# Toolkit for the Integration of Mental Health into General Healthcare in Humanitarian Settings

Integration of Mental Health into General Health Care is not an event, it is a stepwise, long-term process which takes time and varies depending on the context and available resources.

This Toolkit aims to support the understanding and implementation of integrated mental health programs in humanitarian settings. It provides a framework for essential steps and components, with associated key guidance and resources, that strengthen the integration process, and is primarily intended for **(1) implementing agencies**, but may also be useful for **(2) donors**, and **(3) government actors**. Users can access the **three steps & three cross cutting components** relevant to current program needs, or stages of programming.

An additional section of the toolkit includes resources that provide **General Guidance** which is foundational to the toolkit. Please use this section as reference as you explore specific steps and components in the toolkit.

The below framework illustrates the **structure and use** of the mental health integration toolkit. **A description is provided below** for each of the integration steps and cross cutting components in the framework .
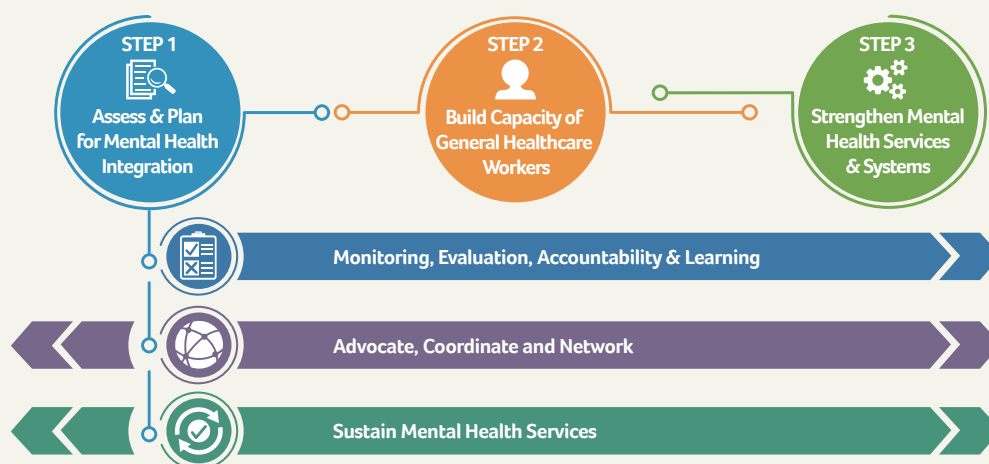
Successful mental health integration programming happens in three steps, with three cross cutting components:

Step 1. Assess & Plan for Mental Health Integration. Conduct a rapid or comprehensive assessment covering contextual information, needs and resources, which helps plan mental health integration programs.

Step 2. Build Capacity of General Healthcare Workers. Use information from the initial assessment (step 1) and identify capacities as well as **existing gaps in knowledge and skills** among general health workers and other targeted trainees. Plan capacity building activities which can include **pre-service** trainings (academic training), foundational theoretical and practical training, and ongoing technical support and supervision.

Step 3. Strengthen Mental Health Services & Systems. Use information from initial assessments (step 1) and work with trainees targeted for capacity building (step 2) and facility and regional level supervisors to strengthen mental health services and systems. This is a **continual process** that includes addressing barriers to accessing care and strengthening systems for case identification, service provision by trained and supervised staff, referral pathways, and follow-up mechanisms, as well as ensuring availability of needed materials and supplies (e.g. psychotropic medication).

Cross Cutting Component. Monitoring, Evaluation, Accountability & Learning. Use information from your initial assessment and planning (step 1) and your project activities and goals (covering step 2 & step 3 as well as the other two cross cutting components) to develop an effective MEAL system. This supports program managers in tracking progress, making adjustments, discovering unplanned effects of programming, and showing outcomes, while also ensuring accountability to stakeholders through information sharing and feedback mechanisms to improve program implementation.

Cross Cutting Component. Advocate, Coordinate & Network. Engage stakeholders and participate in coordination mechanisms starting in the early stages of assessment & planning (step 1). This includes communication and **collaboration** at various levels (national, regional and community). Build effective **partnerships**, raise awareness and **advocate** for mental health with key decision makers.

Cross Cutting Component. Sustain Mental Health Services. Plan for and consider sustainability starting in the early stages of assessment & planning (step 1). This includes **sustainability planning** in the areas of government and policy, human resources and training, programming and services, research and monitoring, and financing.

An additional section of the toolkit includes resources that provide General Guidance which is foundational to the toolkit.

Why create a toolkit for the integration of mental health into healthcare settings?

Mental health problems are an important public health concern in humanitarian crises.
Mental illness affects one in four people during their lifetime and is the main cause of disability worldwide. Populations in humanitarian contexts are especially at risk for developing mental health problems due to their exposure to violence, loss of homes, livelihoods, and loved ones, instability of community or social support systems and damaged health infrastructure. Those with pre-existing and chronic mental problems are especially vulnerable and need access to care. Mental disorders in humanitarian settings impair day-to-day functioning and are key barriers to accessing essential services and support needed to recover from conflict and crises.

Availability of appropriate and integrated mental health services remains a critical gap in countries affected by humanitarian crises*. The majority of people in such settings do not receive treatment and there are not enough specialists such as psychologists and psychiatrists. A key strategy for closing this treatment gap is **integrating mental health care with general health** which is more sustainable, less stigmatizing, more accessible and reaches larger segments of the population (WHO, 2009).

Global guidelines and resources to implement integrated mental health services exist, but there is a need to increase understanding, dissemination and uptake. Staff at agencies who are designing, supporting or implementing integrated mental health programs, are often unaware that these resources exist or do not know how to use them. This can be especially challenging in humanitarian crises with many different actors, weak or absent of MHPSS coordination mechanisms and the need to make quick funding and programmatic decisions. This toolkit aims to support agencies to better plan, design, and implement more comprehensive, effective, and sustainable programs.

"International Medical Corps has been implementing programs integrating mental health into general health care for more than ten years in over 15 countries including Jordan, Syria, Gaza, Iraq, Turkey, Lebanon, Philippines, Indonesia, Sri Lanka, Afghanistan, Pakistan, Nepal, Sierra Leone, Liberia, and Haiti."

"The Toolkit aims to increase understanding of integrated mental health program steps, components, resources and tools among implementing partners, donors and governments. It clearly outlines the steps for integrated mental health programs in humanitarian settings and provides valuable guidance for better resource allocation, program design, contextualization, implementation and evaluation."

