mhGAP
Mental Health Gap Action Programme

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World Health Organization

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PREFACE

Worldwide, mental, neurological and substance use (MNS) conditions impose an enormous global disease burden that leads to premature mortality and affects functioning and the quality of life. MNS conditions account for an estimated 9.5% of disability-adjusted life years and 28.4% of years lived with disability. Left untreated, MNS conditions can result in worse outcomes for commonly co-occurring diseases, such as tuberculosis and cardiovascular disease. Yet mental and physical health conditions are not given equal priority.

People with MNS conditions and their families are also challenged by stigmatization, which reduces social inclusion, limits employment and interferes with help-seeking. Despite its enormous social burden, countries are not prepared to deal with this often-ignored challenge.

Few resources are available for developing and maintaining mental health services in low- and middle-income countries (LMIC). The scarcity and unequal distribution of services means that 76–85% of people with MNS conditions do not receive the care they need; this treatment gap exceeds 90% in many LMIC. The large gap affects not only people with MNS conditions and their families but also economic development, through lost productivity, low participation in labour and increased expenditure on health and social welfare. It is estimated that untreated MNS conditions account for more than 10 billion days of lost work annually – the equivalent of US$1 trillion per year.

Achieving universal health coverage, including coverage with high-quality services and financial protection for all, is target 3.8 of the Sustainable Development Goals (SDGs). To meet this goal throughout the world, prevention, treatment and care for MNS conditions must be integrated into accessible, effective, affordable services in which the rights and dignity of everyone in the population are respected. The aim of the Comprehensive Mental Health Action Plan 2013–2020 is universal coverage of MNS conditions through the provision of evidence-based, integrated, responsive mental health and social care services in communities. The WHO mental health Gap Action Programme (mhGAP) was initiated to meet the targets of the Action Plan and to bridge the significant gap in mental health services. Properly implemented, the interventions outlined in mhGAP represent "best buys" for any country, with significant returns in terms of health and economic gains.

The objective of this mhGAP operations manual is to support district health managers and others responsible for integrating mental and physical health services. It emphasizes the strengthening of health care systems and workforce capacity. It offers practical guidance on implementation of mhGAP and includes solutions to the barriers facing public health leaders in the form of practical tips, lessons learned from projects in which mhGAP has been used and adaptable implementation tools. The manual is an integral component of the mhGAP package.

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Vision and conceptualization

The mhGAP operations manual was prepared under the overall guidance and conceptualization of Shekhar Saxena and Tarun Dua, WHO Department of Mental Health and Substance Abuse.

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WHO headquarters

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ABBREVIATIONS AND ACRONYMS

AMHF	Africa Mental Health Foundation
CBT	cognitive behavioural therapy
CHW	community health worker
e-mhGAP	mental health Gap Action Programme Intervention Guide 2.0 app
IPT	interpersonal therapy
LMIC	low- and middle-income countries
MCH	maternal and child health
mhGAP	mental health Gap Action Programme
mhGAP-IG	mental health Gap Action Programme intervention guide
MNS	mental and neurological conditions and those due to substance use
M&E	monitoring and evaluation
NCD	noncommunicable disease
NGO	nongovernmental organization
PFA	Psychological first aid
PM+	Problem Management Plus
PRIME	Programme for Improving Mental Health Care

INTRODUCTION AND PURPOSE

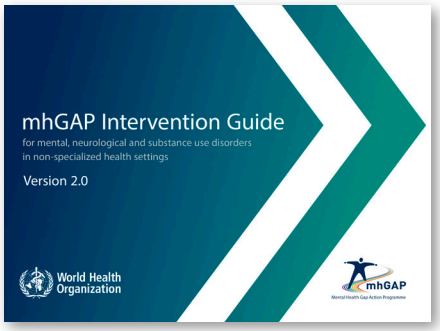
MNS conditions are highly prevalent, representing approximately 10% of the global disease burden *(1)*. People with MNS conditions have significantly reduced life expectancy, with risks for premature mortality and co-morbidity with other chronic diseases *(2)*. The estimates of disease burden do not, however, fully account for the significant social and economic consequences for individuals, families, communities and societies.

The total economic output lost to MNS conditions has been estimated at US$1 trillion per year due to lost production and consumption opportunities at both individual and societal levels *(3)*. People with these conditions also face stigmatization and discrimination, with systematic denial of their basic human rights, ranging from limited opportunities for education and employment to abuse and denial of freedom, sometimes within health care facilities *(2)*.

Health systems, especially in LMIC, are currently failing to meet the mental health needs of the populations they serve. The resources available to tackle the huge burden are insufficient, inequitably distributed and inefficiently used, so that a large majority of people with MNS conditions receive no care at all *(4)*, despite evidence of the efficacy and effectiveness of both psychosocial and pharmacological interventions *(5)*.

In May 2012, the Fifty-sixth World Health Assembly called upon the Director-General of the WHO to prepare the Comprehensive Mental Health Action Plan 2013–2020 *(6)* for scaling up mental health and social care services in the community, integrating mental health into non-specialized health settings, ensuring the continuity of care by providers at different levels of the health system, ensuring effective collaboration between formal and informal care providers and promoting self-care, for instance through mobile technology. The Action Plan recognizes the essential role of mental health in achieving health for all.

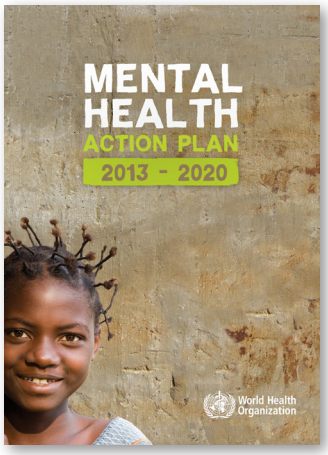
mental health Gap Action Programme (mhGAP)



To reduce the gap in treatment for MNS conditions, WHO launched the mhGAP in 2008 *(7)*. Its main objective is to reinforce the commitments of governments, international organizations and other stakeholders to increase allocation of financial and human resources for the care of MNS conditions. mhGAP contributes to achieving the targets of the Comprehensive Mental Health Action Plan 2013–2020 *(6)* by scaling up high-quality, evidence-based mental health services that promote human rights, equity and dignity for people with MNS conditions. mhGAP contributes to achieving universal health coverage by integrating mental health care into non-specialized health services.

mhGAP is based on evidence-based technical guidelines *(4)* and provides a set of tools and training packages to extend service provision. The mhGAP Intervention Guide (mhGAP-IG) for MNS disorders in non-specialized health settings *(8)* is a clinical decision-making tool for assessing and managing priority MNS conditions (depression, psychoses, epilepsy, child and adolescent mental and behavioural disorders, dementia, disorders due to substance use, self-harm and suicide). The first version of mhGAP-IG was used in over 100 countries, translated into more than 20 languages and widely accepted by a range of stakeholders, including ministries of health, academic institutions, nongovernmental organizations (NGOs) and other philanthropic foundations and researchers *(9)*. Version 2.0 of the mhGAP-IG, introduced in 2016, reflects new findings from the literature, updated guidelines and experience from the field. WHO has also prepared a mobile version (e-mhGAP) (section 3.1) and training manuals (section 2.2).

Cross-cutting principles for mhGAP implementation



The cross-cutting principles listed in Table 1 are drawn from the Comprehensive Mental Health Action Plan 2013–2020 *(6)* and are important considerations for mhGAP implementation. More broadly, they are the basis of any action related to integration of mental health services into non-specialized health settings.

Why is mhGAP implementation needed?

A central focus of the United Nations SDGs is universal health coverage, a key to the global transformation of health care that the world seeks to achieve by 2030 *(12)*. For WHO Member States, "health" in UHC means physical, mental and social well-being and not merely the absence of disease or infirmity *(13)*.

Embedded in the SDGs are targets for achieving universal health coverage. Goal 3.8 is "achieve universal health coverage, including financial risk protection, access to quality essential health care services and access to safe, effective, quality, and affordable essential medicines and vaccines for all". Two other goals that include mental health are:

- Goal 3.4: By 2030, reduce by one third premature mortality from noncommunicable diseases (NCDs) through prevention and treatment and promote mental health and well-being; and
- Goal 3.5: Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol.

Universal health coverage is also one of three strategic priorities in WHO's 13th General Programme of Work 2019–2023 *(14)*, with addressing health emergencies and promoting healthier populations. The programme lists the actions that are necessary, such as policy dialogue, strategic support, technical assistance and service delivery.

People everywhere continue to face a complex mix of interconnected threats to their health and well-being with the increasing burden of NCDs, including MNS conditions. More than half the world's population is still unable to access health services without incurring

Table 1. Cross-cutting principles for mhGAP implementation

Principle	Description
Universal health coverage 	• In universal health coverage, all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, and those services are of good quality and do not put people at risk of financial harm. • Any action should benefit the whole of society, regardless of age, sex, socioeconomic status, nationality, race, ethnicity, religion or sexual orientation. People with MNS conditions should be able to access essential health and social services that enable them to achieve the highest attainable standard of health.
Human rights 	• People with MNS conditions are particularly vulnerable to violation of their human rights *(10)*. • Providers must promote the rights and uphold the dignity of people with MNS conditions, in line with international human rights standards, including the United Nations Convention on the Rights of Persons with Disabilities *(11)* and national legislation for people with disabilities (see also Essential care and practice below). • WHO's QualityRights *(10)* provides practical guidance for improving the quality of care provided by mental health services and for promoting the rights of people with MNS conditions. It offers an approach to care that is rights- based and recovery-oriented.
Evidence-based practice 	• Interventions for the prevention, treatment and care of MNS conditions should be based on scientific evidence and/or best practice, taking the context into account. • mhGAP guidelines are the basis of the mhGAP-IG version 2.0 and the mhGAP operations manual, emphasizing the importance of scientific evidence and best practice in planning, preparing and providing integrated mental health services *(5)*.
Life-course approach 	• Policies, plans and services for mental health should take account of changing health and social needs throughout the life-course (early childhood, adolescence, adulthood and old age). • A life-course approach reflects the United Nations SDG of ensuring healthy lives and promoting well-being for all at all ages. • It also accounts for the importance of prevention and early intervention.
Multisectoral approach 	• MNS conditions are linked to the social, economic and physical environments in which people live. A comprehensive, coordinated response for MNS care requires multisectoral partnerships with many service providers in the health, education, social and private sectors. • mhGAP implementation should not result in the creation of parallel mental health services. To ensure this, partnerships should be formed among departments in district governments. • A collaborative approach at the point of service delivery is vital for the assessment, diagnosis and management of MNS conditions.
Empowerment of people with MNS conditions 	• The empowerment and inclusion of people with MNS conditions should be promoted at all times and should include equal decision-making about care and services, without discrimination. • People with MNS conditions should be placed at the centre of the care they receive; they should thus be involved in advocacy and in decisions on policy, planning, legislation, service provision, monitoring, research and evaluation.

It is important to keep in mind these cross-cutting principles at every stage of mhGAP implementation.

financial hardship *(13)*. Equitable access to good-quality care, fair financing and protection of human rights are important goals of a well-functioning health system that leaves no one behind, including people with MNS conditions *(2)*.

mhGAP is based on a people-centred approach. Many health systems comprise vertical programmes of targeted, often disease-specific care. This fragmented approach does not account for the fact that MNS conditions commonly occur with NCDs such as diabetes and cardiovascular disease and other chronic health conditions such as HIV/AIDS *(15)*. mhGAP calls for the integration of mental health into non-specialized health settings and provides the necessary tools and resources.

mhGAP promotes respect and dignity

In many countries, services remain concentrated in urban psychiatric hospitals and are frequently associated with human rights violations. People with MNS conditions should have access to timely, high-quality, evidence-based health and social care to promote recovery and attain the highest possible standard of health, full participation in society and at work, free from stigmatization and discrimination *(16)*.

Integration of mental health services into non-specialized health settings minimizes stigmatization and discrimination and removes the risk of human rights violations often found in psychiatric hospitals. mhGAP implementation promotes respect and dignity, in line with international human rights standards, including the United Nations Convention on the Rights of Persons with Disability *(11)*, to support equal dignity and equal rights of vulnerable populations. The Convention, in Article 25, states that people with disabilities (including MNS conditions) have the right to the enjoyment of the highest attainable standard of health without discrimination and that countries should provide these populations with the same range, quality and standards of free or affordable health care programmes as provided to other people. mhGAP can help Member States to adhere to this Article by scaling up evidence-based, human rights-oriented interventions in non-specialized health settings close to where people live.

The WHO QualityRights initiative is described in Box 1.

Box 1: WHO Quality Rights

WHO QualityRights is an initiative to support countries in assessing and improving the quality of care and human rights in mental health and social care facilities. The QualityRights Toolkit *(10)* can be used in mhGAP implementation at district level to improve the quality of mental health care provided at all levels (section 2.4) and promote human rights in communities, where people are born, grow, work, live and age.

WHO QualityRights provides support to countries to introduce policies, strategies, laws and services to:

- build capacity to understand and promote human rights and recovery;
- improve the quality of care and respect for human rights in mental health and related services;
- create community-based, recovery-oriented services with respect and promotion of human rights;
- generate a civil society movement to conduct advocacy and influence policy-making; and
- reform national policies and legislation in line with the United Nations Convention on the Rights of Persons with Disability and other international human rights standards.

The QualityRights assessment tool is based on the United Nations Convention on the Rights of Persons with Disability *(11)* and provides local and government agencies with information and guidance on promoting and protecting human rights. As part of the QualityRights initiative, WHO has prepared a comprehensive package of training and guidance modules for building capacity among mental health practitioners, people with psychosocial, intellectual and cognitive disabilities, people using mental health services, families, carers and other supporters, NGOs and others in ensuring a human rights and recovery approach in mental health.

Purpose of the manual

This mhGAP operations manual is designed to provide practical, step-by-step guidance to district health managers and others responsible for integrating mental and physical health services. It includes the tools necessary for preparing, implementing, monitoring and evaluating mhGAP. The aim of the manual is to assist district health managers to:

- undertake decentralized planning in accordance with national and regional programmes and policies;
- build skills in scaling up services to fill the unmet need of people with MNS conditions;
- strengthen existing resources and workforce capacity to achieve the greatest possible benefits of integrated MNS care;
- provide effective mental health services in non-specialized health settings; and
- engage in activities to enhance collaboration, evaluate outcomes and advocate for the inclusion of people with MNS conditions in all aspects of community life, and improving their overall quality of life.

The district is the operational level for integrating MNS care into non-specialized health settings. The concept of a district differs by country (e.g. province or county) and by level of resources (e.g. LMIC). We define a "district" as an administrative division below regional level.

The activities outlined in this manual require a broad range of skills that are best accessed by continuous stakeholder collaboration at national, regional and district levels and staff in development and technical agencies, universities, primary, secondary and tertiary care, civil society, national and international organizations that contribute to or are interested in mhGAP. These stakeholders may be part of the mhGAP operations team (section 1.1) and will also benefit from the information provided in this manual.

Structure of the manual

This mhGAP operations manual is an integral component of the mhGAP package. District health managers and other stakeholders implementing mhGAP are encouraged to use the manual for practical guidance. The contents are linked to the implementation module of mhGAP-IG version 2.0 *(8)* and comprise three phases for addressing the requirements and priorities of district health managers at various points of implementation (Fig. 1).

- **Plan** by assessing health systems and organizing mhGAP implementation at district level.
- **Prepare** for mhGAP implementation by building the capacity of the workforce and ensuring the readiness of the health system for integration of mental health in services.
- **Provide** services to integrate mhGAP into all levels of the health system, in facilities and communities.

Underpinning these phases is a monitoring and evaluation (M&E) framework for measuring progress, identifying challenges, improving the quality of mental health services provided in a district and improving reporting. Annex 1 proposes a list of indicators for the activities outlined in the mhGAP operations manual.

The manual also includes guidance for integrating mhGAP into specific programmes or settings. Practical information is provided for district health managers in the use of mhGAP in the response to humanitarian emergencies, integrating it into existing programmes for maternal and child health (MCH) and linking it with chronic disease care.

Each section contains:

- an overview, definitions and the rationale for the approach to implementation;
- steps for district health managers;
- practical tips;
- proposed indicators of mhGAP operations; and
- lessons learned from mhGAP implementation and experience in the field.

Fig. 1. mhGAP operations

PLAN

1. PLAN

Planning is the systematic identification and specification of desired goals, appropriate courses of action and the resources required to achieve the goals. Strengthening district mental health services is a continuing process, including planning for modification and refinement of the provision of mental health services.

The following are examples of opportunities or entry points for planning mhGAP operations at district level:

- contribution to achieving the SDGs *(12)*, the WHO 13th Programme of Work *(14)* and the WHO Comprehensive Mental Health Action Plan 2013–2020 *(6)*;
- implementation of a national mental health policy, legislation or plan at district level;
- integration of care for MNS conditions at district level into a national general health or NCD programme;
- reformulation of an existing district plan after reviewing the population's need for the care of MNS conditions and providing services that are more effective and efficient, e.g. introducing community and decentralized services to replace hospital treatment;
- maximizing available resources and reallocating funds for mental health in a revised district health budget;
- response to a new health problem with known mental health and psychosocial consequences (e.g. Zika and Ebola virus diseases) or re-emergence or resurgence of a known health problem (e.g. tuberculosis and HIV/AIDS), which might require reconfiguration of existing services or integration of MNS care into public health programmes; and
- response to the influx of large numbers of displaced people (e.g. refugees, asylum seekers and internally displaced people) with dedicated funding from aid agencies to improve mental health care delivery to the host and displaced populations (section 5.1).

