

# mhGAP operational plan

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## ☑ The plan prepared by the mhGAP operations team should include:

- ☐ Identified facilities, communities or geographical areas for mhGAP implementation
- ☐ Mechanism to support facilities with the infrastructure, equipment or support necessary to provide mhGAP services
- ☐ Human resources for whom capacity-building is required and clear descriptions of their roles in mhGAP implementation in the district (e.g. with psychotropic medicine supply, pharmacists and health care providers trained in prescribing)
- ☐ Mechanism for collecting, analysing and disseminating information on the services provided
- ☐ Activities to raise awareness of the services available in the community
- ☐ Collaborative activities with all relevant stakeholders in planning, preparing and providing services within mhGAP

For all the above, clear activities are listed, with timing, resources required and responsible person or agency.

# mhGAP planning
# – potential barriers and solutions –

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| Potential barriers | Potential solutions |
|---|---|
| Mental health is not a public health priority at district level. | • Include stakeholders from health and other relevant sectors in the mhGAP operations team.<br>• Advocate for mental health with policy-makers, and raise awareness in the community throughout mhGAP implementation.<br>• Strengthen user, carer and advocacy groups to be leaders for mental health in the community.<br>• Work with regional and national policy-makers in revising mental health plans and reallocating the budget for MNS care.<br>• Collaborate with other sectors to strengthen the health system generally rather than promoting vertical approaches in which mental health services are provided in isolation.<br>• Provide evidence of effective and cost-effective treatments for MNS conditions.<br>• Support advocacy by user organizations for mental health care. |
| MNS services are centralized in large facilities and around larger cities. | • Include current service gaps in the district situation analysis.<br>• Develop a plan to scale up mental health services in rural and underserved areas of the district.<br>• Involve mental health specialists in planning, so that they understand the benefits of task-sharing, the involvement of non-specialists in providing mental health care and their role in supporting them.<br>• Design clear referral and back-referral pathways, linked to the expected roles and responsibilities of specialists and non-specialists and also between centralized facilities (e.g. district or psychiatric hospitals) and community services. |
| Only limited human resources are available. | • Highlight current gaps in human resources in the situation analysis.<br>• Develop a plan and budget to build the capacity of non-specialist health care providers and community workers in underserved areas.<br>• Make more efficient use of mental health specialists (e.g. build capacity and supervise non-specialist health care providers). |


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## Special thanks to the following contributors for their extensive inputs:

The team at the Programme for Improving Mental Health Care (PRIME), the Department for International Development (DFID) funded consortium of research institutions and Ministries of Health in five countries in Asia and Africa (Ethiopia, India, Nepal, South Africa and Uganda), with partners in the United Kingdom and WHO; Crick Lund (Centre for Global Mental Health, King's College London, UK, and Alan J. Flisher Centre for Public Mental Health, University of Cape Town, South Africa); Charlotte Hanlon and Abebaw

GAP OPERATIONS MANUAL

Fekadu (Department of Psychiatry, Addis Ababa University, Ethiopia); Erica Breuer (Alan J. Flisher Centre for Public Mental Health, University of Cape Town, South Africa); Rahul Shidhaye (Public Health Foundation of India, India); Mark Jordans (War Child Holland and TPO Nepal); Inge Petersen (University of KwaZulu-Natal, South Africa);

# Case stories from PRIME

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PLAN

## Collaboration with the Government led to scaling up of MNS care and a sustainable financing strategy in India

A central focus of the Programme for Improving Mental Health Care (PRIME) project in India was the collaboration established between the research team, the Ministry of Health and the Government of Madhya Pradesh. In the situation analysis undertaken by PRIME, the existing district mental health care plan and budget were reviewed, and potential barriers to implementation were identified. Limited coordination among stakeholders responsible for imple

To ad

## Mental health service planning in Uganda: a situation analysis

Before implementing mhGAP in Uganda, the team from the Programme for Improving Mental Health Care (PRIME) conducted a situation analysis as a basis for designing a programme for scaling up MNS care in targeted district. The analysis was based on both quantitative and qualitative data, including a desk review and analysis of current and relevant documents and reports (secondary data) in the districts and interviews with key informants, focus group discussions with various stakeholders and site visits. These provided an understanding of the mental health situation, the care processes, underlying issues and interactions among stakeholders in the districts with regard to the accessibility, availability and delivery of mental health services.

The desk review of documents and group discussions with stakeholders revealed three main problems: (i) inadequate

# Case stories from PRIME

PREPARE

## Clinical mentoring and supervision: PRIME in Nepal

Within Nepal's district mental health care plan, the mhGAP trained health workers are mentored and supervised by three methods.

**Case conference:** In case conferences, trained health workers at various health facilities are invited to a certain venue (e.g. district public health office) to discuss challenges faced during service delivery. The meetings are facilitated by a mental health professional (i.e. psychiatrist). The aim of case conferences is to stimulate continuous learning and improve clinical practice. Case conferences were initially held monthly but are now held quarterly because of the cost.

**Tele-supervision:** In this method of supervision, trained health workers can telephone specialists whenever they face a problem in the diagnosis or management of cases. Health workers have found this very important and supportive, although it was not always feasible because of technical problems or the unavailability of the specialist.

**On-the-job supervision:** In one-to-one supervision, a specialist visits health facilities, observes heath workers' skill in diagnosing and treating people with MNS conditions and discusses any observed or experienced challenges. This type of supervision has been effective, but regularity has often been difficult to sustain in practice owing to the schedule of the specialist.

The absence of mental health supervisory mechanisms in the existing system and limited capacity and resources to sustain supervision prompted the programme to establish a context-specific support and supervision system to ensure that nonspecialist health workers trained in mhGAP receive the necessary support. The system includes various methods of supervision, including in-person, with alternative methods as needed in accordance with the funds available, technical difficulties, the number of trained specialists and supervisors and their availability.

# Case stories from PRIME

PROVIDE

## Treatment and care in the community: PRIME in Nepal

Nepal's mental health care package, developed as part of the Programme for Improving Mental Health Care (PRIME), consists of three community interventions: detection of MNS conditions, home care and counselling. Female community health volunteers, the least trained health care providers in the health system in Nepal, are well respected in the community and have access to vulnerable populations (especially women) who are less likely to visit formal health services. The volunteers are trained in case detection and referral with the community informant detection tool *(57, 58)* and also provide home care to people receiving services from mhGAP-trained non-specialists, by monitoring adherence to prescribed medicines, assessing care from family members and providing psychoeducation to both patients and family members. These services increase help-seeking behaviour and adherence to treatment.


Thank you