* *World Health Organization. (2008). Scaling up care for mental, neurological and substance use disorders. Mental Health Gap Action Program. Geneva, Switzerland.*
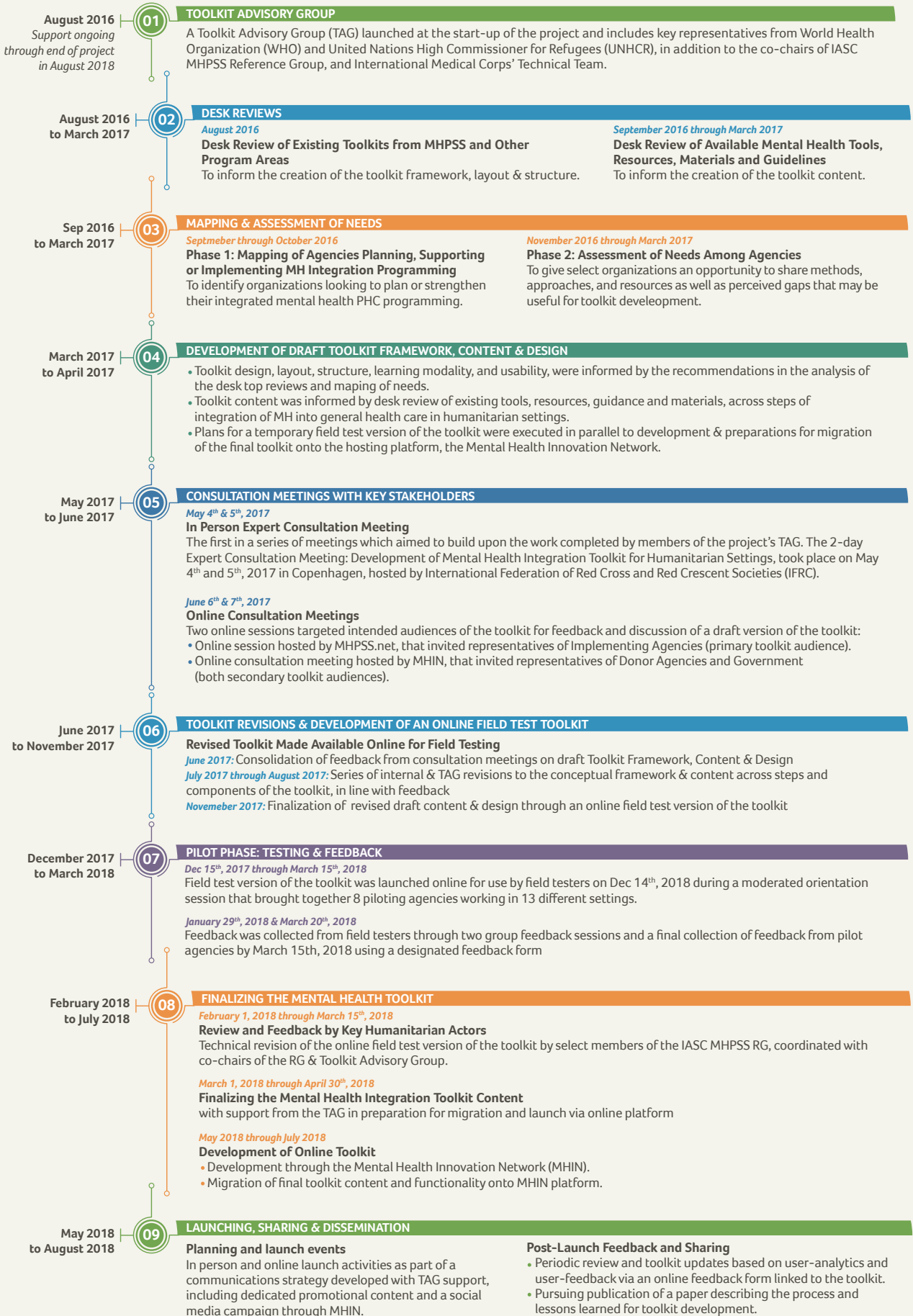
How has this toolkit been developed & evaluated?

The following diagram illustrates the process of the toolkit development.

August 2016
Support ongoing through end of project in August 2018

01 TOOLKIT ADVISORY GROUP

A Toolkit Advisory Group (TAG) launched at the start-up of the project and includes key representatives from World Health Organization (WHO) and United Nations High Commissioner for Refugees (UNHCR), in addition to the co-chairs of IASC MHPSS Reference Group, and International Medical Corps' Technical Team.

August 2016 to March 2017

02 DESK REVIEWS

August 2016
Desk Review of Existing Toolkits from MHPSS and Other Program Areas
To inform the creation of the toolkit framework, layout & structure.

September 2016 through March 2017
Desk Review of Available Mental Health Tools, Resources, Materials and Guidelines
To inform the creation of the toolkit content.

Sep 2016 to March 2017

03 MAPPING & ASSESSMENT OF NEEDS

Septmeber through October 2016
Phase 1: Mapping of Agencies Planning, Supporting or Implementing MH Integration Programming
To identify organizations looking to plan or strengthen their integrated mental health PHC programming.

November 2016 through March 2017
Phase 2: Assessment of Needs Among Agencies
To give select organizations an opportunity to share methods, approaches, and resources as well as perceived gaps that may be useful for toolkit develeopment.

March 2017 to April 2017

04 DEVELOPMENT OF DRAFT TOOLKIT FRAMEWORK, CONTENT & DESIGN

- Toolkit design, layout, structure, learning modality, and usability, were informed by the recommendations in the analysis of the desk top reviews and maping of needs.
- Toolkit content was informed by desk review of existing tools, resources, guidance and materials, across steps of integration of MH into general health care in humanitarian settings.
- Plans for a temporary field test version of the toolkit were executed in parallel to development & preparations for migration of the final toolkit onto the hosting platform, the Mental Health Innovation Network.

May 2017 to June 2017

05 CONSULTATION MEETINGS WITH KEY STAKEHOLDERS

May 4th & 5th, 2017
In Person Expert Consultation Meeting
The first in a series of meetings which aimed to build upon the work completed by members of the project's TAG. The 2-day Expert Consultation Meeting: Development of Mental Health Integration Toolkit for Humanitarian Settings, took place on May 4th and 5th, 2017 in Copenhagen, hosted by International Federation of Red Cross and Red Crescent Societies (IFRC).

June 6th & 7th, 2017
Online Consultation Meetings
Two online sessions targeted intended audiences of the toolkit for feedback and discussion of a draft version of the toolkit:
- Online session hosted by MHPSS.net, that invited representatives of Implementing Agencies (primary toolkit audience).
- Online consultation meeting hosted by MHIN, that invited representatives of Donor Agencies and Government (both secondary toolkit audiences).

June 2017 to November 2017

06 TOOLKIT REVISIONS & DEVELOPMENT OF AN ONLINE FIELD TEST TOOLKIT

Revised Toolkit Made Available Online for Field Testing
June 2017: Consolidation of feedback from consultation meetings on draft Toolkit Framework, Content & Design
July 2017 through August 2017: Series of internal & TAG revisions to the conceptual framework & content across steps and components of the toolkit, in line with feedback
Novemeber 2017: Finalization of revised draft content & design through an online field test version of the toolkit

December 2017 to March 2018

07 PILOT PHASE: TESTING & FEEDBACK

Dec 15th, 2017 through March 15th, 2018
Field test version of the toolkit was launched online for use by field testers on Dec 14th, 2018 during a moderated orientation session that brought together 8 piloting agencies working in 13 different settings.

January 29th, 2018 & March 20th, 2018
Feedback was collected from field testers through two group feedback sessions and a final collection of feedback from pilot agencies by March 15th, 2018 using a designated feedback form

February 2018 to July 2018

08 FINALIZING THE MENTAL HEALTH TOOLKIT

February 1, 2018 through March 15th, 2018
Review and Feedback by Key Humanitarian Actors
Technical revision of the online field test version of the toolkit by select members of the IASC MHPSS RG, coordinated with co-chairs of the RG & Toolkit Advisory Group.

March 1, 2018 through April 30th, 2018
Finalizing the Mental Health Integration Toolkit Content
with support from the TAG in preparation for migration and launch via online platform

May 2018 through July 2018
Development of Online Toolkit
- Development through the Mental Health Innovation Network (MHIN).
- Migration of final toolkit content and functionality onto MHIN platform.

May 2018 to August 2018

09 LAUNCHING, SHARING & DISSEMINATION

Planning and launch events
In person and online launch activities as part of a communications strategy developed with TAG support, including dedicated promotional content and a social media campaign through MHIN.

Post-Launch Feedback and Sharing
- Periodic review and toolkit updates based on user-analytics and user-feedback via an online feedback form linked to the toolkit.
- Pursuing publication of a paper describing the process and lessons learned for toolkit development.

Who should use this toolkit?

Intended Audiences
This toolkit is primarily intended for **(1)** implementing agencies but may also be useful for **(2)** donors and **(3)** government actors.

Settings
The toolkit aims to inform the response to acute, slow-onset and protracted humanitarian emergencies in different contexts including urban, rural and camp settings, primarily in low and middle-income countries that face constraints and complex challenges including limited human and financial resources for addressing increased mental health needs.

What to consider when using the toolkit?

The toolkit includes resources to help agencies and decision makers understand what needs to be implemented, based on the latest global guidelines and evidence on effective mental health integration programming in humanitarian settings, while also including specific field examples. Although there are core steps and cross cutting components that all agencies implementing, supporting or funding integration programming should consider, it is important to acknowledge that every integration process will be unique. For each situation, **programs need to be adapted and tailored** to **(1)** different existing capacities and human resources, **(2)** different systems and contexts, **(3)** cultural and language considerations, as well as **(4)** specific needs and priorities that guide design and implementation of programming.