Once the activities in this phase have been completed, the outputs for district health managers include a functioning mhGAP operations team, completed district and facility situation analyses, an operations plan and a budget for implementing mhGAP.

People implementing mhGAP may face barriers during the planning phase. Table 2 lists the main barriers to introducing mhGAP into non-specialized health care settings and potential solutions.

Keep in mind the cross-cutting principles when planning mhGAP implementation.

Table 2. Potential barriers and potential solutions in the Plan phase

Potential barriers	Potential solutions	Relevant sections
Mental health is not a public health priority at district level.	• Include stakeholders from health and other relevant sectors in the mhGAP operations team. • Advocate for mental health with policy-makers, and raise awareness in the community throughout mhGAP implementation. • Strengthen user, carer and advocacy groups to be leaders for mental health in the community. • Work with regional and national policy-makers in revising mental health plans and reallocating the budget for MNS care. • Collaborate with other sectors to strengthen the health system generally rather than promoting vertical approaches in which mental health services are provided in isolation. • Provide evidence of effective and cost-effective treatments for MNS conditions. • Support advocacy by user organizations for mental health care.	1.1, 1.3, 1.4 and 3.3
MNS services are centralized in large facilities and around larger cities.	• Include current service gaps in the district situation analysis. • Develop a plan to scale up mental health services in rural and underserved areas of the district. • 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. • 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.	1.2, 1.3 and 2.4
Only limited human resources are available.	• Highlight current gaps in human resources in the situation analysis. • Develop a plan and budget to build the capacity of non-specialist health care providers and community workers in underserved areas. • Make more efficient use of mental health specialists (e.g. build capacity and supervise non-specialist health care providers).	1.2, 1.3 and 2.2

Adapted from reference *(17)*.

1.1 Assemble an mhGAP operations team

mhGAP cannot be implemented by a single person. The first step is to establish an operations team that will take responsibility for overseeing implementation, comprising stakeholders in various sectors in the district, to facilitate collaboration and coordination of activities during the three phases.

The team may include a district health manager, a facility manager, a representative of medical records or health information system staff, community and traditional leaders, senior health leaders, other sectors (including relevant NGOs), representatives of various workforce cadres, skilled trainers and supervisors and people with MNS conditions and their families. The operations team may also include representatives of regional and national health authorities who oversee implementation in districts.

The activities of the mhGAP operations team require a variety of skills. The following may be used as selection criteria for identifying team members:

- knowledge of the local health system and public health principles;
- leaders who have been in their position for some time and are likely to remain in their posts;
- early career mental health professionals who may better understand current challenges within the system and propose innovative strategies to solve problems;
- ability to be organized, adhere to deadlines and hold others accountable; and
- ability to communicate with various stakeholders, from government officials to health care providers and administrators and people with MNS conditions and their families.

Systemic change is unlikely in the absence of leadership. The mhGAP operations team facilitates effective participation of all stakeholders, contributes to mhGAP planning and maintains oversight of all mhGAP activities. An official mandate from the national or regional government may be required to reinforce leadership of an mhGAP operations team.

The responsibilities of the operations team are to:

- Lead mhGAP implementation throughout all phases of operations.
- Advocate for mental health.
- Create a forum to bring together district health managers and others concerned with planning and implementingf mhGAP (Annex 2), and assign working groups or focal points to lead certain activities on the basis of their skills and networks.
- Oversee (and sometimes be directly involved in) M&E of activities.

Role of district health managers and other key stakeholders in assembling an operations team

Practical tips

- Team meetings are an opportunity for mutual learning by team members. Teleconferences help to reduce travel time and costs.
- The main roles of all members of the mhGAP operations team are raising awareness and promoting the rights of people with MNS conditions (sections 3.3 and 3.4).

Step 1. Clearly define the purpose, structure and terms of reference of the mhGAP operations team.

Step 2. Identify team members according to the selection criteria.

- Stakeholders in the following sectors may be represented: general and specialist health care services, community programmes, education and employment, NGOs, government services, associations of people with MNS conditions and their families (Annex 2).
- Identify the skills, expertise, capacity and resources of each team member, allocate responsibilities in coordinating operations, and assign focal points to lead specific activities, thus sharing the leadership.

Step 3: Prepare a work plan, including schedules of meetings, expected outputs, roles and responsibilities, timetables and reporting mechanisms. This can be used to inform the mhGAP operations plan and budget (section 1.3).

Step 4. Ensure that the mhGAP operations team is sufficiently resourced and supported to carry out its mandate. This may require:

- public support, especially from people with MNS conditions and family members;
- managerial support and commitment;
- financial resources and physical space;
- tools for mapping existing services and their use;
- support from the health information system workforce; and
- core technical expertise, which may be available regionally or nationally.

Step 5. Early activities of the mhGAP operations team might include:

- learning the views and expectations of people with MNS conditions and their families to guide the care provided;
- learning from local experts, including professional associations and organizations providing psychosocial support in the country or region; and
- participating in training in QualityRights *(10)* to ensure good-quality services that promote human rights.

mhGAP operations indicators

- Existence of an mhGAP operations team, sectors represented and functions of the team
- Total number of mhGAP operations team meetings per year

Means of verification: Terms of reference, meeting minutes, plan and budget for the team's activities.

Tool: Example of stakeholders engaged in mhGAP operations in one district (Annex 2).

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).

1.2 Conduct a situation analysis

A situation analysis defines the circumstances prevailing in a district that may affect people with MNS conditions and may facilitate or obstruct integration of mental health services into the general health system. It is an essential first step for informed decision-making and is used directly in preparing an operations plan and budget. It provides an opportunity to engage with many stakeholders, not only to obtain their practical input but also to make them aware of plans for mental health reform and engage them for the future. Depending on the context, a situation analysis should include assessment of health information systems that are relevant for M&E.

A situation analysis for mhGAP implementation may be based on both quantitative and qualitative data. Available epidemiological data should be used before new data are collected. A cost–effective alternative to collecting new data on the need for mental health care is to use data from neighbouring countries or those with similar contexts. These can be found in estimates of the global burden of disease *(1)*, the WHO Mental Health Atlas *(4)* and the WHO Assessment instrument for Mental Health Systems (WHO-AIMS) *(19)*. Qualitative research with focus groups and semi-structured interviews can be used to better understand the context in which services are being delivered, including the attitudes and beliefs of people with MNS conditions, their families, health workers and policy-makers.

Role of the mhGAP operations team in conducting a situation analysis

Step 1. Appoint a focal point from the operations team to be responsible for conducting the situation analysis and all related tasks, including modifying the tools (Annex 3) for district and facility levels, collecting and analysing data and writing report(s).

Step 2. Adapt the tools (Annex 4). Use the proposed templates for district and facility situation analyses to develop tools specific to a district. Some tools might have to be translated.

Step 3. Collect all possible sources of information for comprehensive use of the tools during field visits.

- published literature (e.g. international scientific journals and national journals);
- unpublished "grey" literature, e.g. local NGO or government publications and reports;
- WHO publications (e.g. the Mental health atlas *(4)*, the Assessment instrument for mental health systems *(19)*);

Practical tips

- Ensure that the tools are aligned with key M&E indicators (Annex 1), as information collected for the situation analysis will provide baseline data for evaluating the programme. Before collecting data, remember to determine whether they are essential and will be used.
- Always look for existing data sources or working groups before initiating new activities.
- When feasible, engage with researchers, epidemiologists or methodologists in the district (in the government or universities) to assist in tool adaptation, analysis and reporting.

- key informants or expert opinion (usually provide qualitative data) on sociocultural factors that might present barriers to mhGAP implementation; and
- routinely collected data (e.g. data collected by the national health information system or census): individual data collected in facilities and population data collected in household or community surveys.

Step 4. Analyse data to clarify the current resources of the district and facilities and barriers to equitable access. Use the results to identify barriers to mhGAP implementation.

Step 5. Preliminary results obtained in the situation analysis can be presented by the working group to the mhGAP operations team for feedback and discussion.

Step 6. If resources permit, a baseline report could be prepared (see checklist in Annex 3), which can then be used to inform planning, adapting and implementing mhGAP.

mhGAP operations indicators

Indicator: The completed situation analysis indicates needs and resources at district and facility levels.

Means of verification: Completed situation analysis

Tool: mhGAP tools for situation analyses in districts and facilities and mhGAP situation analysis report checklist (Annex 3).

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 operationalization of the steps for integrating mental health into primary health care in existing programming; (ii) perception of mental health as a low priority by key individuals in the implementation districts, reflected in limited action or inaction in scaling up access to MNS care; and (iii) provision of mental health care in relatively few health facilities by selected, already overburdened health care staff.

The findings of the situation analysis influenced the activities and revision of priority areas in the planned project for scaling up MNS care in vulnerable and under-resourced districts in Uganda, including increasing training general health care staff in identifying managing and referring regional priority MNS conditions, using mhGAP.

Source:

- PRIME situation analysis tool for planning district mental health care *(18)*.

1.3 Develop an mhGAP operations plan and budget

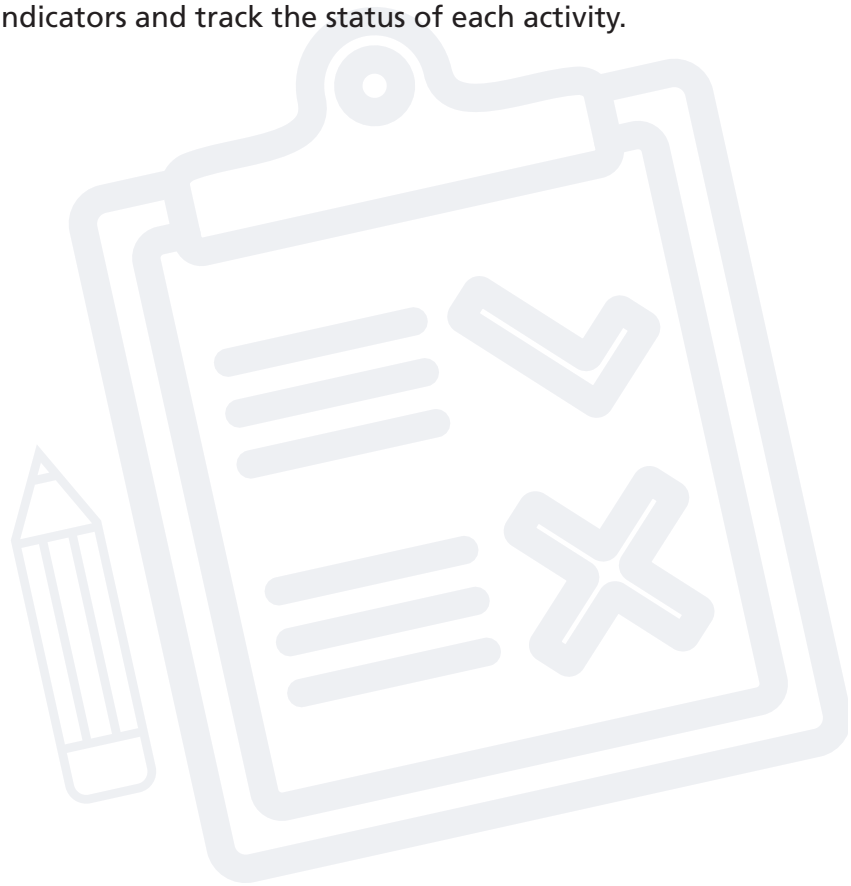
A plan for mhGAP implementation at district level includes specific, sequential activities, a budget for human and financial resources, the responsible agencies or people, the time frame and monitoring indicators. The district budget also includes the estimated costs of the activities for implementing the plan.

Many LMIC currently allocate less than 2% or even 1% of their health budget to the treatment and prevention of MNS conditions, whereas high-income countries typically spend 5–10% *(4)*. This usually results in a lower budget for mental health at district level.

mhGAP cannot be implemented in a haphazard manner, and the steps outlined in the district mhGAP operations plan should be followed. With a structured plan and budget allocated for activities, the mhGAP operations team can track the progress of identified deliverables. The plan should ideally be made after the situation analysis (when feasible) and be reviewed regularly.

A checklist for an mhGAP operations plan (Annex 4) can serve as a template for a minimum set of activities:

- list all activities in all phases of operations,
- decide timelines and deadlines,
- identify reliable funding,
- reallocate funding for MNS care to existing services,
- determine who is responsible for each task,
- list mhGAP operations indicators and track the status of each activity.



Role of the mhGAP operations team in developing an operations plan

Step 1. Review the situation analysis before preparing the mhGAP operations plan to understand the organization of the health system, possible barriers and available resources in the district.

Step 2. Engage stakeholders during regular meetings, or, if feasible, conduct a stakeholder engagement workshop to encourage broad involvement and support.

- Assign a focal point from the mhGAP operations team to lead development, monitoring and revision of the plan and budget during implementation.
- Identify a person to be chiefly responsible for authorizing the overall budget for MNS care, to whom the operations team is accountable for budget approval.

Step 3. Prepare the mhGAP operations plan and draft budget, and ensure that all items on the checklist of minimum activities are included (Annex 4).

- List all the activities and inputs required for mhGAP operations in the district, including support services such as transport, types of personnel, time to be spent on MNS care, psychotropic medicines, communications, M&E, training and supervision.
- Cost the activities, inputs and support services at the government rate.
- See PRIME publications on developing a district mental health plan in Ethiopia *(21)*, Nepal *(22)*, India *(23)*, South Africa *(24)* and Uganda *(25)* and mapping components across countries *(26)*.

Step 4. Determine whether funds are available for mhGAP activities. If the budget is available, initiate implementation; if it is not:

- Advocate for allocation of more funds from the regional or national government (section 1.4).
- Raise funds by liaising with funding agencies or collaborating with new stakeholders.
- Consider more effective use of existing resources to free budget for mhGAP operations.
- As MNS care is important for meeting the targets of other priorities in the district and nationally (e.g. HIV/AIDS, MCH), consider reallocating budget to mhGAP operations *(27)*.

Step 5. Gradually extend activities over larger geographical areas, according to capacity and resources. Adjust the plan and budget accordingly. Ensure that long-term sustainability is also accounted for in the operations plan and budget *(28)*.

Practical tips

- Effective planning requires changes and flexibility. The mhGAP operations plan reflects the resources identified by a situation analysis (section 1.2). The plan and budget may have to be revised and adapted continually or incrementally.
- There should be a distinct, identifiable budget for mhGAP operations, either under the control of district health managers or as a component of the general health budget.
- Setting a timetable for preparing an mhGAP operations plan can avoid extensive planning.
- People with MNS conditions and their carers should be involved in planning, either on the operations team or by regular consultation during drafting or revision of the plan and budget.

mhGAP operations indicators

- MNS care is integrated into the district health plan and approved by the government.
- A budget is available, which specifies the financial, human and physical resources required to implement mhGAP in the district.

Means of verification: Review of meeting agendas and minutes and continual adjustment of the plan and budget.

Tools: mhGAP operations plan checklist and sample operations plan (Annex 4).

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 implementation of mental health programmes was found to result in underuse of allocated funds.

To address this challenge, the PRIME team recommended and advocated that the State budget include dedicated funds for mental health programmes, and they found innovative solutions to leverage funds from the National Rural Health Mission (now the National Health Mission) to procure psychotropic medicines and for other programme activities. Government officials included mental health activities in the annual implementation plan of the National Health Mission. The Government was able to allocate funds for mental health in the financial year 2015–2016, which were increased by 35% for 2016–2017. In addition, a full-time post of Deputy Director for Mental Health was created, which ensured dedicated allocation of funds for scaling up mental health programmes and the appointment of a senior official to oversee project implementation, as part of the mission's efforts to sustain mental health services.

Dedicated Government funding for scaling up MNS care and a designated person in the Government to coordinate mental health activities were instrumental in advocating for sustainable scaling up of mhGAP *(29,30)*.

1.4 Advocate for mental health

Advocacy is widely recognized as an effective method for generating support for health issues. It involves raising the awareness of district stakeholders, particularly policy-makers and public health leaders, about the burden of MNS conditions, self-harm and suicide. According to the WHO Mental health policy and service guidance package (28), mental health advocacy consists of actions to change the major structural and attitudinal barriers to achieving positive MNS outcomes.

The aim of mental health advocacy is to promote the human rights of people with MNS conditions, to reduce stigmatization and discrimination and to respect people's autonomy to be advocates for themselves and each other. Through advocacy for mental health, stakeholders better understand the availability of effective interventions for good mental health, the prevention of MNS conditions, self-harm and suicide and effective treatment and care. Advocacy is also important for raising funds and budget allocations for improving mental health services. Its objective is the provision of accessible, affordable, acceptable, good-quality MNS care.

Role of the mhGAP operations team in advocating for mental health

Step 1. Include advocacy as a standing item on the meeting agenda of the mhGAP operations team:

- Answer the questions: Why should we advocate for scaling up services and ensuring the inclusion of people with MNS conditions? Who is the target of advocacy? What key messages should be conveyed? How can people with MNS conditions and their carers become involved?
- Integrate the answers to these questions throughout the planning phase. For example, build advocacy into the operations plan and budget (section 1.3).