? Resource selection & adaptation

Selection/Use of Resources

Is the resource in its current version...

...relevant to the specific emergency context, national and local level needs and priorities?

...appropriate and practical to program resources, capacities and constraints?

...understandable (translated as required, culturally appropriate and gender sensitive)?

If NO, can it be adapted? - - - →

Adaptation of Resources

Why is adaption needed:
To make resources culturally and/or linguistically appropriate to the target group(s), increase the relevance and usefulness of resources, decrease the chances of harm to the community, increase involvement and participation of target groups, ensure cultural considerations, increase chances of program effectiveness, account for varying and complex needs and context, or to adjust for program capacities and constraints.

What to Consider in the process of adaptation:

o Only make essential adaptations to the selected resource

o Does the resource already include guidance on adaptation? Have you searched for adapted versions or guidance on adaptation?

o Substantial changes should be considered carefully since they may affect the evidence-based content in key resources and guidance.

o Many contextualization & adaptation issues can be addressed by making changes to the training resources (e.g. adapt mhGAP training materials, instead of making changes to the mhGAP-HIG).

o Remember the target group for which the original resource was developed and carefully consider use with different target groups.

o The reasons (e.g. contextual and technical basis) for changes should be discussed and documented

o Contextualization and adaptation of resources & interventions is often a process and not a one-time event (e.g. initial piloting of adapted resources could be followed by further adaptation).

Process for Adaptation (adapted from Davis and Smith, 1996)

Decide what changes are needed
How To Decide Work with members of the target group (e.g. trainees, stakeholders) to identify needed changes

Examples of Possible Changes: translation, changing concepts and examples to make them culturally and contextually relevant, changing the reading level of materials to account for audience, adding or removing sections to address needs and program constraints.

↓ **Get permission**
What permissions are required prior to making changes to this resource?

↓ **Make the Changes**
Translation Needs: Involve staff with relevant technical background speaking the local language, translate and then back translate.

Adapting to Context: Confirm cultural appropriateness of concepts and examples, adjust language to an appropriate reading level, ensure that images and examples are accurate, respectful and do not cause harm to community members (e.g. by perpetuating damaging stereotypes)

Adapting for Program or Community Constraints: Involve program staff and community members in discussions about what program aspects are not feasible, explore rearranging and reorganizing implementation schedules to account for constraints

↓ **Pilot**
Pilot your adapted resource within your program

↓ **Revise**
Make changes as necessary, based on your pilot experience

--> For additional information on translation of resources & instruments, access WHO's *Process of translation and adaptation of instruments*, *Copyright Translation Guidance*, *Guidelines on Translation and Adaptation of Instruments*, in addition to two key publications Bolton (2001) *Translation Across Cultures*, and Van Ommeren (1999) *Translation Monitoring Form As Way To Translate Measures*.

? Acknowledgements

Toolkit Conceptualization & Development
- Led by Zeinab Hijazi, with support from Ashley Leichner, Inka Weissbecker (International Medical Corps).
- Design & creative development by Bilal Lezeik, Communication Specialist at Limelight Productions
- Key writing and editorial conducted by Rebecca Wener (International Medical Corps), and graduate research assistants Kendall Sauer & Jordana Cohen from the Humanitarian Assistance Applied Research Group (HAARG) at the Korbel International School, University of Denver.
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Toolkit Advisory Group
International Medical Corps project team
- Zeinab Hijazi: project implementation, content development & technical lead
- Inka Weissbecker: technical support & oversight
- Ashley Leichner: project management

Key Representatives
- World Health Organization (WHO): Fahmy Hanna and Mark Van Ommeren
- United Nations High Commissioner for Refugees (UNHCR): Peter Ventevogel
- Coordinator of the Inter-Agency Standing Committee (IASC) MHPSS Reference Group (RG): Sarah Harrison

Field Testing Agencies & Focal Points
- Action Contre La Faim in Iraq: Alexandre Letzelter
- International Medical Corps in Ethiopia: Anteneh Mamo, Jordan: Michelle Heidrun Engels, Lebanon: Jihane Bou-Sleiman, and South Sudan: Dr. Esubalew Wondimu.
- International Rescue Committee in NE Syria, Kenya and Myanmar: Ashley Nemiro & Alex Kalatu
- Malteser International in Peshawar: Dr. Rasheed Gulshan
- Médecins du Monde in Egypt: Magdy Eissa
- Syrian Arab Red Crescent & UNHCR in Syria: May Al Laham and Riwa Dahman

Other Contributors/Reviewers
Abdulbaqi Sharif Jannay (ALDA), Alexandre Letzelter (Action Contre La Faim, ACF), Asma Humayun (Consultant Psychiatrist, Pakistan), Ana Maria Tijerino (MSF), Allie Sharma (WHO, consultant), Alison Schafer (representing World Vision International, WVI at time of contribution), Anne Filorizzo Pla (ACF), Barbara Lopes-Cardozo (Centers for Disease Control and Prevention, CDC), Bashir Ahmad Sarwari (Ministry of Health, Afghanistan), Benyam Worku (Department of Psychiatry, Addis Ababa University), Brinda Wachs (Beautiful Mind), Caoimhe Nic A Bhaird (in non-affiliated capacity, MHPSS consultant), Carolina Echheverri (UNHCR), Carmen Martinez (Pan American Health Organization, PAHO), Carrie Vopelak (IMC), Claire Whitney (IMC), Christina Carreno Glaria (MSF), Dan Chisholm (WHO), Dereje Assefa Zewude (Federal Ministry of Health, Ethiopia), Edith van 't Hoff (WHO), Ellen Morgan (Grand Challenges), Georgia Lockwood (in non-affiliated capacity, MHPSS consultant), Georgie Campbell (Birkbeck College), Helen Herman (World Psychiatric Association), Houdou Seyni (in non-affiliated capacity, MHPSS consultant), Jaak Le Roy Roy (in non-affiliated capacity, MHPSS consultant), Jolene Nakao (OFDA), Jorge Castro (PAHO), Katy Wall (Handicap International), Marie Darmayan (Médecins du Monde, MdM), Massimiliano Reggi (GRT Italia), Mohamad El Shazly (UNHCR), Miriam Yu (in non-affiliated capacity, MHPSS consultant), Natalia Tejada (World Bank), Neerja Chowdhary (WHO), Nick Rose (Oxford University), Peter Hughes (Royal College of Psychiatrists, United Kingdom), Rabih Chammay (Ministry of Public Health Lebanon), Richard Gater (WHO EMRO, consultant), Samah Jabr (Ministry of Health, Palestine), Sonia Walia (OFDA), Sudip Ghimire (in non-affiliated capacity, MHPSS consultant), Suraj Koirala (TPO Nepal), Tabasum Abdul-Rasul (in non-affiliated capacity, MHPSS consultant), Taiwo Sheikh (Ministry of Health, Nigeria), Wissam Kher (Ministry of Public Health Lebanon), Yutaro Setoya (WHO).

STEP 1. Assess & Plan for Mental Health Integration

A rapid or comprehensive assessment is a ***process of systematically collecting and analyzing data*** around the country background and context, existing mental health policies, systems and resources as well as needs and barriers to care. This information is needed to plan mental health integration programs.

? WHY is this step needed?

- Information from an assessment is needed to make key decisions about program planning & design such as:
  - What existing government efforts and policies exist that we need to build on and be consistent with? Are there national mental health plans, policies, guidelines, legislation, and budgetary allocations available (e.g. are certain conditions prioritized to be treated at the PHC level)?
  - Who are the actors, academic institutions, or local groups currently working on mental health who need to be engaged (e.g. are others implementing a similar program)?
  - Which trainees and health facilities should we target for capacity building and what do we need to provide or advocate for (e.g. where are providers and what are their roles, what psychotropic medication is available?)
  - What are perceived needs and barriers to accessing mental health care among affected communities?