Step 2. Advocate with policy-makers and other stakeholders to obtain an official mandate for mhGAP operations and budgeting.

- Present technical evidence from the situation analysis (section 1.2) and effective intervention strategies from mhGAP, and align the operations plan and budget with political priorities (section 1.3).
- Advocate to high-level policy-makers for increased access to treatment of people with MNS conditions, including making essential psychotropic medicines available through the national health insurance system (section 2.5) and training non-specialist health care providers in mhGAP-IG version 2.0 (section 2.2).

Step 3. Engage in advocacy indirectly by supporting existing community groups. Mental health advocacy should always apply to the available mental health services, promoting access and uptake of integrated mental and physical health services.

Practical tips

- Consider the roles of people with MNS conditions and their families, NGOs, general and mental health workers and policy-makers and planners in planning and conducting advocacy. People with MNS conditions and their families have played various roles in advocacy, ranging from influencing policies and legislation to providing peer support; they may also be part of the operations team, with leadership roles in implementation of mhGAP.
- Establish partnerships with other relevant advocacy movements, including those for human rights and the rights of people with disabilities. NGOs may support and empower people with MNS conditions and their families.

mhGAP operations indicators

Indicator: Number of advocacy activities completed

Means of verification: Feedback from mental and public health leaders; pre–post surveys of knowledge, attitudes and perceptions of key stakeholders; changes in mental health policies or plans.

Tool: Template for adapting the mhGAP-IG version 2.0.

Advocating for mental health budget allocation in Kenya

In Kenya, psychiatrists are concentrated in urban areas, and clinics in the counties do not have the material or human resources to support mental health care, such as mental health specialists, medical supplies or physical infrastructure.

The Africa Mental Health Foundation (AMHF) is a not-for-profit research organization based in Nairobi, Kenya, which conducts and shares mental health research for the improvement of mental health services nationally and across Africa. In view of the scarcity of resources available for mental health, particularly outside the capital, AMHF lobbied for several years for a budget to be allocated to mental health at national and county levels.

The long-standing presence of AMHF in Makueni County, one of the 47 counties of Kenya, provided credibility and trust with the Ministry. The organization had been collecting data on patient access to mental health services and were able to demonstrate the treatment gap to decision-makers when Kenyan Government services were transferred to the local level.

Using stakeholder analyses, AMHF engaged strategically, targeting the information to the right county health officials. Their policy message was based on two types of information of interest to the Ministry and the Governor: need and return on investment. By lobbying numerous health directors, AMHF found that highlighting the economic rationale of returning citizens to work was key to persuading decision-makers to consider committing funds to improve mental health services.

AMHF achieved policy change by providing clear, reputable data, building trust in the community and capitalizing on a policy window.

PREPARE

2. PREPARE

In low-resource settings in which the number of mental health providers is limited, the best strategy for increasing access to care is to strengthen health systems to deliver mental health services as part of general health care. This is possible only by building the capacity of policy-makers, planners and service providers.

In many mental health services, the largest portion of the recurrent annual budget is spent on personnel, yet major difficulties are frequently encountered in preparing, training and supporting the workforce. Many countries have few trained available personnel, or staff are concentrated in urban hospitals; staff competencies may be outdated or may not meet the population's needs; and the available personnel may not be used appropriately *(28)*.

In addition to training and supervising the workforce, mhGAP implementation also requires that the health system be ready to integrate treatment and care for MNS conditions. It also includes improving access to the psychotropic medicines and psychological interventions recommended in mhGAP-IG version 2.0 for the treatment and care of people with MNS conditions. The system's capacity to support these activities requires use of national and international guidelines at district level (e.g. essential psychotropic medicines lists), better coordination, strengthened referral systems, allocation of resources, reporting and information systems to monitor the availability and use of interventions.

The aim of this section is to provide practical guidance to the mhGAP operations team in developing their human resources and health systems for mental health, including:

- appropriate pre-service and in-service training of various cadres of health care provider according to the adapted mhGAP-IG version 2.0;
- training in use of information systems and reporting in order to monitor and evaluate mhGAP with nationally endorsed indicators;
- continuous supportive supervision and peer support for providers;
- preparation of the health system to enhance coordination at all levels of care and sectors; and
- improve access to psychotropic medicines and psychological interventions.

Table 3 lists potential barriers and solutions in the Prepare phase.

Be mindful of the cross-cutting principles when preparing the health system for rolling out mhGAP.

Table 3. Potential barriers and solutions in the Prepare phase

Potential barriers	Potential solutions	Relevant sections
Training materials not relevant to local context and culture	• Adapt mhGAP-IG version 2.0 *(8)* and training manuals *(31)* to local context. • Engage relevant academics in conducting research on implementation in the local context.	2.1
Workforce limitations in the district: limited knowledge and skills of non-specialists; staff attrition	• Build capacity of non-specialists to perform some tasks with specialists and enhance peer support. Provide assurance about setting practice boundaries for non-specialists. • Schedule refresher training, and adapt materials to changing contexts. • Innovative incentive strategies: institutional capacity- building such as university qualifications, promotion of career development trajectories in government health services, opportunities to receive and provide mentorship and favourable workplace conditions. • Establish a selection process to identify staff motivated to be trained in mental health.	2.1, 2.2 and 2.3
Too few specialists including trainers and supervisors available at district level to support the scale up	• Use the WHO mhGAP training manuals *(31)* to build a national team of master trainers who can then give local training. If in-country capacity is limited, use outside trainers as feasible. • Consider distance supervision by telecommunication, including telephone, Internet and social media. • Enhance supervision structures in facilities or community services and coordinated, multidisciplinary care with clearly defined roles to help initiate services after training. • Advocate for employment incentives to decentralize specialists and MNS supervisors.	1.4, 2.3 and 2.4
Fragmented services and resources	• Prepare the health system by coordinating intersectoral care for people with MNS conditions. • Work in multidisciplinary care pathways, and establish good referral systems, including referral to specialists and back referral to community workers.	2.4
Limited supply of psychotropic medicines	• Local adaptation and use of national and international essential psychotropic medicines lists and education of health care providers • Make realistic predictions of demand, assess existing supply chains for other medicines, and secure funds. • In coordination with the Ministry of Health, advocate with suppliers for affordable access to psychotropic medicines.	1.4, 2.1 and 2.5
Few providers trained in delivering psychological interventions	• Adapt psychological interventions to the local context, train non-specialist health care providers in delivering them, and train supervisors. • Clearly define roles and coordinate care across the levels of trained providers. • Engage with NGOs that provide psychosocial support for other health conditions, e.g. people living with HIV/AIDS.	2.1, 2.2 and 2.6

2.1 Adapt components of the mhGAP package

The countries in which mhGAP may be used vary widely with regard to policies and legislation, mental health and the general health system, public health infrastructure, culture and resources. Thus, some of the components of the mhGAP package might have to be adapted.

Adaptation involves deciding on and making necessary changes to components of the mhGAP package for a particular context. At a minimum, mhGAP materials can be translated into the first language of the facilitators and users. Adaptation could be as simple as changing the names of people in case studies used during training to names that are more common in the district where mhGAP will be implemented. Or the changes might be complex, such as acknowledging spiritual beliefs or local concepts of healing in the management of MNS conditions.

Components of the mhGAP package that may be adapted:

- mhGAP-IG version 2.0 *(8)*: This is the basis for trainers and for clinical decision-making. Use the adaptation template in Annex 5.
- mhGAP training manuals *(31)*: These can be adapted for training trainers, supervisors and health care providers according to the available human resources (sections 2.2 and 2.3).
- e-mhGAP: Use of the electronic form is highly recommended in settings where providers have access to smartphones and tablets or areas and it is difficult to distribute hard copies of mhGAP-IG version 2.0 (section 3.1, Box 2).
- M&E: Select indicators, and work with existing health information systems to adapt the M&E system to the local context (section 4.0), and adapt tools to assist the mhGAP operations team and providers in recording data (Annex 1).
- Community services by community workers, lay workers or equivalent: Adapt roles and training to the local context (section 3.2).
- Psychotropic medicines: Adapt essential medicines list according to the national drug formulary and recommendations from the mhGAP evidence resource centre *(5)* (section 2.5).
- Psychological interventions: Adapt training manuals, and define referral criteria (section 2.6).

Role of the operations team in adapting the mhGAP package

Step 1. Communicate with the national mental health authority to check whether an adapted version of mhGAP-IG is available and discuss with mhGAP operations team whether adaptation for the district level is required.

Step 2. Select a working group to conduct the adaptation, comprising 10–15 experts in relevant disciplines (e.g. addiction, neurology, paediatrics, social work, psychology) as well as people representing various cadres in the health workforce (e.g. family medicine, nursing).

- Familiarize the group with mhGAP materials: mhGAP-IG version 2.0, the mhGAP training manuals *(30)*, e-mhGAP, examples of mhGAP adaptations and the mhGAP-IG adaptation template (Annex 5), if necessary.

Practical tips

- A workshop is an effective setting for adaptation. If a face-to-face workshop is not possible, feedback and translation may be requested by e-mail or videoconferencing, which may be more cost–effective.
- Adaptation is continuous, and some may also be done during training and supervision. Detailed notes on adaptations and translations of mhGAP materials should be recorded.
- It is sometimes better to test interventions or modes of delivery. If necessary, changes can be made in a subsequent revision.

Step 3. Consider an mhGAP adaptation workshop with a facilitator who clearly understands the mhGAP materials.

- Review any local literature and clinical practice guidelines about MNS conditions and the services available in the country or district, as well as results from the situation analysis (Annex 3). Discuss priority MNS conditions in the district on the basis of this review, and contextualize mhGAP accordingly.
- The preferred local language should be agreed upon and cultural concepts of MNS conditions and help-seeking behaviour discussed.

Step 4. Finalize adaptations with the working group after the outcomes of any workshops or feedback have been received.

- The completed mhGAP-IG adaptation template (Annex 5) should be sent to the WHO Department of Mental Health and Substance Abuse for information and any feedback.

mhGAP operations indicators

Indicator: mhGAP-IG version 2.0 training and supervision materials and e-mhGAP have been adapted and are available for implementation in the district.

Means of verification: Adaptation workshop minutes, adapted mhGAP-IG 2.0 training and supervision materials and e-mhGAP

Tool: mhGAP-IG adaptation template (Annex 5)

Adapting mhGAP in Uganda for nurses and other non-prescribers

In Uganda, there is a growing demand for mental health services as a result of population growth, an increasing prevalence of mental health problems and greater community awareness and willingness to seek treatment. mhGAP has been introduced with the support of WHO, the Programme for Improving Mental Health Care (PRIME) team in Uganda and other partners.

Before introduction of the programme, two national consultative workshops (with participants from a wide spectrum of mental health service providers) were conducted to contextualize and adapt the mhGAP-IG manual to the country's mental health system. These workshops were preceded by a situation analysis of selected districts, which provided the team with relevant background information on needs, resources, capacity and priority MNS conditions.

One of the challenges faced during adaptation was that the mhGAP-IG was designed for non-specialist health care providers trained in prescribing medicines. The Ugandan primary health care system is dominated by nurses and nursing aides, who are legally allowed to manage medicines only after an initial prescription has been provided by a medical doctor. Nurses seldom manage medication because of staff shortages and other institutional factors. Comprehensive adaptation of mhGAP training manuals and the implementation plan were required to meet the specific training needs and roles of different cadres in health facilities who collectively provide MNS care. Adaptation of the training materials for non-specialist health care providers included simplifying technical language and focusing on non-pharmacological interventions for non-prescribers.

2.2 Train the workforce in mhGAP

Training builds the competencies of non-specialist health care providers (family doctors, clinical officers, nurses, midwives and other general para-professionals) in mental health care; it requires coordination with mental health specialists to ensure optimum delivery and continued support and supervision. These principles also apply to training programmes for other material, such as the mhGAP Humanitarian Intervention Guide (section 5.1), e-mhGAP (section 3.1, Box 2) and psychological interventions (section 2.6).

The mhGAP training manuals *(31)* are designed to be used in service (i.e. continuing education). This broadens the attitudes, knowledge and skills of health care providers, primarily through a clinical training block, with lectures, active teaching and accompanying practical aids catered to the specific type of health care provider and the extent of their previous training.

The mhGAP operations team may also be in a position to strengthen the basic curriculum of the district's health workforce. The aim of pre-service training is to introduce core skills much earlier, as a training module within health education. While the mhGAP training manuals are designed for in-service training, pre-service training could be based on adapted mhGAP materials, with a number of benefits.

- Pre-service training can lower costs and increase returns on investment by leveraging both limited training resources and captive student audiences.
- Pre-service training involves examinations that students must pass, ensuring strong motivation to learn the materials.
- Pre-service training tends to have its own sustained funding model that often does not require ministry of health or project funds.
- Mainstreaming of mental health care and its acceptance as a core skill will reduce stigmatization of the subject and its practitioners.

Importance of building capacity through training

Non-specialist health care providers in many low-resource settings are trained to identify and treat physical health problems but not MNS conditions. If they do receive training in mental health, it is often brief in-service training with little practical focus, which in turn limits their competency and confidence to treat and care for people with these conditions. Training should be relevant to the mental health needs of the district population and take account of the knowledge and skills that non-specialist health care providers have already by adapting mhGAP to the local context.

The mhGAP training manuals *(31)* follow the "cascade" model, with two levels: master trainers who train trainers or facilitators, who then train non-specialist health care providers. The cascade model is ideal in settings in which there are some mental health services and specialists who can act as master facilitators, thus enhancing referral routes after training and supervision.

Training of trainers and supervisors: The objective is to ensure that these groups are skilled and confident in their ability to train non-specialists and/or provide supervision. See Annex 7 for a suggested schedule for training trainers and supervisors over 5 days.

Training of health care providers: The objective is to familiarize providers with clinical concepts in MNS care, such as clinical assessment and management, using the mhGAP-IG version 2.0. Others in the health system may also be trained.

Training of policy-makers and planners: Few models of capacity-building for policy-makers and planners have been evaluated in low-resource settings. Most models combine brief training with long-term mentorship, dialogue and/or the establishment of support networks *(8)*. District health managers and members of mhGAP operations teams might also benefit from knowledge-exchange workshops and mhGAP training and supervision resources.

Training of community and care workers: Community workers (e.g. lay providers or community health workers) and care workers (e.g. social workers, case managers) are uniquely placed and skilled to identify people with MNS conditions, reduce stigmatization, provide psychoeducation and other low-intensity psychosocial interventions, monitor adherence to medication and provide links to resources and rehabilitation services in the community. A community version of mhGAP is being prepared.

Capacity-building of service users and carers: People with MNS conditions and their carers have valuable knowledge, expertise and information on MNS care that no one else can provide, including the impact of these conditions on their lives. They should be equipped to participate in planning or implementing mhGAP to ensure better understanding of and respect for their perspectives.

Preparation of mhGAP training at district level

Step 1. Focal points on the mhGAP operations team might refer to the situation analysis (Annex 3) and also assess training needs *(31)* when planning the training programme.

- Assess the current numbers of staff at each service level, e.g. numbers of specialists in the district, their current functions and their competencies, to determine the resources required to conduct training and continuous supervision.
- Determine how many people should be trained, where and when they might be trained, and the gaps in training for non-specialist health care providers in relation to the prevalence of MNS conditions and service utilization; and map the services required.
- Select trainees by considering: probable retention in a relevant post, support from senior management for allocation of MNS-related tasks upon completion of training, readiness of the facility or community to support their work, interest in mental health, likelihood of their using new skills and their basic training to date (i.e. qualifications).

Practical tips

- Training can be provided in various ways. While the mhGAP training manuals suggest timetables, they might have to be modified for the setting. Training may be face to face or online with e-learning methods *(32)*.
- Any training of a health care provider in mhGAP-IG version 2.0 should immediately be integrated into a service to ensure optimal transfer of knowledge into practice *(28, 33)*.
- Training alone is insufficient, and it is becoming increasingly clear that continuous supervision is necessary.
- Evaluation of training and feedback from supervision help to shape future training.

Step 2. Prepare a training model suitable for the setting and a process for evaluating all training activities. Adapt the mhGAP training manual to the local context.

Step 3. Prepare and train health care providers to build core competencies (see mhGAP training manuals).

- Evaluate the course, for example with pre and post tests.
- Train specialists as trainers and supervisors (section 2.3). Prepare refresher courses and ongoing support from master trainers.
- Train health care providers in routine data collection and in using information systems (section 4.0).
- When resources are available, also provide training in brief psychological interventions (section 2.6).
- Train community workers in providing interventions in the community (section 3.2).

Step 4. Arrange for non-specialist health care providers to begin seeing people with priority MNS conditions during supervision (section 2.3).

Step 5. Provide refresher training, and observe skills using case studies.

mhGAP operations indicators

- Number of trainers and supervisors who participated in mhGAP training of trainers and supervisors
- Proportion of non-specialist health care providers who were trained in mhGAP [number trained / number of non-specialists in the district]
- Number of community workers trained and who meet competency standards in mhGAP.

Means of verification: Training evaluation forms (mhGAP training manuals), competency assessments.

Tools: Situation analysis (Annex 3), assessment of training needs and pre–post training evaluation forms (mhGAP training manuals).

From virtual to practical: mhGAP in the Caribbean

In the Caribbean region, mental health services are often inaccessible to vulnerable populations and are often segregated from the primary health care system. Geographical challenges such as services spread across islands and limited resources require innovative training approaches to scale up MNS services.

A programme was led by the WHO Regional Office for the Americas to build the capacity of non-specialist health care providers through a "virtual campus for public health" *(32)*. The programme provided 65 h of e-training over 20 weeks, with self-directed exercises, evaluations and constant interaction with tutors. The training taught the skills and knowledge required to assess and manage people with priority MNS conditions using mhGAP-IG version 2.0, as part of a longer-term goal of devolving mental health services from expensive, centralized, specialized services.

Use of the virtual platform in the Caribbean region offered adaptability, flexibility and accessibility of mhGAP training. The length of the programme enabled participants in countries across the region to make changes to their practice, thus improving their communities' access to mental health care. Participants became advocates for mental health and motivated other non-specialized health care providers to enrol in virtual mhGAP training. The benefits were not having to travel, no interruption of daily work and the opportunity to be trained at their own pace and preferred time of the day or week.

The virtual platform offers both face-to-face and virtual online training. This makes it potentially cost-effective for scaling up treatment of MNS conditions and overcoming the geographical challenges, limited training capacity and resources in regions such as the Caribbean.

Sources:

- From virtual to practical: mhGAP in the Caribbean. mhGAP Newsletter. June 2014:2 (http://www.who.int/mental_health/mhgap/Newsletter_June_2014.pdf?ua=1).

2.3 Prepare for clinical and administrative supervision

Two types of supervision are required in mhGAP: administrative and clinical. Administrative supervision ensures adequate documentation and record-keeping and addresses administrative problems in monitoring overall implementation of mhGAP in a service. Clinical supervision ensures fidelity to mhGAP guidelines, reinforces the initial training of health care providers, strengthens clinical skills in providing MNS care and promotes the use of mhGAP-IG version 2.0 in an integrated model of service delivery. Deviations from practice can be detected, and clinical challenges can be addressed, while continuously improving the quality of the clinical care provided. Both types of supervision are essential in any mhGAP training programme.

The specific goals of supervision are to:

- ensure the transfer of skills and knowledge from training to clinical practice;
- ensure adequate delivery of mental health interventions in accordance with mhGAP-IG version 2.0, and identify areas for further skill development;
- identify and assist in resolving problems faced by mhGAP trainees in managing complicated cases;
- help to motivate non-specialist health care providers to provide a high standard of care for individuals with MNS conditions;
- ensure that the necessary records and administrative procedures for MNS conditions (such as referrals and follow-ups) are established and/or integrated into existing systems at local health care facilities;
- ensure that medicines, medical equipment and other systems for mhGAP
- implementation are operational; and
- encourage a respectful, nonjudgemental attitude and ethical treatment, promoting and protecting the rights of individuals with MNS conditions.

mhGAP implementation requires supervision of non-specialist trainees by mental health specialists in a collaborative, stepped approach to care. The importance of consistent, supportive supervision has been confirmed in studies of mhGAP implementation *(34)* and in a systematic review of studies of fundamental barriers to task-sharing *(35)*.

A single training course is unlikely to bring about long-term change in providing care for MNS conditions. Supervision must be seen as an essential component of training in any capacity-building programme to ensure a sustained change in behaviour at clinical level, which will ultimately improve the quality of care for people with MNS conditions.

Introduction of mhGAP supervision in districts

Step 1. Base the supervision structure on the situation analysis (Annex 3) and the available human resources. See the WHO mhGAP training manuals that include supervision forms *(31)*, the apprenticeship model *(36)*, and dyadic, triadic and group models *(37)*.

Consider:

- the number of facilities that integrate MNS care,
- the number of supervisors who know about MNS care and mhGAP,
- the geographical distribution of facilities,
- travel time among facilities,
- reporting structure and
- feasibility of supervision.

Step 2. Train supervisors in relevant mhGAP materials, either during training of trainers and supervisors or separately (section 2.2). Train supervisors in tracking, monitoring and evaluation. Assess supervisors' feedback regularly and its effect on MNS care. Refer to the mhGAP training manuals for supervision reporting forms.

Practical tips

- During the first 6 months, clinical supervision could focus on acquisition of core mhGAP knowledge and skills, in which the supervisor observes the provider, and skills transfer and learning. Ideally, supervisors visit facilities at least once a month during this time.
- The schedule of supervision may be adapted as necessary (e.g. consultations on complicated MNS conditions), integrated into an existing supervisory system in the area and/or constitute long-term consultation with specialized facilities.
- Supervision may allow identification of people who could become future trainers.

Step 3. The supervision programme should ideally begin during or immediately after mhGAP training for non-specialist health care providers but no later than 4–6 weeks after.

Step 4. Conduct regular supervision and periodic evaluation (see mhGAP training manuals for supervision and reporting forms).

Step 5a. Consider asking supervisors to complete the following forms during and after each visit:

- record of supervision of trained health care providers,
- clinical support and supervision form,
- difficult case report form and
- supervisory report and feedback form.

Step 5b. Consider asking supervisors to collect the following forms during each visit as part of M&E:

- monthly report forms and
- facility mhGAP report form.

Further recommendations with regard to supervision are listed in Table 4.

Table 4. Further recommendations with regard to supervision

Supervision	Recommendations
Choosing supervisors*	• Choose supervisors on the basis of the following criteria (when possible): – formal qualifications, clinical skills and experience in mental health and/or management of MNS conditions; – skills and experience in administrative aspects of managing MNS conditions, including record-keeping, follow-up and referral; – good facilitation and problem-solving skills; – enthusiasm for, interest in and commitment to training and supervision; and – availability to provide support and supervision (including regular visits).
Provision of supervision in the programme	• Ideally, a mental health specialist or trainer. • Could also be peers or non-specialist health care providers with experience in using mhGAP. • The best supervisors are enthusiastic, empathic, interested, accessible and competent clinicians.
Timing of supervision	• Consider frequency and duration. • Supervision should be at least monthly to begin with. Ensure as much supervision as resources allow, and build supervision costs into financial planning.
Place of supervision	• Consider whether the location will remain constant or be rotated, whether space is available for direct observation or whether it should be done remotely. If supervision is provided to a group, the location that is convenient for most people should be selected. • Use telephone, videoconferencing or social media when feasible and available, especially when travel times are long. Keep in mind confidentiality when using social media (i.e. not to use them to discuss specific cases).
Mode of supervision	• The structure and agenda of supervision sessions are predetermined and adhered to. • Multiple methods are used, including direct observation, instruction, demonstration, role-play, discussion and reflection. If direct observation cannot be done, consider bringing taped sessions to a supervisory visit. • Reach an agreement on how each supervisory visit will run, including criteria for membership in group supervision, how feedback will be given and the session structure.

* Note: mhGAP supervisors may be specialists in MNS health care (e.g. psychiatrist, psychiatric nurse, neurologist), physicians or nurses trained and experienced in managing MNS conditions with mhGAP-IG version 2.0 and/or supervisors in the general health system.

mhGAP operations indicators

- Proportion of supervisors who received training in administrative and clinical mhGAP supervision [number trained / number of supervisors (or specialists) in the district]
- Frequency and adequacy of supervision as defined in the situation analysis
- Proportion of facilities in the district that provide mhGAP supervision [number of facilities that provided at least one supervision per month / number of facilities with trained supervisors].

Means of verification: Supervision notes, group supervision attendance forms, case summaries and assessment sheets from direct supervision.

Tools: Situation analysis (Annex 3) and supervision reporting forms (mhGAP training manuals).

Clinical mentoring and supervision: PRIME in Nepal

In Nepal's district mental health care plan, developed as part of the Programme for Improving Mental Health Care (PRIME), mhGAP-trained non-specialist health care providers are mentored and supervised by three methods.

Case conferences: Trained non-specialists are invited from health facilities to a venue such as a district public health office to discuss any difficulties in service delivery. The meetings are facilitated by a professional psychiatrist. The case conferences stimulate continuous learning and improve clinical practice. They were initially held monthly but are now held quarterly to reduce the cost.

Tele-supervision: Trained providers can telephone specialists whenever they have a problem in the diagnosis or management of cases. They have found this method important and supportive, although it was sometimes difficult because of technical problems or lack of availability of the specialist.

On-the-job supervision: A specialist visits a health facility, observes non-specialist health care providers' 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 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 non-specialist health care providers trained in mhGAP receive the necessary support. The system includes various methods of supervision, such as in-person, with alternative methods as necessary, depending on the funds available, logistics, the number of trained specialists and supervisors and their availability.

2.4 Coordinate care pathways

The wide range of needs of people with MNS conditions and their carers cannot be addressed by one discipline or one sector alone. Therefore, preparing for mhGAP implementation requires coordination of providers and services within and outside the health system. "Care pathways" are the routes by which people with MNS conditions access treatment and care. They influence the organization of services and comprise a collaborative system of care, with various public and private service providers at multiple levels. As MNS conditions are inextricably linked to the wider social environment, addressing individual needs goes beyond the provision of mental health services and requires a multidisciplinary approach. For example, a person may require medicines to manage the symptoms of both an MNS condition and a physical health condition, such as diabetes or cardiovascular disease. They may need support in accessing educational or employment opportunities or in finding affordable housing. These multiple and often complex needs require broad knowledge and skills that cannot be provided by one person (Table 5).

The mhGAP operations team can create or support an existing referral system for addressing the complex care needs of people with MNS conditions. An effective referral system ensures close relations at all levels of the health system and mechanisms for referral to and from service points outside the health sector. A good referral system helps to ensure that people with MNS conditions receive the best possible care closest to their homes. It also contributes to cost–effective use of bidirectional care pathways, in which referrals are made between hospitals, non-specialized health settings and the community.

A strategic approach to coordination for the mhGAP operations team may include:

- **Coordinating care for individuals:** Coordination can help to achieve better continuity of care and enhance the experience of people with MNS conditions in services, particularly during transitions or referrals. The focus of improvement is delivery of care to individuals, with services coordinated to meet their needs and those of their families.
- **Coordinating mhGAP implementation and provision of services:** Coordination bridges administrative, informational and funding gaps among levels of care and providers. In the health sector, this includes linking departments and levels of care such as non-specialized health services, medicines and medical supplies, treatment of NCDs, nutrition and food security, health promotion, maternal and child health care, ageing and long-term care, information systems and mental health.
- **Coordinating across sectors:** Successful coordination of health involves many actors both within and beyond the health sector. It encompasses social affairs, social welfare, education, justice, housing and employment (government or nongovernmental agencies), media, academia and institutions, local and international NGOs that deliver or advocate for mental health services, private sector organizations, professional associations, faith organizations and institutions, traditional and indigenous healers, service users and family or caregiver advocacy groups. It requires strong leadership to ensure intersectoral action, including for early detection and rapid response to crises.

Table 5. Examples of roles in the care pathways of individual cases

Care provider*	Role
Community and lay workers	• Facilitate or provide basic social support and raise awareness. • Provide basic psychological interventions and/or psychoeducation in the community. • Refer cases from the community to non-specialists or specialists, as appropriate. • Follow up cases in the community.
Social workers, case managers, counsellors	• Conduct a comprehensive assessment. • Prepare a treatment plan with the individual, in consultation with various care providers. • Monitor and support adherence to the treatment plan. • Provide basic counselling, psychological interventions and psychoeducation in facilities and communities. • Follow up cases. • Discharge cases.
Non-specialist health care providers	• Follow standard guidelines for assessing and managing priority conditions in non-specialized health settings (e.g. mhGAP-IG version 2.0). • Consult specialists, and refer complex cases. • Supervise community health workers (CHWs), and accept referrals.
Mental health specialists	• Coordinate services, advocate and advise the government on service development. • Diagnose and treat patients after specialized training in pharmacological and psychological interventions. • Accept referral of the most complex cases. • Supervise non-specialist health care providers and CHWs.

* The roles of mental health service providers may differ in low-, medium- and high-resource settings *(38)*.

Coordination of care pathways within district services

Map existing referral resources and relevant stakeholders, and identify strategies to engage them in scaling up services for MNS conditions. Include departments in the health sector (intrasectoral) and with other sectors (intersectoral).

Clarify the role of each care provider in the workforce and in district facilities that provide care for individual cases; look for shared responsibilities and the skills that each contributes to MNS care (see Table 5).

Practical tips

- Good communication skills are essential in care pathways and for effective linkage of providers and services. Case managers may be assigned to facilitate care pathways.
- Regular meetings of the cadres of the workforce can be good opportunities to discuss and revise processes for referral, treatment and care.

Organize (or adapt) service provision within care pathways so that integrated, linked care can be provided by all professionals in health facilities throughout the district.

Ensure uniform referral documentation, and agree on pathways, procedures and standards for making referrals (e.g. according to the severity or duration of the MNS condition).

See Annex 8 for sample referral forms and registers. Train relevant staff in use of documentation, standards and procedures for making and receiving referrals.

Monitor the effectiveness of the care pathways and referral system with the proposed indicators.

mhGAP operations indicators

- A functioning referral system is established.
- Number of health facilities, social services and community programmes that apply procedures for referring people with MNS conditions.
- Number of referrals and back-referrals made monthly.

Means of verification: Service utilization records for monthly referrals; explicit criteria for referral between primary, secondary and tertiary care and outside the health sector.

Tools: Referral and back-referral forms, facility referral register (Annex 8).

Enhancing the care pathways for mental health services in Lebanon

In view of the large number of refugees in Lebanon and their growing mental health and psychosocial needs, mental health services in the community must be scaled up. Often, stigmatization of refugees dissuades them from seeking mental health services. In addition, the largely privatized mental health system and the small number of MNS specialists limit access to affordable mental health services.

Integration of mental health into health services is a policy priority in Lebanon. In May 2014, the Ministry of Public Health launched the National Mental Health Programme, with the support of WHO, UNICEF and the International Medical Corps. The aim of the programme is to reform MNS care and provide services beyond medical treatment in the community, to respect human rights and to provide services in line with the latest evidence on best practice.

To ensure the sustainability of services within the country's strategy for reform and to extend its approach, the International Medical Corps is integrating mental health into primary health care by setting up case management teams in non-specialist health care facilities and implementing mhGAP. The teams consist of two case managers (social workers), one psychotherapist and one psychiatrist. The case managers use a comprehensive, multidisciplinary approach in providing psychosocial support. People who require specialized mental health services are referred to psychotherapists and psychiatrists. Once they are stabilized, they are referred to mhGAP-trained non-specialist health care providers for follow-up and monitoring of treatment. Training and supervision of non-specialist health care providers and mental health case management teams can strengthen mental health support services in areas with limited access to specialist services and can ensure the continuity of care.

2.5 Improve access to psychotropic medicines

Access to essential medicines is a component of "the right to the highest attainable standard of health" and offers people with MNS conditions a chance for transformative improvement in their health and the opportunity to re-engage in society *(14)*. Psychotropic medicines can be used to reduce the symptoms of MNS conditions and improve functioning. Four main groups of medicines are used in priority MNS conditions in mhGAP-IG version 2.0: antipsychotics for psychotic disorders, drugs for mood disorders (depression or bipolar), anticonvulsants and antiepileptics and medicines for management of substance withdrawal, intoxication or dependence.

Psychotropic medicines are on the WHO Model List of Essential Medicines, which defines the minimum medicine requirements for a basic health system. This list can be used as a model and be modified to reflect district health priorities and needs. There are, however, barriers to access to psychotropic medicines at district level. The demand for psychotropic medicines depends on the acceptability of MNS conditions and the help-seeking behaviour of individuals, who may be inhibited by stigmatization, discrimination and other sociocultural factors. Supplying psychotropic medicines may be difficult, as the currently limited availability of mental health services means that the number of people who require medicines is not recorded and use of these medicines is low. This in turn leads those involved in the supply chain to believe that the true demand is low.

At district level, the appropriate medicines can be selected by local use and adaptation of national or international lists of essential psychotropic medicines as well as by information and education for health professionals. Their availability at district level can be improved by strategies to provide MNS care and raise community awareness in remote and rural areas. Appropriate use can be ensured by education and training of health care providers in mhGAP and other clinical guidelines on prescribing, use and monitoring.

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

Step 1. Review the results of the situation analysis (Annex 3) on the selection, availability, affordability and appropriate use of psychotropic medicines in the district.

- It is good practice to estimate the treatment demand for psychotropic medicines from available data sources. Consult with staff in health information systems to obtain data on the number of diagnoses of each priority MNS condition. Facility surveys, including the situation analysis, can provide data on stocks of psychotropic medicines, the facility catchment population and monthly diagnoses.
- Assess which cadres of the workforce are legally allowed to prescribe psychotropic medicines. If this is restricted to specialists, the mhGAP operations team may advocate for task-shifting.

Practical tips

- Refer to national and international lists of essential psychotropic medicines and in particular those recommended in mhGAP-IG version 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.

Step 2. Build the capacity of non-specialist health care providers in facilities in which mhGAP will be implemented.

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

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

Step 4. Design local strategies to ensure the availability of medicines in primary health facilities and in remote and rural areas.