- An assessment is a dynamic and often continual process and ensures that we design a program that is tailored to the local context, is consistent with government guidelines, builds on existing resources and meets identified needs.

- Planning in accordance with national and regional programs and policies and acquiring an understanding of the needs and demands of the local community supports sustainability planning and community engagement from the start.

? HOW is this step done?

- Plan your assessment based on global tools (*WHO/UNHCR assessment toolkit*, *IASC assessment guide* and *IASC ethical guidelines*).

- Conduct a desk top review of available information (e.g., data and reports from implementing agencies of mental health and psychosocial programming, peer reviewed publications, newspaper articles).

- Collect data in the field (e.g. by integrating MHPSS into existing multi-sector assessments or conducting a specific MHPSS focused assessment), by utilizing a variety of assessment tools and techniques such as semi-structured interviews, direct observation, and focus group discussions with stakeholders including service providers, people affected by mental health problems, policy makers and community members.

- Analyze and summarize data to obtain an understanding of the sociocultural context, mental health policies and legislation, mapping of mental health resources and services as well as mental health and psychosocial needs of the community.

- Share what you have learned through discussion with key stakeholders, presentation at coordination meetings, and/or dissemination of your assessment report.

- Use assessment information for planning including meetings and workshops that explore who to train, how to provide short term and longer term support & supervision, which stakeholders to involve, how to make drugs regularly available, coordination with government, establishing referral pathways, funding, etc.

STEP 1. Assess & Plan for Mental Health Integration

A rapid or comprehensive assessment is a ***process of systematically collecting and analyzing data*** around the country background and context, existing mental health policies, systems and resources as well as needs and barriers to care. This information is needed to plan mental health integration programs.

MINIMUM elements of assessment & planning

Link to existing sources of information and identify the following critical information:

- **Country level analyses:** Quick assessment of existing health systems and policies, and available resources, and efforts (e.g. based on *WHO AIMS*, *AIMS country reports*, and *MH Atlas*, discussion with key national stakeholders).

- **Community level analyses:** Discussion (e.g. with key members of affected community, service providers, service users) about attitudes toward persons with mental disorders, help-seeking for mental health problems, ways of coping and community support, formal (e.g. health clinics) and informal (e.g. social supports, religious and traditional healers) resources and barriers to accessing services.

- **Health facilities assessments:** Focus on understanding which levels of the health system mental health services exist (if any), to what extent staff are trained in providing mental health services, and which health clinics/settings would be optimal for MH integration (e.g. discussion with heads of health facility and potential trainees).

- **Mapping** of existing programming, services and gaps, using the *basic 4Ws table* that outlines who is doing what, where and until when.

COMPREHENSIVE additional elements of assessment & planning

Identify additional information within each of the assessment categories:

- **Country level analyses:** Conduct comprehensive desk top review (e.g. National Health Policy, National Mental Health Policy), meet with many actors to understand how mental health systems and services are already supported and funded.

- **Community level analyses:** Assessment of key aspects (see minimum considerations for more information) through engaging diverse groups and sub-groups among affected populations as well as various service providers (formal and informal).

- Health facilities assessments: Assess different health facilities *(e.g. using MH PHC integration checklist)* to explore staff skills, staff roles, service provision, referral systems and processes, pharmacy and medication supply, health information system and clinic management.

- Mapping of existing programming, services and gaps, using the more comprehensive *IASC 4Ws mapping tool* or IASC 4Ws online mapping tool available by logging onto *mhpss.net*; part of an inter-agency process moderated through coordination groups (e.g. cluster coordination, MHPSS Coordination Group).

WHEN is this step done?

At the time of planning your integrated mental health program:
- A rapid assessment can be carried out during the initial stage of a humanitarian crisis over the course of multiple days*.
- A more comprehensive assessment is generally carried out at any time over the course of weeks to months.

* Number of days to complete an assessment ranges and is contingent on available expertise and local capacity to support the assessment, whether translation is needed, distance to and number of locations where assessment is taking place, and other factors.

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Toolkit for the Integration of Mental Health into General Healthcare

STEP 1. Assess & Plan for Mental Health Integration

A rapid or comprehensive assessment is a ***process of systematically collecting and analyzing data*** around the country background and context, existing mental health policies, systems and resources as well as needs and barriers to care. This information is needed to plan mental health integration programs.

KEY CONSIDERATIONS

✅ **Do** carry out a desk review first to identify information gaps and inform data collection in the field.

✅ **Do** involve mental health service users and carers at every stage of assessment, planning and development

✅ **Do** coordinate with other agencies to find out about existing and planned assessments.

✅ **Do** ensure MHPSS technical experts are involved from the beginning when designing assessments.

✅ **Do** include local secondary level mental health care in your assessment and consider how it can be strengthened and how local mental health professionals can be engaged to support training, supervision, referral and consultations.

✅ **Do** assess needs and resources of people with pre-existing and serious mental disorders, such as psychosis.

✅ **Do** consider and include the diverse cross-section of the population in terms of age, gender, educational level, geographic location, etc.

✅ **Do** use trained data collectors who speak the language of respondents.

✅ **Do** ask questions that have practical implications for programming.

✅ **Do** ensure the anonymity and protection of the data collected.

✅ **Do** document or record consent and protect identifiable personal data when carrying out assessments.

❌ **Do not** collect data with pre-conceived notions or expectations.

❌ **Do not** conduct surveys on the prevalence of mental disorders (that is, psychiatric epidemiology).
  --> Such surveys can be important for advocacy and academic value but are of limited practical value when designing a humanitarian response.*
  --> Why: WHO has existing prevalence estimates of MH issues (e.g. see *WHO UNHCR Assessment toolkit, page 18*); It is difficult to distinguish between normal psychological distress and mental disorders in humanitarian settings (which can lead to over-estimates), Studies with the right methods and expertise are lengthy, costly and resource intensive.

❌ **Do not** create protection risks for vulnerable segments of the populations by visibly targeting them for assessments, target broad segments of affected populations and ensure privacy, consent and confidentiality when asking sensitive questions or speaking with specific population groups.

❌ **Do not** ask potentially distressing questions (e.g. about stressful events, MH problems) without ensuring they are asked in a sensitive way, and that information about available follow-up support is provided.

❌ **Do not** ask questions that may stigmatize people or endanger them.

* Note: If you have to make a quick estimate on the prevalence of mental disorders, you can use existing WHO projections for a general indication of mental disorders in crisis-affected populations (refer to UNHCR/WHO Assessment toolkit, tool 2).

RESOURCES

Follow this link to access resources:
http://www.mhinnovation.net/collaborations/IMC-Mental-Health-Integration-Toolkit/step1-access-and-plan-for-mental-health-integration

STEP 2. Build Capacity of General Healthcare Workers

Capacity building includes **_theoretical_** and **_practical training_**, as well as ongoing technical support and **_supervision_** for general health workers such as doctors and nurses as well as community health workers. Additional MHPSS workers to be trained is dependent on the context and can include social workers, counsellors, psychosocial workers and volunteers.

WHY is this step needed?

• Treatment **coverage** for people with mental disorders is increased significantly by offering accessible and affordable mental health services as part of general health care.

• Building the **knowledge and skills** of facility and community level general health care providers and non-specialist MHPSS providers through training, supervision and mentorship over time helps ensure that trainees are confident and able to apply their skills to provide quality services.

• **Raising awareness** among health care providers and other trainees about mental health and their roles in mental health integration (e.g. access, combating stigma, affordability, etc.) makes such services more accessible and acceptable.

HOW is this step done?

• **Select** up to 5* priority mental health conditions to focus on (based on situational analysis/national guidelines), in addition to covering general principles of care.

• **Identify** targeted geographical regions and health facilities and select the number and types of trainees to include.

• **Develop the training curriculum content** (based on WHO mhGAP materials and guidelines), and **adapt** it to the context (local, social, and cultural considerations) and to the capacity and roles of trainees.

• **Prioritize topics** to emphasize better quality training on a smaller number of conditions vs training on all conditions. Training on additional conditions can be rolled out over phases as needed.

• **Develop a training and supervision schedule** which allocates the needed time and resources for on the job supervision sessions, with follow up sessions and refresher trainings as needed, avoiding a one-off training with no supervision.