- The mhGAP operations team may take measures to ensure the availability of medicines in both rural and urban localities (e.g. ensuring that local pharmacists and hospitals supply psychotropic medicines at a fair price).
- Quality must be guaranteed throughout the distribution chain. Generic medication from a trusted, approved manufacturer may be cost–effective.

Step 5. Monitor the supply chain of MNS medicines to ensure that they are continuously available throughout the district.

- The procurement and supply management team should be well qualified.
- Skill in planning operations is required to design a cost–effective distribution system.
- Designing an efficient system for procuring, storing and distributing medicines is both challenging and critical.

mhGAP operations indicators

Indicator: Number of months per year when at least one medication in each psychotropic medication category is available in health facilities.

Means of verification: Medication supply records from health facilities; service utilization records for evidence of initiation of medication for new cases.

Improving access to medicines through enhanced referral mechanisms. mhGAP training and an online health information system in Turkey

Turkey was one of the first countries to plan and extend mhGAP implementation throughout the country, starting with adaptation of the mhGAP-IG version 2.0 to local languages and contexts. As of September 2017, 349 Turkish family physicians and 150 registered Syrian doctors had received mhGAP training, and 85 registered Syrian doctors are now working in migrant health centres across Turkey, with support and supervision for the assessment, pharmacological and nonpharmacological management of MNS conditions in refugee and affected host communities.

With an online health information system that allows pharmacies to access information on prescribed medication, recommended dosages and instructions for use, people with MNS conditions who require pharmacological interventions can obtain prescribed psychotropic medications from any pharmacy outlet. This allows proper monitoring and a regulated process, which limit misuse of psychotropic medications.

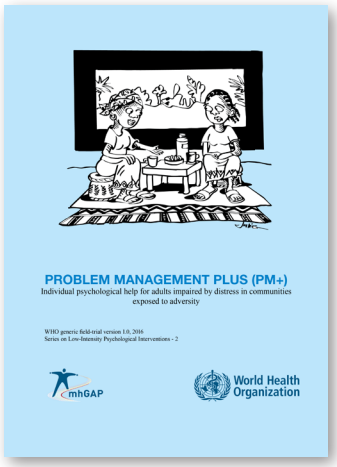
A committee was set up to advocate for mental health with the Turkish Ministry of Health, including issues linked to implementation of mhGAP. For example, not all psychotropic medications recommended for use in mhGAP-IG version 2.0 can be prescribed by trained family physicians and Syrian doctors. Efforts are under way to improve the mental health referral system at provincial level and to set up a functioning referral mechanism for people with psychoses and epilepsy so that they can access services through primary health care. This includes mapping specialists and hospitals that can take referrals for severe MNS conditions that cannot be managed by non-specialist health care staff. Referral pathways, coordination channels and feedback mechanisms to ensure follow-up and management of prescribed medication by non-specialist health care staff are crucial, particularly in provinces with large numbers of refugees, where the referral system is being pilot-tested.

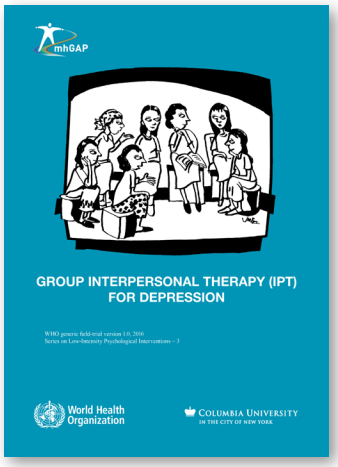
2.6 Improve access to psychological interventions

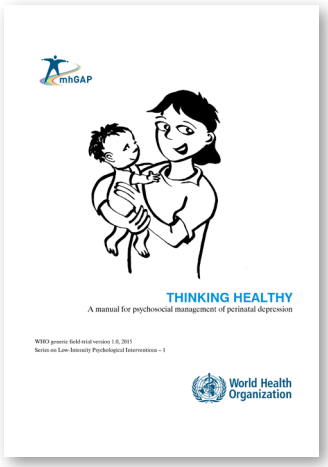
mhGAP recommends a number of evidence-based psychological interventions to be delivered by well-trained, supervised non-specialist health care providers. These include self-help strategies, cognitive behavioural therapy (CBT), interpersonal psychotherapy (IPT) and training in relaxation. Examples of WHO manuals of psychological interventions that are mentioned in mhGAP-IG version 2.0 include Problem management plus (PM+) for depression, anxiety and stress *(39–41)*, IPT for depression *(42, 43)* and "Thinking healthy" for perinatal depression *(44, 45)*.

Until recently, psychological interventions were considered time-consuming by mental health specialists, who tend to be few in low-resource settings. As a result, most people do not have access to such care. During the past 15 years, however, substantial evidence has been accumulated on the effectiveness of psychological interventions by non-specialists in treating MNS conditions in LMIC *(46)*. Consequently, WHO and partners are making available a number of innovative psychological interventions that do not rely on specialists and can be scaled up. These modified interventions can be used for various age groups and populations and can be delivered by trained, supervised non-specialists.

The objective of this section is to provide practical guidance for the mhGAP operations team for increasing access to psychological interventions as part of mhGAP implementation. The health system should be readied to implement psychological interventions by training trainers and supervisors of non-specialist health care providers; establishing care pathways for referral and back-referral to community care; and improving health information systems to monitor progress during interventions. Annex 7 summarizes the psychological and pharmacological interventions used for priority MNS conditions in mhGAP-IG version 2.0.







Role of the mhGAP operations team in improving access to psychological interventions

Step 1. Identify a focal point or form a psychological intervention working group from the mhGAP operations team that includes (preferably local) experts on psychological interventions.

Step 2: Select a psychological intervention, and decide where implementation will take place:

- Refer to the situation analysis (section 1.2) for the availability of providers trained in delivering psychological interventions and to determine the need for a psychological intervention.
- The interventions should be appropriate for the mental health needs of the population, the number of people to be treated and the available resources. For example, "Thinking healthy" *(44)* might be implemented for pregnant women.
- Ensure that the intervention is evidence-based (Annex 7) and that the location and delivery model are appropriate for the local context and available resources.
- When deciding on appropriate interventions, strike a balance between the effectiveness of the intervention and its implementation in the district to ensure maximum impact.

Step 3: Translate and adapt psychological interventions to the local setting and context (section 2.1).

Practical tips

- If psychological interventions are to be delivered by community workers, combine training with awareness-raising about mental health.
- Hold focus group discussions or interviews with specialists, non-specialists and users of interventions to identify any adaptation of the intervention manual to fit the context. Parts of intervention manuals could be read and illustrations shown to future providers to determine their relevance, acceptability and comprehensibility.
- Consider assigning case managers to coordinate care among non-specialist health care providers who have been trained to deliver psychological interventions and those who monitor other aspects of care, such as midwives who might be responsible for coordinating care for MCH in the district (section 5.2).
- Administer a short questionnaire at the start and end of a psychological intervention to assess any change in symptoms.

Step 4: Prepare to identify, assess and refer cases and provide psychological interventions.

- Decide who will provide the psychological intervention, their place in the system and any need to strengthen referrals. Busy primary care providers are unlikely to be able to deliver numerous 60- or 90-min sessions of psychological treatment, while other staff in the health system (e.g. community workers, NGO staff) might have the time. Establish direct referral among health facilities in which mhGAP is implemented and in which providers have been trained in delivering psychological interventions.
- Establish inclusion, exclusion and referral criteria for the psychological intervention. Before people receive the intervention, they should be assessed to ensure that they will benefit from the services and to establish a baseline.
- During a psychological intervention, it is important to monitor the person's suicidal thoughts to ensure that they receive the type of care they need.

- Conduct relevant awareness-raising activities to gain support from stakeholders, including the community and mental health specialists.
- Determine whether certain psychological interventions require a physical space and, if so, how confidentiality will be maintained in facilities with limited resources.

STEP 5: Plan, prepare and budget for selection, training and continuous supervision.

- The importance of high-quality training and continuous clinical supervision in the delivery of psychological interventions should not be underestimated. Lack of funds for supervision (including for transport) is a frequent barrier. Refresher training is important to ensure the quality of the care provided.
- All service providers (trainer, supervisors and providers) should have the relevant knowledge, experience and skills.
- The competencies of providers of psychological interventions should be assessed, and their fidelity to treatment should be evaluated to ensure the quality of the intervention. Competency might have to be re-assessed to ensure that skills are maintained.

STEP 6: Monitor and evaluate psychological interventions (Annex 4).

- Collect data on both the intervention and the level of service.
- Intervention: Use appropriate questionnaires to monitor symptoms and functioning. In all cases, evaluate improvement at the end of the intervention in order to assess impact. Progress may also be assessed at the beginning of each session (e.g. PM+ and IPT-G incorporate measures in every session).
- Service implementation: Collect data on the number of providers trained in psychological interventions and on the number of referrals made from and to services.

mhGAP operations indicators

- Number of non-specialists in the district who have been trained to provide psychological interventions
- Proportion of people who receive psychological interventions who report a decrease in symptoms.

Means of verification: Referral of people with MNS conditions for psychological interventions; MNS symptom tools, e.g. the WHO Disability Assessment Schedule (WHO-DAS) *(47)*, Patient health questionnaire (PHQ) *(48)*.

Extending treatment of depression in Uganda with a scalable psychological intervention

In Uganda, the health system is increasingly equipped to offer care for depression, however, similar to many low-resource settings the vast majority of people with depression do not receive mental health care.

To reduce the gap in treatment of depression, the NGO StrongMinds adapted a simple, cost-effective, evidence-based intervention recommended by WHO, group IPT *(42)*. This scalable psychological intervention (as shown by research in Uganda *(43)*) was adapted to a structured, 12-week programme to help community members to identify and manage their interpersonal difficulties. The intervention had good results in reducing symptoms of depression, and group members also built strong social bonds with their peers. Most groups continue to meet after the formal sessions end, enabling women in the community to manage and prevent future depressive episodes.

The integration of evidence-based, scalable psychological interventions into non-specialized health services or their provision by local organizations is an important part of scaling up treatment for MNS conditions and can have a large impact. In 2015, an evaluation of the programme in Uganda indicated that 86% of the 1800 women had reduced depression at the end of formal sessions. The evaluation also demonstrated the importance of continuous supervision of providers trained in psychological interventions to ensure the quality.

Sources: StrongMinds Mental Health Africa. Quarterly summary (2nd Qtly Report). https://strongminds.org/

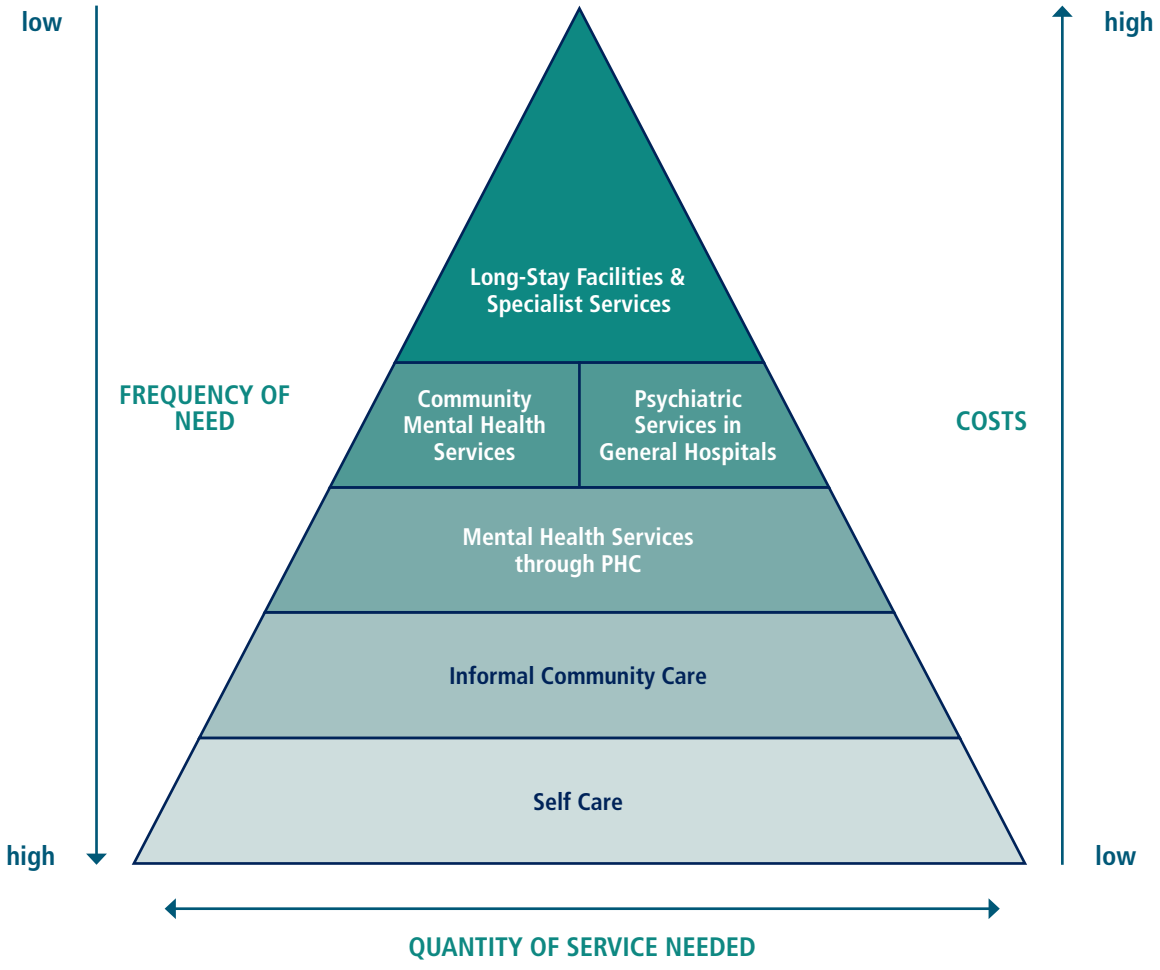
PROVIDE

3. PROVIDE

Integration of treatment and care of MNS conditions into non-specialized health settings is fundamental to ensuring that all people receive the high-quality essential health services they need, without financial hardship. The WHO Comprehensive mental health action plan for 2013–2020 *(6)* proposes a systematic shift from long-stay psychiatric hospitals to community mental health services, including short-stay inpatient care and outpatient care in general hospitals, primary and other non-specialized health services, comprehensive mental health centres, day care centres, support of people with MNS conditions living with their families and supported housing.

The WHO Mental health policy and service guidance package *(28)* provides a framework for integration of different service levels and settings for mental health into a coherent system of care (Fig. 2). In this pyramid, most care is provided informally by families and community networks and by self-care and peer support.

Fig. 2. Optimal mix of mental health services



Source: reference *(28)*

mhGAP-recommended interventions should be integrated into various levels of the pyramid. For example, teachers, parents and carers can be trained to support children and adolescents who are in contact with services at primary, secondary and tertiary levels of health systems and in social and educational care to ensure learning and development of those with mental and behavioural disorders. Non-specialsts can be trained in both primary and secondary health to provide MNS care by using mhGAP-IG version 2.0. Community workers and health care providers linked to primary, secondary and tertiary health care services can be trained in scalable psychological interventions to bridge the gap in the availability of mental health services.

In the Provide phase, the mhGAP operations team, including district health managers, should support MNS care at the primary, secondary and tertiary levels of health services. A clear referral, back-referral and linkage system should be established in consultation with managers and health care providers at all levels. Networks should be strengthened within the community and self-care and coordination with other sectors.

Potential barriers to service delivery (Table 6) depend on the services available in the district and the country.

Table 6. Potential barriers and solutions in Provide

Potential barriers	Potential solutions	Relevant
Delay in initiation of service provision in facilities and the community: training provided, but service is not started.	• The mhGAP operations team, including district health managers, collaborates with other stakeholders to move from the Plan and Prepare phases to the Provide phase. • Identify, with the mhGAP operations team, the barriers to implementing mhGAP in facilities and the community, and consult and/or revise the operations plan and budget as necessary.	1.3, 2.3, 3.1 and 3.2
Limited supply of psychotropic medicines: services initiated, but essential medicines are not available.	• Follow the recommendations in the Prepare phase on improving access to psychotropic medicines in facilities.	2.5 and 3.1
Imbalance between supply and demand: services available, but the community is not aware that they exist.	• Inform the community about the MNS care available (e.g. purpose and importance of MNS care, services available at a clinic, clinic location and hours), and increase awareness about MNS conditions. • Use population and community interventions to promote mental health and well-being and prevent MNS conditions.	3.2 and 3.3
Lack of information on the progress of services provided: services provided, but no progress reports are available.	• M&E should be continuous as part of the Plan, Prepare and Provide phases. • Even with limited resources, the mhGAP operations team can collect routine data and conduct periodic audits to identify the weaknesses and strengths of services.	4.0

Be mindful of the cross-cutting principles when preparing the health system for rolling out mhGAP.

3.1 Provide services at facility level

Integration of mental health into general health services can resolve shortages of human resources to deliver mhGAP-recommended interventions. Nevertheless, a sufficient number of non-specialist health care providers should be available, with the requisite skills and competencies to identify MNS conditions, provide essential psychotropic medicines and psychosocial interventions, intervene in crises, refer patients to specialist mental health services when appropriate, provide psychoeducation and support to people with MNS conditions and their families.