• **Engage local mental health professionals** (where possible) in conducting training and providing longer term support, consultation and supervision (e.g. as co-trainers, to receive a training of trainers (TOT)) to ensure sustainable and quality mental health care.

• **Engage mental health care providers** (e.g. international psychiatrist, national psychiatrist, psychiatric nurse) to provide **training** as well as ongoing **supervision** (e.g. on the job mentorship, case discussions)

• **Monitor and evaluate** baseline and improvement in knowledge and skills to determine follow up and refresher training focus and content.

* More than 5 mental health priority conditions may be chosen if in line and in accordance with national level discussions, policy and planning.

STEP 2. Build Capacity of General Healthcare Workers

Capacity building includes _**theoretical**_ and _**practical training**_, as well as ongoing technical support and _**supervision**_ for general health workers such as doctors and nurses as well as community health workers. Additional MHPSS workers to be trained is dependent on the context and can include social workers, counsellors, psychosocial workers and volunteers.

MINIMUM elements of capacity building

- Provide **training and supervision** sessions to local health professionals over a minimum of 4 months to recognize and treat and refer persons with mental disorders.

- Ideally, **train** on **one mhGAP topic per day** (2 maximum topics depending on assessment of foundational knowledge). If fewer training hours are restricted and few due to budget or logistical constraints or political/institutional considerations, consider reducing the number of priority conditions covered and include more supervision hours.

- **Provide supervision** (e.g. on the job supervision, group and/or individual supervision sessions) following completion of foundation training for a minimum of 3 months (e.g. 3 sessions per trainee, 1 session per month).

- **Train community level non-specialists** (e.g. community health workers, volunteers, psychosocial workers) to assist with case identification, follow up, community awareness raising and provide basic psychosocial support (e.g. Psychological First Aid (PFA).

- **Use M&E tools** to track knowledge (pre-post test), and skills (on the job supervision checklist) among trainees.

COMPREHENSIVE additional elements of capacity building

- Carry out periodic evaluations (FGDs, interviews, questionnaires, supervision visits etc.) to **assess remaining training gaps** in knowledge and competencies and **develop follow up and refresher trainings**.

- Set up **peer level supervision** between PHC staff.

- Develop additional **supplemental materials** (e.g. job aids).

- Support national stakeholders and health facilities in developing resources and strategies to promote **staff well-being**.

- Develop **longer term strategy** with national stakeholders to leverage role of **national mental health professionals** to provide training and **ongoing supervision and support** to general health workers and non-specialist MHPSS providers, and to provide consultation or manage complex cases.

- Collaborate with **academic institutions and professional associations** to integrate mental health into pre-service training and continuing education for health professionals.

- Develop capacity of **local non-specialist MHPSS providers** (e.g. community health workers, social workers, psychosocial workers) in mental health case management, and evidence based **scalable psychological interventions*** (e.g. cognitive behavior therapy, _Problem Solving Plus (PM+)_ or interpersonal therapy (including _group IPT_).

* *Use the manuals in the Psychological Interventions category resource below if you are developing an integration program with a component that teaches local non-specialist MHPSS providers to deliver evidence-based scalable psychological interventions for common mental disorders.*

WHEN is this step done?

After conducting the initial needs assessment and planning which would inform the selection of target facilities, trainees, geographical locations and training content as well as the identification of resources, partnerships, and local capacities to support in the short, medium, and longer term.

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Toolkit for the Integration of Mental Health into General Healthcare

STEP 2. Build Capacity of General Healthcare Workers

Capacity building includes *__theoretical__* and *__practical training__*, as well as ongoing technical support and *__supervision__* for general health workers such as doctors and nurses as well as community health workers. Additional MHPSS workers to be trained is dependent on the context and can include social workers, counsellors, psychosocial workers and volunteers.

KEY CONSIDERATIONS

✓ **Do** establish links and communication between trained healthcare providers and specialized mental health services (e.g. psychiatrist) for ongoing technical support and referral/ back-referral of persons with severe and complex mental health problems.

✓ **Do** identify supervisors before the training is conducted and define a timetable for supervision.

✓ **Do** ensure careful consideration and assessment of training needs, existing structures and resources.

✓ **Do** ensure training is within implementing agency's capacity and based on current best practices and standards.

✓ **Do** use results of pre/post training tests to inform key aspects of supervision sessions.

✓ **Do** coordinate with the state health office or ministry of health on planning, implementing and longer-term support, training, and supervision.

✓ **Do** pay attention to staff well-being (e.g. work load, schedules, breaks, stress management sessions).

✗ **Do not** decide on topics for training without consulting national guidelines and other relevant aspects of the needs assessment.

✗ **Do not** set up stand-alone training without proper follow up, support and supervision.

✗ **Do not** forget to monitor progress in knowledge and skills during training and supervision.

✗ **Do not** overwhelm the health staff (e.g. training on too many modules at the same time, asking them to do much more than what they usually do on a day to day basis).

RESOURCES

Follow this link to access resources:

http://www.mhinnovation.net/collaborations/IMC-Mental-Health-Integration-Toolkit/step2-build-capacity-of-general-healthcare-workers

STEP 3. Strengthen Mental Health Services & System

Strengthening of mental health services at facility and community levels provided by trained and supervised healthcare staff in addition to strengthening systems through improved coordination and referral between service providers, HMIS documentation, and psychotropic medication supply.

WHY is this step needed?

While staff capacity building is a critical component, it is not enough to establish a functioning system of community based mental health care. Various parts of the system need to work together to ensure that persons with mental health problems can be **identified**, appropriately **managed and cared for**, have access to psychotropic medications and can be **referred** to essential clinical or community services **and followed up**, as part of a functioning **system**. Strengthening these systems means that persons **receive the care** they need, and that integration can be **sustained**.

HOW is this step done?

Use your assessment/situational analysis to identify where your planned mental health program falls within the larger systems of health, mental health and community services as well as within humanitarian response efforts. Work with national, regional and local authorities as well as with health facility staff to strengthen MH services (e.g. identification, management, referral) and systems (e.g. space and time for services, mapping of service providers, HMIS, psychotropic medication). Ensure that trained staff and other service providers understand their role in the MH system.
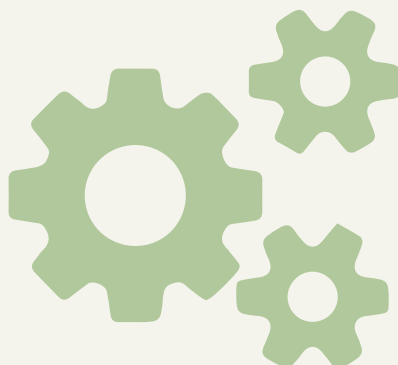
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STEP 3. Strengthen Mental Health Services & System

Strengthening of mental health services at facility and community levels provided by trained and supervised healthcare staff in addition to strengthening systems through improved coordination and referral between service providers, HMIS documentation, and psychotropic medication supply.

MINIMUM elements of strengthening mental health services & systems

Strengthening of mental health services
provided by **trained health staff** (doctors, nurses and CHWs) consisting of:

- Identification, assessment and diagnosis (e.g. initial identification through CHWs, assessment by PHC providers).

- Management of mental disorders (e.g. psycho-education for patients and family members, psychosocial interventions, psychotropic medication- if needed).

- Follow-up (e.g. continued appointments, visits by CHWs, phone calls/text messages).

- Referral to other services including to more specialized mental health service providers.

Strengthening of mental health system through:

- Ensuring that trained staff understand their **roles** in MH service provision (e.g. outlining protocols, referral pathways, job descriptions).

- Ensuring there is designated and **appropriate space** (e.g. private space, locked files) and **time** (e.g. afternoons one day a week) for staff to see persons with MH problems.

- Adapting **Health Information Systems**, in line with national systems, to collect data on persons with mental disorders identified in primary care.

- **Supporting procurement of essential psychotropic medications** in coordination with the government.

- **Mapping** of community services (e.g. protection, social services) and specialized MH service providers.

- Setting up **processes for referral** to and from MH PHC services.

- Establishing **links and communication with local specialized MH services** (e.g. psychiatrist) for referral of persons with severe mental health problems.

COMPREHENSIVE additional elements of strengthening mental health services & systems

Strengthening of mental health services through additional capacity building such as:

- Training of non-specialized staff (social workers, counselors, case managers, etc.) to provide **evidence based psychological interventions** with mechanisms for support, follow up and supervision by specialized mental health professionals.

- **Peer to peer support** activities with leadership from mental health *service users*.

- Setting up mechanisms for **patient identification**, **basic support and follow up** by mobilizing community health workers.

Strengthening of mental health system through:

- Supporting **communication**, **care coordination and multi-disciplinary teamwork** among various staff (e.g. health and social services, psychiatrists, psychologists and other MH professionals) to address multiple and complex needs of persons with mental illness and their families.

- Supporting **Health Information Systems**, in line with national systems, to collect and report data on persons with mental disorders treated at different levels of care (e.g. in primary care, mental health outpatient facilities, mental hospitals). **Comprehensive Mapping** of formal and informal service providers in the area (e.g. specialized MH services, protection services, community services, traditional healers).

- Supporting the availability and affordability of **psychotropic medications** including effective maintenance or establishment of sustainable supply chains (e.g. staff know when and how to order medication and feel empowered to advocate for availability of medication with government or other stakeholders).

- Setting up an effective **monitoring and evaluation** system for MH services and organizational level change.

- Setting up **interagency referral workshops** to establish clear referral pathways and guidelines among different service providers.

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WHEN is this step done?

This is **a continual process which requires ongoing monitoring, planning and active participation of all stakeholders** from the beginning. The resources presented as Specific Tools and Materials should be used by those who have been trained as mental health care providers.

KEY CONSIDERATIONS

✅ **Do** ensure that investment in primary care is preceded by, or at least carried out in tandem with, development of community and secondary mental health services.

✅ **Do** invest in local human resources (displaced and host) to respond to MH needs.

✅ **Do** help ensure provision of a quiet and private space to meet with persons with mental health problems.

✅ **Do** address mental health needs at the appropriate level of care, while being aware of available up and down referral systems and pathways if needed.

✅ **Do** set up a system where trained health staff can connect with MH specialists for support and guidance, and for emergencies (e.g. responding to acute suicidal ideation).

✅ **Do** utilize CHWs and community leaders for outreach and connect with formal and informal service providers for referrals.

✅ **Do** respect the privacy and confidentiality of persons with MH problems.

✅ **Do** take into consideration that families/carers of people with mental disorders may also need support.

✅ **Do** discuss in training how to establish referral links with traditional healers and religious leaders who are often the first point of contact for persons with severe mental illness.

❌ **Do not** refer all persons to a specialized provider (e.g. psychiatrist or psychologist).

❌ **Do not** set up a parallel system of MH care.

❌ **Do not** forget that persons with mental health problems may have other complex needs that also need to be addressed (e.g. other general health conditions or injuries, protection concerns, housing issues).

❌ **Do not** assume people with mental illness will come to a health care facility on their own.

❌ **Do not** introduce expensive psychotropic medications that cannot be sustained in the long term and work in line with the ministry of health's essential drug list.

❌ **Do not** allow medication supply to be interrupted.

❌ **Do not** contribute to an influx of referrals to already stretched services, without working to strengthen those existing services first.

RESOURCES

Follow this link to access resources:

http://www.mhinnovation.net/collaborations/IMC-Mental-Health-Integration-Toolkit/step3-strengthen-mental-health-services-and-systems

Cross Cutting Component. Monitoring, Evaluation, Accountability & Learning

Monitoring, evaluation, accountability and learning (MEAL) is part of the planning, designing and day to day management of integrated mental health programming. An effective MEAL system supports program managers in tracking progress, making program adjustments, discovering unplanned effects of programming, and showing outcomes of mental health integration. MEAL also supports accountability to stakeholders through information sharing and feedback mechanisms.

BREAKING DOWN THE MEAL SYSTEM (1/2)

SYSTEM FOR MONITORING, EVALUATION, ACCOUNTABILITY AND LEARNING

Design Program

Analyze Situation & Assess Needs → Develop/Adapt Program Objectives → Develop/Adapt Logical Framework & Indicators → Collect Baseline → *Process, Input, Output & Outcomes* Implement & Monitor → *Process, Outcome & Impact* Review & Evaluate

Feedback Loop ← Learning ←

Community Participation & Stakeholder Engagement

ACCOUNTABILITY

ANALYZE SITUATION & ASSESS NEEDS

A situational analysis and needs assessment are carried out to determine whether an integrated mental health program is appropriate and feasible and, if so, to inform its planning and design through systematically collecting and analyzing data. This includes information about mental health needs, capacities, resources and national efforts for mental health system strengthening, and overall sustainability of planned services. *> See Step 1. Assess & Plan for MH Integration*

DESIGN PROGRAM

- **Develop/Adapt Program Objectives.** Findings from a situational analysis and/or needs assessment are used to design and tailor the program to the local context. This includes being consistent with government guidelines and global best practices, building on any existing or emerging mental health components of a system, and meeting identified needs while also considering existing resources.

- **Develop/Adapt Logical Framework & Indicators.** This includes the development of a logical framework, and associated activities for monitoring and evaluation (M&E) as well as program specific quantitative and qualitative indicators. Indicators track key elements of program performance as well as results. Some donors also require specific M&E templates and additional elements such as outlining a Theory of Change (TOC) that helps you check the validity of your assumptions by setting end objectives and working backwards to ensure that activities, outputs and outcomes will link to program objectives. *> See MHIN TOC practical guide & example ToC map* for integrating mental health into primary care in India, Nepal, Ethiopia, Uganda and South Africa – the PRIME study. A free *20-minute course* by Save the Children on Theory of Change is available on DisasterReady.

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BREAKING DOWN THE MEAL SYSTEM (2/2)

COLLECT BASELINE

This is the measurement of the initial conditions as determined by project indicators, that occurs before the start of a program. Baselines can help monitor changes and contribute to program evaluation by making comparisons with later follow up data. Relevant data that is still current and was acquired in the situational analysis and needs assessment phase can also be used as part of the baseline.

When no formal baseline is completed, or the baseline data is incomplete, the following strategies may be employed:
- Consult and utilize existing secondary data (e.g. *WHO AIMS*, *AIMS country reports* , *WHO proMIND*, *MH Atlas*, *MHIN*, and *mhpss.net*) from other NGOs, government, or community organizations (e.g. survey data, health registers or project activity records).
- Utilize recall of staff and/or affected populations (e.g. asking staff about past training, activities, practices for addressing mental health problems).

IMPLEMENT & MONITOR

This includes the systematic monitoring of mental health programs over time. It involves the ongoing collection and review of data to provide program managers and other staff with indications of progress against program plans and towards program objectives. This information should be used to improve program implementation through adjustments to programs activities, timelines and stakeholder engagement.

REVIEW AND EVALUATE

This helps determine to what extent programs are meeting or have met their goals. Evaluation is essential to planning strategies, improving programs, demonstrating results, and justifying resource allocations.
- A formative evaluation with a focus on improvement is carried out during the life of the program .
- An end of project evaluation takes place towards the end of the program and is used to reveal its overall impact.

ACCOUNTABILITY & LEARNING

- **Learning** includes systematic documentation and use of lessons learned, recommendations, and observations, that emerge from monitoring, evaluation and accountability mechanisms to improve program design and to publish and communicate results internally and externally. Reporting, reflection and learning should occur throughout the whole program cycle.

- **Accountability** to stakeholders, service users and wider communities involves ongoing participation, information sharing, and development of feedback mechanisms, to guide program design and implementation in line with local priorities.