In many countries, psychiatric institutions and specialist services are the only mental health care available to the population. Such institutions are often located in major towns and cities, far from where many people live. Consequently, many individuals do not seek the care they need. When mental health services are delivered by non-specialist health care providers in district facilities, people can access treatment and care near their homes, thus keeping families together, maintaining their support systems, ensuring their integration and activity in the community and their continuing contribution to household productivity *(49)*.

At health facility level, provision of treatment and care involves two phases: (1) assessment and (2) management of MNS conditions.

Once a MNS condition is suspected, a health care provider should assess individuals in the mhGAP-IG version 2.0, Essential care and practice module *(8)* by conducting:

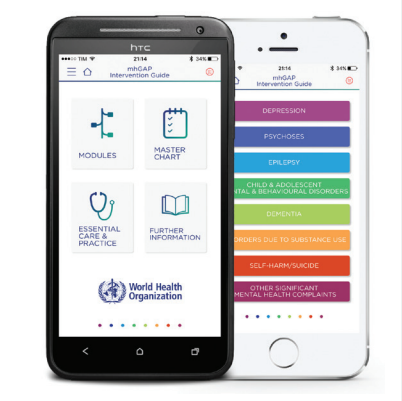
- a physical examination,
- a mental status examination and differential diagnosis,
- basic laboratory tests.

Management of people with MNS conditions in facilities comprises a number of steps.

- Prepare a treatment plan. Modify treatment plans for special populations.
- Offer psychosocial interventions: psychoeducation, stress reduction, strengthening of social support, promotion of functioning in daily life and psychological interventions when available and indicated.
- Treat the MNS condition with psychotropic medicines when indicated.
- Establish two-way care pathways, with referral to specialists or a hospital when indicated and available in order to stabilize people with MNS conditions, and ensure management and follow-up in the community.
- Ensure that an appropriate follow-up plan is in place, and address barriers to follow-up or access.
- Work with carers and families.
- Foster strong links with education and social services (including housing), programmes for poverty reduction and livelihoods and other relevant services.

Box 2. Service delivery tool: e-mhGAP

e-mhGAP consists of a smartphone, tablet and the web app version of mhGAP-IG version 2.0. It was developed on the basis of feedback from users of mhGAP-IG version 1.0, who indicated the potential benefits of a more interactive decision support tool. The feedback was explored in reviews and expert consultations, which confirmed that an electronic version of mhGAP-IG version 2.0 might be beneficial, particularly in low-resource settings with limited access to health facilities. The first version of e-mhGAP was released in October 2017; updates will follow.



The clinical algorithms in mhGAP-IG version 2.0 were designed to form the basis for an electronic version, with a Yes/No answer format to support decision-making on priority MNS conditions. The first version was developed over 9 months, with input from experts and user testing, to arrive at the first release version.

e-mhGAP has several innovative features that may facilitate teaching and learning and the delivery of care to people with MNS conditions in LMIC:

- Easy to disseminate: e-mhGAP will be available in both the android and Apple app store and will be free to download by users with suitable devices.
- User-friendly interface: e-mhGAP has been designed to be easy to use, with clinical algorithms presented in a simple Yes/No format.
- Notes function: This feature records each decision and presents it in an easy-to-view summary, which is useful for learning and decision-making.
- Management summary function: As individuals may present with more than one MNS condition, e-mhGAP identifies the management options (e.g. protocols to be completed) recommended during completion of the clinical algorithms for multiple conditions. These are summarized in an easy-to-read format to facilitate implementation of the protocols.
- Records: e-mhGAP is not an electronic record of service utilization; it does not store patient data. Notes stored in e-mhGAP can, however, be sent with the touch of a button.
- Usable offline: e-mhGAP does not require an Internet connection after an initial download.

Future developments

e-mhGAP will be updated regularly on the basis of feedback from users to ensure that future features respond to their needs. WHO is developing e-learning and supervision systems to further assist implementation of mhGAP, and these features will interface with e-mhGAP.

For more information and to download the app, see: http://www.who.int/mental_health/mhgap/e_mhgap/en/.

Enhancing provision of services in non-specialist care health care facilities

Step 1. Immediately after mhGAP training, use the tools provided to deliver integrated mental and physical health services.

- Improve clinical case management in facilities by ensuring that health care providers have the competencies to assess and manage MNS conditions according to mhGAP-IG version 2.0.
- Strengthen supervisory structures after training trainers and supervisors.
- Increase opportunities for in-service professional training and refresher training in mhGAP.

Step 2. Ensure that facilities take a human rights approach to the provision of services to achieve universal coverage for MNS conditions. All people in the district should receive the quality of essential health services they need, without financial hardship.

- Raise awareness and coordinate with relevant stakeholders in health and other sectors to strengthen the services delivered in district health facilities.

Step 3. Work with district facilities to improve information management systems. Provide training in data recording. Encourage use of standard forms to record intake and follow-up in facilities.

- Collect, analyse and disseminate the findings of M&E (section 4.3), and is the findings to adjust the programme as needed to strengthen MNS care and reach the targets in the mhGAP operations plan.

Practical tips

- Consider ensuring that at least one trained staff member is physically present at any time, on "MNS duty", to assess and manage people with MNS conditions.
- Consider holding a weekly or twice-weekly "MNS clinic" in a general health facility to provide follow-up care or facilitate peer–carer support groups. Care must be taken to ensure that MNS clinics do not reinforce stigmatization of people with MNS conditions and their families.
- Arrange for a private space, preferably a separate room, to hold consultations for MNS conditions. Consider having the MNS consultation room in the same area as other consultation rooms, unmarked, to limit avoidance of mental health services because of fear of social stigmatization.
- Establish services that meet the needs of people throughout their life-course. For example, "family- friendly" spaces can provide age-appropriate information for children and encourage adolescents to speak with health care providers alone.

Step 4. Monitor the supply of essential psychotropic medicines in district facilities (section 2.5).

Step 5. Build the capacity of providers in non-specialist health care facilities to initiate and receive referrals and link with specialists, care providers and CHWs (section 2.4).

- Link to specialists and non-specialists who have been trained in delivering psychological interventions (section 2.6). Link to community interventions when available and appropriate (section 3.2).

mhGAP operations indicators

Indicator: Proportion of people with MNS conditions identified and treated in facilities

Means of verification: Service utilization records from health information systems; supervision records.

Mental health nurses lead in the provision of services in Fiji, a country with limited resources

Fiji, a lower–middle-income country, faces many of the challenges to scaling-up treatment of the MNS conditions that characterize other LMIC. In particular, there are significant gaps in resources and treatment coverage, relatively low expenditure on mental health, a concentration of treatment in designated tertiary facilities and a significant lack of training and resources for non-specialist health care providers. The vast geographical area of Fiji and the remoteness of much of its population complicate provision of services. Lack of transport for the limited number of mental health staff exacerbates the problem. The priorities for improving delivery of MNS care include increasing the number and capacity of the health workforce in facilities.

The Fijian Ministry of Health and Medical Services, with support from WHO and district health managers, has sought to enhance mental health services by decentralization. More than 500 non-specialist health care providers have been trained in mhGAP, including general practitioners and nurses, to assess and manage priority MNS conditions in health care facilities. In the absence of specialists, mental health nurses in some districts have been trained as mhGAP trainers, and, with the support of mental health specialists, they train, support and supervise non-specialist health care providers and manage cases in coordination with general practitioners in facilities for pharmacological treatment and with nurses for non-pharmacological psychosocial support. The stress management units at three provincial hospitals receive people with moderate-to-severe MNS conditions referred by trained non-specialist health care providers.

3.2 Provide treatment and care in the community

The combination of community treatment and care and facility services is more effective than hospital-based care alone, and evidence is growing for a balanced approach to service provision at district level *(50, 51)*. In this approach, mental health services are provided in communities, close to the population served, by non-specialist health care providers, family doctors and community workers, (e.g. government community health workers, NGO psychosocial workers and Red Cross or Red Crescent volunteers), and hospital stays are as brief as possible, arranged promptly and prescribed only when necessary.

The primary providers of formal health services in the community are community workers, defined as health care providers without formal qualifications, who have been selected, trained and are working in the communities from which they come *(52)*. CHWs are increasingly proving to be an important resource for delivering health services in the community, particularly in areas with the greatest shortages of a skilled workforce. CHWs in many settings may, however, be overwhelmed by more acute or more highly prioritized health needs *(53)*, leaving them with limited capacity to deliver mental health interventions effectively. In recent policy initiatives to achieve universal health coverage in LMIC, the definition of the community platform for delivering health care services has been broadened to include non-health care settings, such as schools, neighbourhoods, communities and workplaces, and individuals such as teachers, police officers, social workers, traditional healers, service users, peers, parents, village elders and the general public. This may be an important strategy for extending not only access to mental health services in low-resource settings but also the spectrum of interventions that can be provided. Examples of community interventions are given in Annex 7.

Treatment and care in the community are effective in reducing disability and symptoms *(54)*, ensuring better acceptance and fewer hospital admissions and suicides in the management of severe MNS conditions *(55)* and improving social functioning *(56)*. The approach is often relatively cost–effective and therefore particularly appealing in LMIC, where stigmatization often limits access to high-quality care.

Community mental health interventions can be categorized broadly into three groups:
Awareness and mental health literacy (section 3.3): to reduce stigmatization and improve access to treatment by improving the community's understanding of mental health and mental disorders and their ability to identify the signs of mental ill health in themselves and others. Activities include mental health first aid training and provision of information about local referral pathways.

Prevention and promotion (section 3.4): to prevent mental ill health and maximize the mental health and well-being of individuals and communities. Prevention and promotion target the psychosocial determinants of mental health and include life skills training, parenting skills, promotion of physical activity and healthy eating and social connectedness.

Management and rehabilitation: to reduce and manage symptoms of mental disorders, prevent relapses, minimize disability and support rehabilitation and recovery. Management activities can include psychological therapy, psychoeducation, stress management, vocational support and consumer self-help groups.

An mhGAP community toolkit is being prepared as a practical resource for district managers and local providers.

Role of the mhGAP operations team in increasing the provision of community services

Step 1. Refer to the situation analysis (section 1.2) to identify the community treatment and care available in the district. Map community resources, and identify stakeholders in other sectors (e.g. social welfare, protection, education, judiciary, civil society) who could provide formal or informal support for mental health.

- Engage these groups in awareness-raising (section 3.5).
- Work with service user groups and carer support groups to link community treatment and care. Encourage CHWs to establish such groups if they do not exist.

Step 2. Prepare care pathways to strengthen referral from the community to non-specialized health settings (section 2.4). Encourage CHWs and other care workers to manage cases in order to better coordinate treatment and care in the community.

Step 3. Train CHWs in using mhGAP materials (e.g. the mhGAP community toolkit (forthcoming), psychological interventions) and other community interventions (see Annex 7) after adaptation to the local context. Interventions will require strong engagement of various sectors and by policy-makers (section 1.4).

Practical tips

- Use existing resources and infrastructure to provide treatment and care in the community by establishing collaboration with community stakeholders. For example, instead of selecting a new room as a venue for a peer support group, use careful scheduling and good collaboration to use the usual community meeting rooms.
- Informal community resources and social networks such as women's groups, youth organizations, community centres and religious leaders should be involved in advocacy and awareness-raising, as both participants and organizers.
- Traditional healers may include faith healers, spiritual healers, religious healers and practitioners of indigenous and alternative systems of medicine. In many countries, they are the first point of contact for people with MNS conditions. Involve them in advocacy and awareness-raising.
- Raise awareness among community organizations about the roles they can play and the effect they can have on mental health outcomes (section 3.3).

mhGAP operations indicators

Indicator: Proportion of people with MNS conditions who are receiving care in the community.

Means of verification: Community resource maps; attendance at service user and carer support groups; service utilization records

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.

The programme faces two challenges. Although the female community health volunteers are an integral part of the Government health care system, they are not on the payroll, so it is difficult to ask them to undertake additional tasks. Secondly, non-specialist health care providers are already overburdened. In the absence of mental health specialists in a district, treatment of MNS conditions by community volunteers is complemented by community interventions to increase access, adherence and the quality of care and by training mid-level mental health and psychosocial workers in the district health care system.

Paraprofessional counsellors are mobilized to provide psychosocial support in health facilities and the community, ensuring that psychological treatment is an integral part of Nepal's mental health care package. The absence of a position for counsellors in the health care system, however, is a challenge for sustaining psychosocial services, and advocacy is needed for a long-term mental health strategy and programme that include allocation of a sufficient budget to sustain mental health services and development of personnel, with the support of NGOs and local communities.

3.3 Raise awareness of mental, neurological and substance use conditions and the services available

Awareness-raising in the context of mhGAP operations at district level may include dissemination of information to various groups: people with MNS conditions and their families, health care providers (specialists and non-specialists), community workers, faith and traditional healers, schoolteachers and other community leaders, NGOs, government stakeholders and the wider public.

Awareness-raising can improve understanding and change attitudes and behaviour towards mental health and people with MNS conditions. Providing information to the public can create a demand for integrated services and improve attitudes towards people with MNS conditions and their families. Without accessible, accurate information about the treatment options for MNS conditions and services in the district, service use may be limited.

Awareness-raising is relevant, because:

- People affected by MNS conditions and those at risk for self-harm or suicide experience violations of their human rights, stigmatization and discrimination.
- They may be subjected to extreme stigmatization and discrimination because of widely held misconceptions about the causes and nature of MNS conditions, self- harm and suicide, and they may experience physical and sexual abuse. They are often restricted in the exercise of their political and civil rights, such as the right to vote, marry or start a family, on the basis of the incorrect assumption that people with MNS conditions cannot meet their responsibilities and make decisions about their lives.
- They are often unable to participate fully in society, such as by taking part in public affairs, including policy decision-making.
- They may be restrained at home or in traditional or religious healing sites.
- They face significant barriers to attending school and finding employment, leading to further marginalization. Poor education reduces employment opportunities.

Practical tips

- People with MNS conditions and their carers contribute to awareness-raising in their districts by recounting the advantages of their own care and by contributing their expertise and skills to making decisions about mental health services.
- People with MNS conditions and their carers may be directly involved in mhGAP operations and can also be encouraged to establish support groups or to join local ones. If there is no peer support group for mental health in the district, they could establish one. For more information, see the WHO QualityRights Toolkit: advocacy actions to promote human rights in mental health and related areas *(10)*.

Awareness-raising promotes the rights of people with MNS conditions and those at risk of self-harm or suicide and ensures that their needs are met by existing or new mental health services.

Step 1. Identify awareness-raising activities that are suitable for the district and target audience, through:

- workshops with community leaders and healers and face-to-face meetings;
- empowering people with MNS conditions as members of the mhGAP operations team to lead activities to reduce stigmatization and discrimination in the community; and
- working with service user and carer groups in the community to raise awareness about mental health.

Step 2. Adapt mhGAP materials, and prepare information, education and communication materials to meet the needs of the target audience.

- Disseminate adapted, translated awareness-raising materials.

Step 3. Raise awareness in both facility and community services. Engage health care providers, CHWs and other community members in activities to improve the mental health of the workforce. Raise awareness during school visits and community gatherings.

mhGAP operations indicators

- Number of awareness-raising activities that involve people with MNS conditions and their carers and families
- Number of people in the district reached by awareness-raising activities.

Means of verification: Results of a community survey on changes in knowledge, attitudes or practice related to MNS conditions.

Bringing epilepsy out of the shadows in Mozambique

In Mozambique, as in many countries, cultural beliefs and practices can prevent people with epilepsy from receiving the necessary care. Epilepsy is often believed to be caused by evil spirits. People with epilepsy may turn to traditional or faith healers rather than a health facility for support. They face stigmatization and discrimination in their communities, resulting in isolation and shame. The Fight Against Epilepsy Initiative is raising awareness in communities to increase access to treatment and to remove the barriers to early identification, treatment and social integration of people with epilepsy by a holistic approach that includes training non-specialist health care providers to identify and manage cases and sensitization sessions in communities.

In 4 years, the programme has trained 1161 CHWs in delivering interventions for epilepsy. These community health activists, faith leaders, health workers and traditional healers have conducted sensitization sessions to raise awareness about epilepsy in their communities, reaching more than 90 000 people. Mobilizing people within the community, including community health activists, religious leaders, health workers and traditional healers, and giving them the knowledge and methods to raise awareness has empowered them to play an active role in removing the stigmatization associated with epilepsy. The number of people who accessed services for epilepsy each year has increased by seven times.

3.4 Support delivery of prevention and promotion programmes

The mental well-being of all people with MNS conditions should be promoted and mental illness prevented in people at risk. Prevention and promotion are key tenets of SDGs 3.4, "to reduce by one third premature mortality from NCDs through prevention treatment and promote mental health and wellbeing" *(12)*.

Prevention begins with awareness and understanding of early warning signs and symptoms, including self-harm. Interventions can therefore reduce the risk, incidence, prevalence and recurrence of a condition and the time spent with symptoms and decrease the impact of the condition on the person and family members.

Promotion fosters individual competencies, resources and mental well-being. Strategies include health-enhancing public policy on the social determinants of health. For example, employment opportunities, antidiscrimination laws, creating supportive environments such as interventions at school, strengthening community action by connecting people to resources or building social capital, developing personal skills (e.g. resilience) and reorienting health services (e.g. screening for perinatal depression).