- **Community Participation and Stakeholder Engagement** in MEAL is essential to identify and address challenges and gaps as they arise, in ways that are appropriate for the community and context. This can lead to increased relevance of programming, transparency, accountability, sustainability and ownership. Communities and stakeholders can be engaged and participate in:
  - Needs assessments and situational analyses
  - Resource mobilization
  - Discussing the program design, activities, outcomes and impact
  - Data collection for monitoring and evaluation
  - Providing feedback and suggestions in a safe and dignified manner (e.g. through feedback and complaint mechanisms)
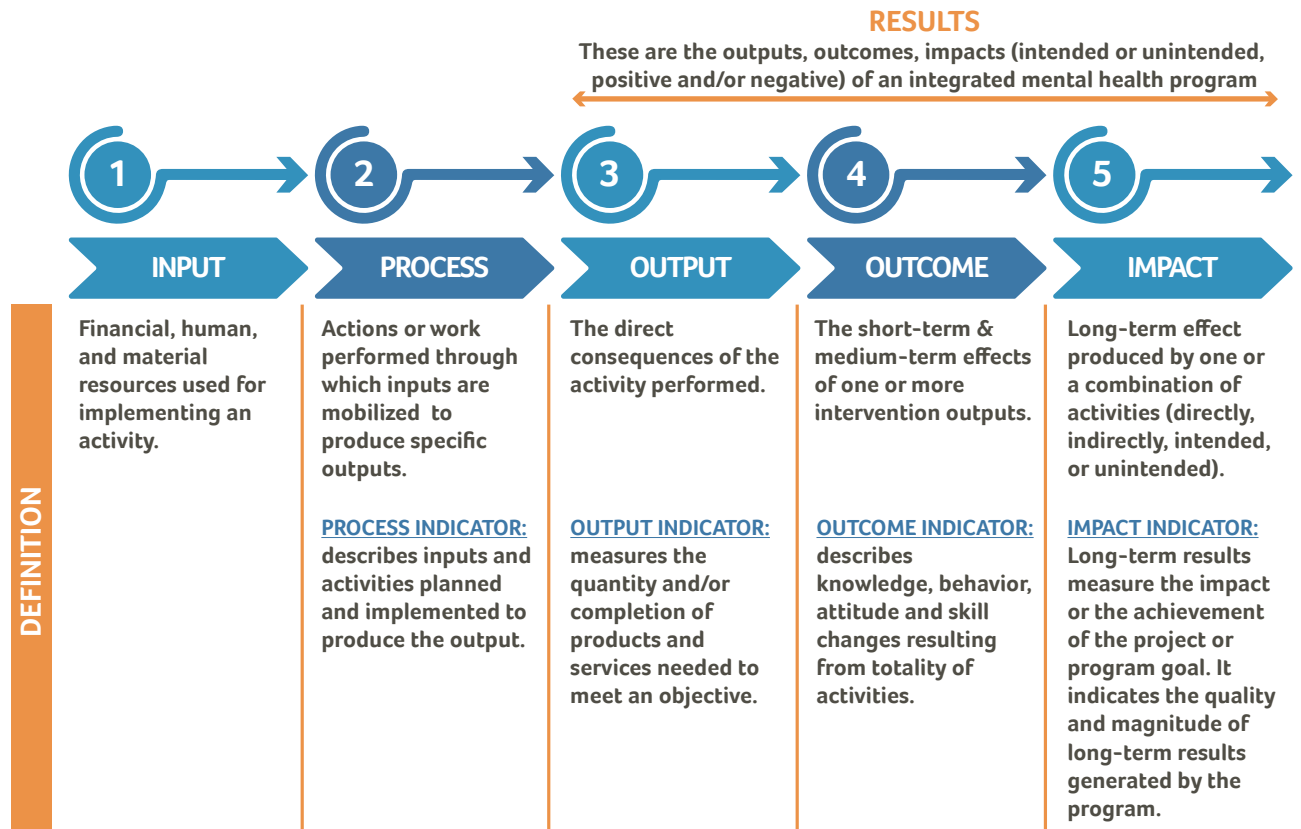 - Interpretation of MEAL data to make recommendations

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IDENTIFYING INDICATORS FOR INTEGRATED MENTAL HEALTH PROGRAMS

RESULTS

These are the outputs, outcomes, impacts (intended or unintended, positive and/or negative) of an integrated mental health program

① INPUT	② PROCESS	③ OUTPUT	④ OUTCOME	⑤ IMPACT
Financial, human, and material resources used for implementing an activity.	Actions or work performed through which inputs are mobilized to produce specific outputs.	The direct consequences of the activity performed.	The short-term & medium-term effects of one or more intervention outputs.	Long-term effect produced by one or a combination of activities (directly, indirectly, intended, or unintended).
	PROCESS INDICATOR: describes inputs and activities planned and implemented to produce the output.	**OUTPUT INDICATOR:** measures the quantity and/or completion of products and services needed to meet an objective.	**OUTCOME INDICATOR:** describes knowledge, behavior, attitude and skill changes resulting from totality of activities.	**IMPACT INDICATOR:** Long-term results measure the impact or the achievement of the project or program goal. It indicates the quality and magnitude of long-term results generated by the program.

(DEFINITION)

KEY CONSIDERATIONS FOR DEVELOPING INDICATORS

- Carefully consider the **time and resources** required to collect specific indicators and ensure that the information collected is practical and useful for documenting and informing programming.
- Ensure that indicators are prioritized to inform programming and demonstrate outcomes; avoid overburdening the community with data collection that is not useful or effective.
- Support the standardization of **core indicators** for mental health integration programs among agencies and partners.
- Whenever possible, track indicators using **data collection systems that already exist**, instead of external systems that will require special efforts to maintain.
- Indicators should be **SMART**: **S**pecific, **M**easurable/Quantifiable, **A**ttainable, **R**elevant, **T**ime-bound; they should be well defined, so that they are understood, and data is collected and interpreted in a consistent manner

Examples of indicators across levels of MH integration are available in the *SAMPLE IMC Mental Health Integration Results Framework*.

RESOURCES

Follow this link to access resources:

http://www.mhinnovation.net/collaborations/IMC-Mental-Health-Integration-Toolkit/cross-cutting-component-monitoring-evaluation-and-learning

Cross Cutting Component. Advocate, Coordinate & Network

Coordination, networking and advocacy take place at _**various levels**_ (national, regional and community) and promote regular flows of information, help fill gaps, strengthen referral between service providers, support inclusion of national expertise and community voices, and _**raise awareness**_ on mental health issues among key stakeholders such as governments.

WHY is this component needed?

When planning and implementing an integrated mental health program, it is important to communicate with national actors and other international agencies from the start, to makes sure the program fits within the larger context and is well understood by different stakeholders. **Coordination and networking** are necessary to obtain relevant input from different stakeholders and keep them informed about the program. **Advocacy** activities can help promote the human rights of persons with mental disorders and reduce stigma and discrimination. Such activities also support equitable access to quality mental health services while ensuring that mental health is on the national agenda of governments and humanitarian actors including donors. Advocacy can ultimately lead to improvements in policy, resource allocation, legislation and service development.

HOW is this component done?

Coordination, networking and advocacy efforts are conducted with key stakeholders (e.g. local and international NGOs, national and local government, UN agencies, civil society organizations, program managers, mental health professionals, and PHC staff). This can include:

- Regular **coordination**, discussions and collaboration with MoH and district level government agencies, and peripheral health facilities and with other relevant stakeholders at the community level.

- Facility level and community-based **awareness** activities that tackle issues of stigma and provide information about mental health and accessing services.

- **Advocacy** for allocating needed resources and efforts for integration of mental health within general health care.

- Support to mental health **service user and carer groups** in leading advocacy efforts at various levels, including government, facility and community levels.

Cross Cutting Component. Advocate, Coordinate & Network

Coordination, networking and advocacy take place at *various levels* (national, regional and community) and promote regular flows of information, help fill gaps, strengthen referral between service providers, support inclusion of national expertise and community voices, and *raise awareness* on mental health issues among key stakeholders such as governments.

MINIMUM elements of advocacy, coordination and networking

- Ensure to communicate about your MH PHC integration project as part of **MHPSS coordination** groups, relevant clusters and working groups (e.g. Health Cluster, Protection Cluster).

- Work in line with **existing national mental health strategies, plans or policies***.