Together, prevention and promotion programmes can reduce risk factors and strengthen protective factors. The aim of target 3.1 of the WHO Comprehensive mental health action plan is for 80% of WHO Member States to have at least two functional prevention and promotion programmes by 2020. Action for the mhGAP operations team requires a multisectoral approach and should be mainstreamed in communities.

Role of mhGAP operations team in delivering prevention and promotion programmes

The mhGAP operations team, including the district health manager, can enhance the delivery of prevention and promotion programmes in a district or the activities of other stakeholders.

- Facilitate dialogue with traditional and faith healers and other community leaders about mental health (section 3.2).
- Given the close links between mental and physical health (section 5.3), it is important to establish collaboration with programmes for chronic diseases and prevention and promotion of physical health problems.

Practical tips

- The impact of prevention and promotion programmes is often difficult to evaluate because of poor-quality data. Indicators should be identified and measured from the onset of an mhGAP programme.
- Include provision for prevention and promotion in the district mental health budget.

A life-course approach should be considered in designing prevention and promotion programmes, so that the needs of children, adolescents, men, women and older adults guide the objectives and delivery. This will also require coordination among sectors. The life-course approach includes:

- early monitoring of the growth and development of low birth-weight infants by mothers, with appropriate advice and training in parenting from educators and nurses, to prevent poor intellectual development;
- engagement with schools, businesses, community leaders and media professionals to promote mental health development in children aged 3–6 years;
- establishment of social and emotional learning programmes in schools to prevent problematic conduct in childhood and to reduce the risks of adolescents for substance misuse, self-harm and suicide;
- establishment of programmes in the workplace for stress management and management training for staff at risk; and
- establishment of social inclusion campaigns for older people, including those with depression or dementia.

Engage the wider community in prevention and promotion.

- Deliver mass public awareness campaigns to raise public awareness in the district about the importance and availability of mental health services, e.g. anti-stigmatization campaigns.
- Disseminate awareness-raising materials on MNS conditions and treatment for mental health in health facilities (section 3.3).
- Ensure that people living with MNS conditions play an active role in awareness-raising.

Box 3. Prevent suicide

- Restrict access to means of self-harm by involving the community in finding feasible ways to reduce access to pesticides, firearms and high places, and establish collaboration between health and other relevant sectors.
- Work with the media to ensure responsible reporting about suicides, avoiding language that sensationalizes or normalizes suicide or presents it as a solution to a problem, avoiding pictures and explicit descriptions of the methods used and providing information about where to seek help.
- Implement school interventions, which can include mental health awareness and skills training to reduce the numbers of suicide attempts and suicide deaths among adolescent students.
- Implement policies to reduce harmful use of alcohol in the district.

Source: reference (59)

mhGAP operations indicators

Indicator: Number of functioning mental health prevention and promotion programmes in the district.
A functioning prevention and promotion programme must fulfil at least two of three criteria:

- dedicated financial and human resources,
- a defined plan for implementation and
- documented evidence of progress and/or impact.

Means of verification: Results of a community survey on changes in knowledge, attitudes or practice related to MNS conditions.

Suicide prevention strategies in Bhutan

In Bhutan, suicide is among the first six causes of death, outnumbering deaths due to tuberculosis, malaria and HIV infection combined. Suicides are, however, underreported, partly because the data collection instruments used by health and law service providers do not include questions that would elicit information on the prevalence of suicidal behaviour. It is therefore difficult to advocate for policy and programmes on suicide prevention.

Bhutan lacked a national suicide prevention strategic plan, as suicide prevention was not considered a priority. Barriers included poor identification, management and referral of individuals who show suicidal behaviour within the general health care system, which offers health services only on demand. Social barriers, stigmatization and sociocultural beliefs significantly contribute to suicidal and help-seeking behaviour. In 2015, building on the strong political commitment of the Government, a multi-stakeholder committee within the Ministry of Health prepared a comprehensive 3-year suicide prevention action plan (2015–2018), with a combination of population, community and individual strategies. A relatively short-term plan may be more effective than a long-term plan, which often loses momentum and accountability.

One of the strategies at district level was to integrate suicide prevention into non-specialist health care facilities, by (i) training and mobilizing a network of non-specialist health care providers as advocates for suicide prevention in their communities; (ii) improving identification of MNS conditions, self-harm and suicide, reducing risk factors and promoting protective factors; (iii) assessing patients with chronic diseases for MNS conditions, self-harm and suicide; (iv) undertaking suicide prevention activities, including identification and follow-up, through CHWs; and (v) engaging and mobilizing community members in setting up and implementing prevention activities, including dialogue with traditional and religious leaders about mental health and suicide.

Sources:

- Ask the policy expert: national suicide prevention strategies, presentation by Dr Yeshi Wangdi, Deputy Chief Programme Officer, National Suicide Prevention Programme, Department of Public Health, Ministry of Health, Thimphu, Bhutan (http://www.mhinnovation.net/series-ask-policy-expert-national-suicide-prevention- strategies).
- Royal Government of Bhutan. Suicide prevention in Bhutan – a three year action plan (2015–2018). Thimphu; 2015 (http://www.searo.who.int/bhutan/suicide_action_plan.pdf?ua=1).

4. FRAMEWORK FOR MONITORING AND EVALUATING mhGAP OPERATIONS

District health managers use health information systems to generate data about the district population and make decisions about how to improve services with the most efficient use of limited resources. An M&E system for mhGAP operations should build upon existing health information systems. It should guide data collection, analysis and use of proposed mhGAP operations indicators (Annex 1).

Although the terms "monitoring" and "evaluation" are often used in conjunction, they refer to two separate but complementary activities. "Monitoring" is the systematic collection of information to assess progress over time and thus involves continuous collection of programme information. "Evaluation" comprises assessment of specific information at specific times to determine whether the actions taken have achieved the intended results *(60)*. An "indicator" specifies the desired impact, outcome or output and is intended to show whether it has been achieved. Indicators may be quantitative or qualitative.

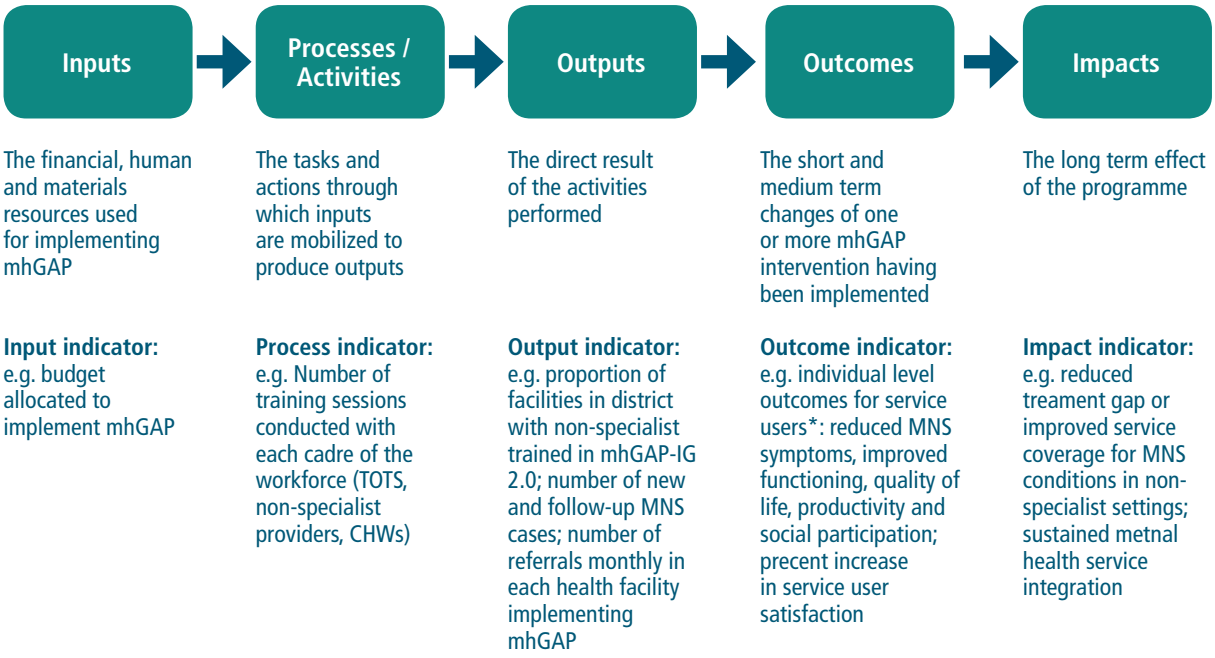
Integration of qualitative and quantitative methods yields rich detail about programme implementation that neither method can achieve alone. While we focus on quantitative indicators in the M&E framework in Annex 1, periodic interviews and focus group discussions with key informants, including non-specialist providers and service users, can reveal the barriers to and facilitators of mhGAP implementation.

"What gets measured gets done." M&E is an essential part of any programme, large or small. It can indicate whether a programme is effective and for whom, whether the investments of implementers and funders are paying off and which programme areas are on target or that should be adjusted. M&E provide government officials, health authorities, development managers and civil society with experience to improve service delivery, planning and allocation of resources and to present results as part of their accountability to key stakeholders.

Ideally, each district should have dedicated or part-time individuals who coordinate and build capacity in facilities for M&E of mhGAP operations through use of health information systems. Annex 1 lists mhGAP operations indicators that may be used to measure the progress of implementation in the three phases. A key function of data collected for mhGAP operations is use in taking decisions that will improve services.

Figure 3 shows examples of indicators that should be measured in districts implementing mhGAP. District health managers may adapt the proposed indicators according to the information needs at district and national levels.

Fig. 3. Example key indicators for mhGAP implementation



* The choice of measure depends on those that have been locally validated. They may be broad measures of emotional distress (such as the Self-reporting questionnaire-20 (SRQ-20) or the General health questionnaire-12 (GHQ-12)) or measures of depression and anxiety (such as the Patient health questionnaire-9 (PHQ-9) and the Generalized anxiety disorder 7 item) and measures of daily functioning (such as the WHO Disability assessment schedule (WHO-DAS)). TOTS, training of trainers and supervisors

Adapted from references *(14, 33, 60)*

Ensuring continuous M&E throughout implementation of mhGAP

Plan

Identify an M&E focal point on the mhGAP operations team who will be responsible for overseeing M&E procedures, training M&E officers and advising on changes to the mhGAP operations plan or budget as a result of ongoing M&E findings.

Review information on the burden of MNS conditions and the available resources for reducing the burden.

- If a national mental health policy and plan are available, familiarize the mhGAP operations team with it, including any targets for improving coverage for MNS conditions.
- Some information might also be available from the situation analysis (section 1.2). Analyse the current M&E system in the district to determine which data are currently collected, identify data sources and frequency of collection and how data are processed, analysed, disseminated and used.
- Use information on existing resources and institutions from the situation analysis, formalize links with implementing partners (leading NGOs, private sector, donors and research institutions) to coordinate M&E planning.

Budget for M&E as part of mhGAP operations planning (section 1.3). The recommended budget for M&E is 10% of the total programme budget. Include it in budget estimates (section 1.3).

Prepare

Adapt the mhGAP operations indicators to those collected in existing health information systems (Fig. 3). When mental health indicators are not collected routinely, advocacy to include a minimum set may be required with the health information systems staff and policy-makers.

Build the capacity of all stakeholders involved in M&E.

- Discuss potential barriers with the operations team and how to address them. Ensure that a process is in place to check the quality of data.
- Train teams in health facilities and communities and district administrators before launching data collection.
- Advocate and work closely with policy-makers outside the mhGAP operations team who will also use the data.

Practical tips

- Collect only indicators that will be used and that are feasible to collect in health facilities (Annex 1).
- To better understand how data flow through the existing health information system, the M&E focal point in the mhGAP operations team may conduct a "walk-through" analysis, which usually requires site visits to facilities and a review of routine data collection forms and databases.
- Ensure mechanisms to feed back the results of data analysis to facilities and communities.
- Ensure that aspects of M&E are included in capacity-building for health care providers and others. People being trained in mhGAP should also be trained to record information.

Provide

Implement the M&E system at facility level by collecting and analysing data for the adapted mhGAP operations indicators (see Annex 8 for sample facility forms).

Disseminate data in a regular M&E report (at least annually) and at meetings, with clear guidance on how the information can be used to improve the provision of services at different levels of the health system.

Integrate the mhGAP operations indicators into the data collected at district level, and advocate for inclusion into routine data collected in the national public health system. Refer to international reporting recommendations, e.g. the United Nations SDGs *(12)*, the Comprehensive Mental Health Action Plan 2013–2020 *(6)* and the United Nations Convention on the Rights of Persons with Disabilities *(11)*.

Develop continuous quality improvement mechanisms to monitor and evaluate mhGAP implementation: PRIME South Africa

The Programme for Improving Mental Health Care (PRIME) in South Africa introduced continuous improvement of the quality of data to assist in embedding and improving the PRIME package integrated into primary health care facilities in three districts. Continuous quality improvement encourages health care providers to repeatedly ask the questions, "How are we doing?" and "Can we do it better?" The PRIME team began quality improvement in one district, namely, Amajuba, KwaZulu-Natal, in three steps: establish M&E governance structures, develop a M&E strategy and provide mentorship and support.

Step 1. Establish M&E governance structures. As a key element of continuous quality improvement is building incentive, the team held consultative meetings with front-line staff and managers in the Department of Health, which resulted in agreement to establish a governance structure comprising quality improvement teams at provincial, district and facility levels, resulting in better understanding of the context and challenges of scaling up MNS care. Once the facility team had identified gaps and areas for improvement, the district team provided guidance on operations, and the provincial team advised on budget and policy amendments. The continuous quality improvement approach was thus used to guide improvement in activities related to the cascade of integrated mental health care.

Step 2. Develop an M&E strategy. In collaboration with the provincial quality improvement team, a few minimum or essential indicators were identified to be tracked by the facilities to monitor progress towards targets and inform continuous quality improvement. The indicators included screening, assessment, management and follow-up of people with MNS conditions. Charts were then used to identify and compare facilities with regard to the targets. Highly functioning facilities were identified for learning and sharing "what works", while poorly functioning facilities were identified in order to provide support.

Step 3. Provide high-quality mentorship and support. A district mentor was trained in continuous quality improvement, and facility and district task teams were mentored so that these skills could be embedded in the Department of Health for sustainable monitoring and quality improvement. Tests of change were repeated until solid solutions could be found that result in improvement.

These three steps resulted in a functioning system for measuring the effectiveness of M&E.

5. INTEGRATION INTO PROGRAMMES AND SERVICES FOR SPECIAL EVENTS AND POPULATIONS

Countries around the world are facing challenges of conflict and natural disasters, steady increases in the prevalence of chronic NCDs, the continuing threats of HIV/AIDS and other infections and calls to address the social determinants of health and to move towards universal health coverage. The health and social consequences of MNS conditions are also increasingly recognized as major threats to health and development.

Mental health service delivery should be integrated into a wide range of settings and populations, such as humanitarian emergencies, MCH care, HIV/AIDS, chronic NCD programmes and care for the elderly. Individuals in these populations are at increased risk for MNS conditions or worsening mental health.

Recognition of the risk can inspire potential strategies for prevention and management. Health system strategies to organize and deliver integrated care in these settings and populations can include prevention of MNS conditions, with better access to care and more cost–effective interventions than the usual treatment in specialized care settings, which is often neither available, accessible nor affordable.

mhGAP-IG version 2.0 provides guidance for diagnosing, treating and managing MNS conditions in special populations, including pregnant and breastfeeding women, the elderly and people with cardiovascular disease. This section of the manual offers guidance for the mhGAP operations team in integrating mhGAP to promote accessible treatment and care.

Be mindful of the cross-cutting principles when preparing the health system for rolling out mhGAP.

5.1 Humanitarian emergencies

Priority of mhGAP implementation in humanitarian settings

People with MNS conditions can be extremely vulnerable during humanitarian emergencies. Basic health care may be disrupted in an acute emergency, appropriate medicines may be scarce, and human resources may be inaccessible or overburdened. People with severe MNS conditions often suffer serious neglect and sometimes mistreatment during emergencies. Institutions for people with MNS conditions may be neglected or become the targets of violence, creating further vulnerability.

The rates of MNS conditions increase during and after crises. Epidemiological studies indicate that the rates of MNS conditions increase significantly during and after humanitarian emergencies. While many people recover naturally without treatment, the long-term prevalence rates for a wide range of conditions remain elevated. WHO has projected that the 12-month prevalence of severe disorders (e.g. psychoses, severe depression, severely disabling anxiety disorder) in adult populations increases from 2–3% before an emergency to 3–4% afterwards and that of mild or moderate mental disorder (e.g. mild and moderate depression and anxiety disorders, including post-traumatic stress disorder) from 10% to 15–20%. *(61)*. The increases amplify the requirement for services and programming. Good MNS services are comprehensive and target a broad spectrum of issues, including care for people with severe MNS conditions.

Cost-effective, evidence-based interventions to manage MNS conditions during humanitarian crises exist. Interventions have been designed to increase the availability of MNS care in emergencies. mhGAP has been implemented in many humanitarian emergencies, which has been pivotal in scaling-up the management of MNS conditions during and after the crises.