- Identify **pre-existing advocacy** efforts led by groups such as **service users** or other relevant civil society organizations and link with any champions in the government who have an interest in supporting mental health.

- Carry out and/or participate in **mapping** of other agencies and their activities, to find opportunities for partnerships and alignment of agendas (*See Step 1: Assess & Plan for MH Integration*).

* Access resources within Mental Health Plans & Polices subcategory below to understand and support national mental health plans and policies.

COMPREHENSIVE additional elements of advocacy, coordination and networking

- Conduct information sessions about mental health PHC integration at MHPSS and non-MHPSS coordination groups (e.g. MHPSS, health, protection, wash, nutrition, etc.), describing **cross sectoral importance**.

- Work with government representatives and others on developing and/or implementing **national mental health policies and plans** in line with global recommendations.

- Promote the **participation of persons with mental disorders** in decision making processes on issues affecting them, including policy, law, and service reform.

- Identify the key factors for maximizing mental health sustainability and scalability, including advocating for the expansion and improvement of universally accessible and affordable **mental health services** (e.g. including mental health as part of the basic service package for health, including mental health in public or private coverage and **insurance benefits**).

Cross Cutting Component. Advocate, Coordinate & Network

Coordination, networking and advocacy take place at _**various levels**_ (national, regional and community) and promote regular flows of information, help fill gaps, strengthen referral between service providers, support inclusion of national expertise and community voices, and _**raise awareness**_ on mental health issues among key stakeholders such as governments.

KEY CONSIDERATIONS

✔ **Do** use locals with communications and media expertise in national advocacy efforts.

✔ **Do** involve mental health service users to help promote their rights and receive valuable input to guide programs and activities.

✔ **Do** support participation of various vulnerable groups identified in the community.

✔ **Do** develop, adapt and disseminate targeted key messages for building awareness on mental health and mental health services within communities.

✔ **Do** identify opportunities to advocate for staff & self-care, ethical considerations, and human rights.

✔ **Do** take ethical and protection considerations into account when involving mental health service users and their families or specific groups in the community that may be vulnerable.

✖ **Do not** conduct any MHPSS assessments, trainings or service provision without coordinating with local leadership, and other relevant sectors and agencies.

✖ **Do not** plan or carry out MH advocacy activities and events without involving key stakeholders, including MH service users and their families.

RESOURCES

Follow this link to access resources:

http://www.mhinnovation.net/collaborations/IMC-Mental-Health-Integration-Toolkit/cross-cutting-component-advocate-coordinate-and-network

Cross Cutting Component. Sustain Mental Health Services

A key component of success in integration is the ***sustainability of mental health services through general healthcare, and transition of these services from the emergency to longer-term development phases***. It should be considered throughout the MH integration process, starting at the very start of project planning. Aspects of sustainability are related to government and policy, local partnerships, human resources and training, programming and services, research and monitoring, and financing.

WHY is this component needed?

To promote a smooth **transition from emergency to long term development**, and to ensure **continued availability of accessible, and quality mental health care**. Funding streams usually differentiate between short and long-term interventions, creating an artificial division between MH integration programming in the emergency context, and those that focus on long-term development goals. Even where government support or collaboration exists, securing commitments from development donors and/or governments after the emergency phase and in the longer term can be challenging. Finding ways to **sustain MH services** is important to secure **continued services and capacity**.

HOW is this component done?

• Work in partnership with governmental health authorities, CBOs/NGOs and donors, to develop **national, district or region specific mental health programming**. This will be informed by the situational analysis/assessment (*step 1*), coordination/discussion with stakeholders (*cross cutting component - Advocate, Coordinate & Network*), and in line with existing health systems and strategies.

• Maximize the use of **existing local and regional health care infrastructure and resources** and ensure **consistency with local capacities and national strategies**.

• Establish **partnerships** that can serve to create longer timelines for investment of funds and human capital, thus **pooling resources to achieve sustainability**. A mixture of support from government, private, academic, faith based, foundation, and NGO funds can effectively support **long-term development of human resources and sustainable services**.

• **Advocate for mental health components within national health financing systems** (e.g. MH services and medications as part of national basic package of health services or covered by insurance) which can play an important role towards **securing long-term funding**.

Cross Cutting Component. Sustain Mental Health Services

A key component of success in integration is the ***sustainability of mental health services through general healthcare, and transition of these services from the emergency to longer-term development phases***. It should be considered throughout the MH integration process, starting at the very start of project planning. Aspects of sustainability are related to government and policy, local partnerships, human resources and training, programming and services, research and monitoring, and financing.

MINIMUM elements of sustainability

- Involve **government and local organizations from the start** to discuss how capacity of services providers and supportive systems can be strengthened and sustained at the district level.

- Set up **peer level supervision** organized between PHC staff for sustained supportive supervision system in absence of local mental health professionals and trainers.

- Foster **continued dialogue** with key stakeholders in order to solve issues such as a continued supply of medicine, ongoing supervision, and annual planning for policies and funding.

- Advocate for inclusion of **longer term support and supervision, scale up and handover** as part of donor funding.

COMPREHENSIVE additional elements of sustainability

- Design a **sustainable capacity building and supervision model** as part of mental health PHC integration in close collaboration with the government and key stakeholders (e.g. integrating MH in pre-service training and continued education for health professionals, tasking national MH staff with longer term training and supervision/consultation of PHC providers).

- Support government and advocate for incorporating mental health into **health policy and legislative frameworks, insurance covered health services and implementation plans**, that are accompanied by adequate resources.

- **Support the formalization of local or regional agreements that sustain and institutionalize services**, even in the face of changing government structure or shifts in political will.

- Contribute to sustainable long-term **improvements in MH systems** (e.g. supply of psychotropic medications, processes and forms, HMIS, strengthening referral networks, and annual planning for policies and funding).

- Include elements of mental health systems sustainability in **monitoring and evaluation framework** for MH integration activities.

Cross Cutting Component. Sustain Mental Health Services

A key component of success in integration is the _**sustainability of mental health services through general healthcare, and transition of these services from the emergency to longer-term development phases**_. It should be considered throughout the MH integration process, starting at the very start of project planning. Aspects of sustainability are related to government and policy, local partnerships, human resources and training, programming and services, research and monitoring, and financing.

KEY CONSIDERATIONS

✅ **Do** plan for sustainability from the very start of the program design (e.g. discussing and considering handover, exit or phase out from the beginning).

✅ **Do** advocate for government involvement, partnership during implementation, and overall buy in, as this is central to sustainability.

✅ **Do** advocate with funders and international agencies for longer integration program timelines to ensure more sustainable outcomes and impacts, and support for transitioning programming from emergency response, to recovery to development.

✅ **Do** attempt to partner and coordinate with national organizations who can support and advocate for continuation of services.

✅ **Do** consider pre-existing human resources and MH service structures to identify expertise and service providers that can be sourced locally so that staff members can be trained to function better in their existing roles.

✅ **Do** explore opportunities to set up a TOT (a cascade of training in which trained and supervised master-trainers teach knowledge, intervention techniques, activities or skills to trainees).

✅ **Do** provide patients and families with essential information in the case that services are handed over to other agencies or affected populations have to move to different locations (e.g. information about diagnosis, treatment plan, medication given, medication instructions).

❌ **Do not** depend on government involvement when there are issues of poor governance or political sensitivity related to the provision of services.

❌ **Do not** solely depend on government involvement or commitment as a standalone strategy for sustaining MH integration services.

❌ **Do not** expect the government or other organizations to take over activities from international organizations when the emergency phase is over without significant planning and coordination from the start of the emergency phase (e.g. areas of human resources and training, programming and services, and financing).

❌ **Do not** create staffing positions with very high pay scales that are not commensurate with local ability to pay long term.

❌ **Do not** make expensive psychotropic medication available that cannot be sustained in the long term but use generic medications in line with the WHO list of essential medicines and national lists.

RESOURCES

Follow this link to access resources:
http://www.mhinnovation.net/collaborations/IMC-Mental-Health-Integration-Toolkit/cross-cutting-component-sustain-mental-health-services