There is clear international, inter-agency consensus on the management of MNS conditions during humanitarian emergencies. In 2007, a task force of 27 humanitarian agencies, including United Nations organizations, international NGOs and the International Federation of Red Cross and Red Crescent Societies, published guidelines for mental health and psychosocial support in emergency settings, which include the recommendation to care for people with severe mental health conditions in non-specialized care *(60)*. These guidelines are widely accepted and used. Other consensus-based standards for MNS care include the Sphere standards *(62)*.

If left untreated, MNS conditions negatively affect physical health, social structures, the economy, human rights and overall recovery. Mental health and psychosocial well-being are intrinsically related to physical health, social and community functioning, economic productivity and human rights. If left unaddressed, these conditions can strongly affect overall recovery after emergencies.

Crisis can be opportunity. Not only the need but also political interest in resources for mental health can increase during humanitarian emergencies. This may provide an impetus to address and promote sustainable treatment and management of MNS conditions in communities affected by emergencies *(61)*.

The mhGAP humanitarian intervention guide

The mhGAP Humanitarian intervention guide is an adaptation of the mhGAP intervention guide that provides recommendations for first-line management of MNS conditions by non-specialist health care providers in humanitarian emergencies, when access to specialists and treatment is limited *(63)*. It is a practical tool for general health facilities in areas affected by emergencies for assessing and managing acute stress, grief, depression, post-traumatic stress disorder, psychosis, epilepsy, intellectual disability, harmful substance use and risk of suicide. It is compatible with other mhGAP materials and may serve as an introduction to mhGAP implementation in general health systems.

Coordination of mhGAP implementation in humanitarian emergencies

Plan

- Ensure that the mhGAP operations team has representatives in relevant coordination mechanisms (see section 2.4). Consider forming such an operations team if it does not exist.
- Assemble a team responsible for overseeing integration of MNS care into general health care in the district affected by the emergency, in coordination with the group.
- Rapidly assess needs and resources in the initial phases of the emergency, and conduct a more comprehensive assessment subsequently (64).
- Prepare a plan to design and coordinate a minimum set of activities for integration of MNS care.
- Work with decision-makers to ensure a constant supply of essential medicines, which should include, at a minimum, the five psychotropic medications in the Interagency Emergency Health Kit *(65)*.

Practical tips

- The supply of psychotropic medicines may be interrupted during humanitarian emergencies. When procuring medicine, take account of the continued needs of individuals who were receiving MNS care before the crisis.
- The mhGAP operations team should also take account of safety, basic physical needs (water, food, shelter, sanitation and medical care) and human rights. Basic mental health and psychosocial care should be available throughout the crisis for people with severe MNS conditions living in hospitals and residential homes, especially early in the crisis, as the risks of severe neglect or abuse of people in institutions is extremely high.

Prepare

- Build the capacity of non-specialist health care staff in assessing, diagnosing and managing MNS conditions.
- Orient all staff in psychological first aid (including those who are not trained in assessment and management of MNS conditions).
- Organize continuous clinical supervision and refresher training.
- Arrange for a private space to assess and manage people with MNS conditions and to ensure confidentiality.
- Coordinate with relevant emergency clusters and sectors, e.g. protection, education, camp management and nutrition. (Do not work in isolation.) Gather information on who is doing what, where and when (4Ws) in the cross-sectoral mental health and psychosocial support working group *(66)*.

Provide

- Identify, treat and care for people with MNS conditions in the general health system. Ensure that at least one staff member is present at all times or at a regular designated time (e.g. one day per week) in the health care facility in which staff have been trained in managing MNS conditions.
- Include referral pathways and appropriate follow-up in the management of MNS conditions.
- Engage with emergency responders (e.g. camp managers, humanitarian health workers) and community leaders to raise their awareness about the need for and availability of MNS care (section 3.4).
- Use various information channels, e.g. radio, posters at health clinics, community workers and others who can inform the general population.
- When appropriate, consider discussing the messages with local indigenous and traditional healers who may be providing care for people with MNS conditions and who are willing to collaborate and refer certain cases. (For guidance, see Action Sheet 6.4, *(60)*).

Framework for monitoring and evaluation

- Ensure that information on mental health and psychosocial support is collected routinely and reported to relevant clusters, e.g. health, protection and education.
- Collect a minimum set of data from health facilities with trained staff and systems for providing care for MNS conditions.

mhGAP operations indicators

- Percentage of the population affected by the humanitarian emergency who receive care for MNS conditions at district health services (disaggregated by age, sex and MNS conditions)
- Number of health facilities, social services and community programmes with staff trained to identify and support people with MNS conditions.

Means of verification: Service utilization records in the district

Providing a coordinated response to mental health needs in the aftermath of a natural disaster in the Philippines

In the aftermath of typhoon Haiyan, which struck the Philippines in 2013, WHO, in collaboration with the Philippines Government and NGOs, took steps to improve access to mental health care in the affected regions. Eastern Visayas, with a population of 4.3 million, had only four psychiatrists and seven generalists providing mental health care. After typhoon Haiyan, it was selected as a model region for integrating mental health care into primary and secondary care through mhGAP.

WHO adopted a community-based, task-sharing model of MNS care, with training and supervision by specialist mental health workers, rather than supplying clinical services directly. WHO also supported the training of a cadre of non-specialist providers of mental health and psychosocial support within or linked to existing health care facilities.

More than 1020 community workers were trained in psychosocial care and support, and 290 non-specialist health care providers received training in assessment and management of mental health conditions, including on-the-job supervision. By the end of March 2015, 155 of 159 (97.5%) primary health care units, 21 of 24 district hospitals (87.5%) and all eight provincial hospitals had a doctor and a nurse trained in assessing and managing mental health conditions. Supervised sessions benefited 50–200 people with MNS conditions in each location. The regional medical centre added a 10-bed unit for people with severe MNS conditions; all provincial hospitals established the capacity to admit two to four patients for acute psychiatric care, and additional capacity was established in at least six district hospitals. Services were enhanced to include access to and prescription of psychotropic medicines and a functioning referral system among levels of MNS care. This example shows that emergencies, in spite of their tragic nature and adverse effects on mental health, are unparalleled opportunities to build better mental health systems for all people in need. This example also suggests that mhGAP can be used to strengthen a mental health system as a whole and at scale.

5.2 Maternal and child health care

mhGAP takes account of mental health needs at all stages of the life-course, including infancy, childhood, adolescence, adulthood and older age. The aim of the Global strategy for women's, children's and adolescent's health (2016–2013) *(67)* is the highest attainable standards of health and well-being – physical, mental and social – at every age. A person's health at each stage of life affects health at other stages and also has cumulative effects on the next generation. MCH care can be an entry point for early action to address the mental health needs of women, children and adolescents, who have a high burden of MNS conditions.

Pregnancy and birth can affect the mental health and well-being of many mothers, making coping with the many tasks of child care difficult. Perinatal depression is diagnosed in 1 in 10 women in high-income countries and in 1 in 5 women in LMIC. Without treatment, perinatal depression can affect the health of the mother and the development of the fetus and the infant and have a lasting impact on the child's psychological and physical development.

In mhGAP-IG version 2.0, women of child-bearing age are identified as a special population group, and specific, evidence-based clinical guidance is proposed to address their needs. The guidelines indicate that psychosocial interventions should be first-line treatment during pregnancy and breastfeeding *(4)*, and "Thinking healthy" is an evidence-based approach for CHWs to reduce perinatal depression *(44)*. Such interventions could be integrated into routine MCH services by training non-specialist health care providers. Integration of MNS care into routine antenatal and postnatal health care will overcome shortages of human resources and bridge the treatment gap for perinatal MNS conditions.

Worldwide, 10–20% of children and adolescents have MNS conditions. Half of all mental health problems have begun by the age of 14 years and three fourths by the mid-20s. Children and adolescents with mental and developmental disorders are at increased risk of suboptimal health care because of a greater likelihood of unhealthy habits, risky behaviour, neglect and reduced access to health care. Physical conditions may contribute to, aggravate or resemble mental and developmental disorders in children and adolescents. mhGAP includes a family approach, with guidance to promote the well-being and functioning of children and adolescents (e.g. sleeping and eating habits, physical exercise) and parenting advice for caregivers. mhGAP accounts for the importance of intervening at home and in schools and other social environments to address psychosocial stressors and activate support.

Integration of mhGAP with MCH services by the mhGAP operations team

Plan

Identify a focal point on the mhGAP operations team to coordinate with MCH partners and policy-makers to advocate for the inclusion of mhGAP as part of comprehensive MCH programmes.

Use the situation analysis tool (section 1.2) to identify existing services and the training needs of providers for services to address maternal, child and adolescent mental health.

Prepare

Adapt mhGAP materials for use in MHC programmes (section 2.1). For example, adapt mhGAP-IG version 2.0, "Thinking healthy" and caregiver skills training for families of children with developmental delays and disorders[1] to the local context. A key component of adaptation is determining how MCH workers can practically integrate mhGAP components into their routine practice in health facilities.

Integrate training and supervision on mhGAP tools into pre- and in-service education of health and MCH workers (sections 2.2, 2.3).

- Improve recognition of perinatal depression and mental distress by MCH workers. Improve their capacity to provide psychoeducation, parenting advice and support to children and adolescents with developmental and mental disorders and their families (including appropriate referral to available services), and promote their participation in community activities.

Strengthen care pathways between specialist MNS services and MCH programmes to enhance the quality of care provided to women and children (section 2.4). This includes consultation by specialists in MNS care and bidirectional referrals based on clear guidance.

Provide

Provide services in facilities in a gender-sensitive, age-appropriate way. Confidentiality and communicating in an age-appropriate way are particularly important for adolescents (section 3.1).

Raise the awareness of health and community workers associated with MCH programmes about the purpose and importance of MNS care, the services available at the clinic and the clinic location and hours (section 3.3).

Practical tips

- Integrate MNS care into the work of MCH and community workers, such as infant nutrition and early childhood development, so that they can engage with mothers with MNS conditions to empower them and provide support, practical help and caregiver skills.
- Coordinate with planners, managers and workers to liaise with teachers and school staff and provide guidance on developmental disorders, child and adolescent well-being and links to community resources.

1 The WHO caregiver skills training programme for families of children with developmental delays and disorders is available upon request (http://www.who.int/mental_health/maternal-child/PST/en/).

Implement interventions to prevent MNS conditions, and promote mental health and well-being as part of MCH services (section 3.4). These might include early monitoring of growth development by mothers, advice to prevent poor intellectual development of low birth-weight infants by nurses, visits by CHWs to prevent poor child care and perinatal depression and early identification and care by educators of adolescents with depression.

Framework for monitoring and evaluation

Ensure that mhGAP operations indicators are included in routine data collection, analysis and use of MCH programmes. Ensure that the mhGAP operations indicators collected, analysed and used in non-specialist district health facilities are disaggregated by gender and age to ensure the mental health needs of women, children and adolescents.

Indicator: Number of women and children and adolescents with MNS conditions identified and treated in MCH services

Means of verification: CHW records, facility databases, plans and records from MCH services and programmes within health and social care.

Developing and scaling up a maternal mental health intervention in Pakistan

The high prevalence of perinatal depression and its association with disability, poor infant development and family disruption make it a major public health problem in LMIC like Pakistan. Many women and their families do not consider depression a problem requiring intervention, and stigmatization often prevents women from seeking help. A programme for optimal infant development in Pakistan involved all key family members and allowed mothers and their families to access interventions and support. As the lady health workers who provide health care to mothers in the community were already overburdened, training in mental health interventions had to be integrated into existing training in such a way that it was perceived not as an extra burden but as facilitating their work. In health care facilities, interventions were highly medicalized, disregarding the recommendation not to give antidepressants as first-line management for depression to pregnant and breastfeeding women. This model had to be changed to a community-based, nonpharmacological intervention model integrated into the system of care in primary care facilities.

The "Thinking healthy" programme, based on the mhGAP recommendation that psychosocial interventions be used as first-line management of depression during pregnancy and breastfeeding, was adapted in partnership with an NGO (Human Development Research Foundation), an academic institution (University of Liverpool) and a local implementation partner (the Lady Health Worker Programme). An evidence-based psychosocial

intervention for depression in the perinatal period was adapted culturally and contextually for provision in areas of low socioeconomic development in Pakistan to reduce perinatal depression, improve the health outcomes of the children and encourage mothers to actively seek and practise health-promoting activities. Lady health workers in villages were trained in simple CBT techniques. A robust scientific evaluation demonstrated the effectiveness of the "Thinking healthy" programme in reducing depression and improving child outcomes *(44, 45).*

5.3 Integration of mhGAP into chronic disease care

MNS conditions are strongly associated with other chronic disorders, both NCDs such as diabetes and cardiovascular disease as well as communicable diseases such as TB, HIV/AIDS and neglected tropical disease like leprosy and filariasis. They share many underlying causes (e.g. a combination of genetic and biological factors, psychosocial and behavioural factors, social and environmental factors) and consequences (e.g. persistence over time and significant disability, which may limit socioeconomic opportunities and community integration).

MNS conditions and other chronic disorders are also interdependent and tend to co-occur. For example, there is evidence that depression predisposes individuals to cardiovascular disease and cardiovascular disease increases the likelihood of depression *(68)*. They are therefore best managed with integrated approaches. The major modifiable risk factors for NCDs, such as physical inactivity, an unhealthy diet, tobacco use and harmful use of alcohol, are exacerbated by poor mental health.

The mortality rate of people with severe MNS conditions, including moderate-to-severe depression, bipolar disorder and psychosis, is two to three times higher than that of the general population, resulting in a 10–20-year reduction in life expectancy *(69)*. Numerous causes have been proposed for this increase in mortality, including the well-known bidirectional relation between mental disorders and other NCDs, as elaborated above; differential exposure to risk factors; iatrogenic effects of medications for MNS conditions; increased risk for communicable diseases; and inequitable access to health care services. In addition, people with MNS conditions are less likely to seek help for NCDs, and their symptoms may compromise adherence to treatment and their prognosis. The other causes of death among people with MNS conditions include suicide, homicide and accidents (Box 4).

Care for people with MNS conditions and chronic diseases must be provided in a person-centred, integrated approach, with integration at various levels, from screening and early detection of physical health conditions, counselling for behavioural risk factors including assessment and management of cardiovascular disease risk and management of established physical and mental health conditions. Psychosocial interventions to promote adherence to treatment are particularly important for the physical health of people with MNS conditions.

Box 4. Excess mortality associated with MNS conditions

People with severe MNS conditions such as psychosis, bipolar disorder and moderate-to-severe depression, are more likely to die 10–20 years earlier than the general population, partly from suicide but also from preventable physical diseases such as cardiovascular, respiratory and infectious diseases *(69)*.

mhGAP, which provides interventions at individual, health system and society levels, can improve the health and prolong the lives of people with severe MNS conditions. Individual interventions include prevention of self-harm and suicide (e.g. by reducing access to means) and targeting behaviour (e.g. tobacco use). mhGAP-IG version 2.0 incorporates screening for physical health conditions, coordination of care between mental health and non-specialist health care providers and delivery of medical treatment in mental health services. Interventions at social level, including programmes to reduce stigmatization, can improve attitudes towards people with severe MNS conditions, thus improving their help-seeking behaviour and reducing discrimination.

The following evidence-informed strategies could be used by district health managers to reduce excess mortality in people with severe MNS conditions.

Increase training of health care providers:
- Include key areas of physical health care in the mental health training curriculum of specialist and non-specialists (e.g. resuscitation and management of chronic physical conditions).
- Ensure that non-specialist health care providers and specialists have the knowledge and skills required to detect and manage mental illness in people seeking physical health care.
- Be aware that cultural factors may influence the presentation of physical and mental symptoms.

Provide physical health care for people with severe MNS conditions in inpatient facilities:
- Ensure that people with severe MNS conditions have access to physical health care (including early recognition of physical symptoms or illness, timely diagnosis and management) in psychiatric inpatient facilities, especially those for long-term care that are not located in general hospitals. In facilities in general hospitals, strengthen liaison and referral mechanisms with specialists for prompt response to physical health needs.

Provide integrated, responsive care for people with severe MNS conditions::
- Systematically provide care outside long-stay mental hospitals in non-specialized health settings. Increase coverage of evidence-based interventions for severe MNS conditions, and use a network of community- based mental health services, including short-stay inpatient care and outpatient care in general hospitals, comprehensive mental health centres and day care centres.

Use continuous quality improvement mechanisms in mental health services:
- Monitor and evaluate the implementation of programmes to reduce excess mortality among people with severe MNS conditions.
- Integrate and coordinate holistic care and support to meet both mental and physical health care needs and facilitate the recovery of people with severe MNS conditions of all ages.
- Supervise health care providers who deliver mental health services.

Increase awareness and address stigmatization and discrimination, which limit access to health care by people with severe MNS conditions:
- Disseminate information about mental health, and improve staff attitudes towards people with MNS conditions.
- Engage constructively with the media to ensure that they portray people with severe MNS conditions in a non-stigmatizing manner.

An integrated approach that covers all the health needs of a person is a feasible, efficient means of preventing and managing MNS conditions and other chronic diseases. Models of integrated care include:

- the chronic care model, an integrated, person-centred, shared-care approach based on six ways to improve care: community resources, the health care system, patient self-management, decision support, delivery system redesign and clinical information systems *(70)*; and
- the innovative care for chronic conditions framework *(71)*, which is based on the previous model, with added emphasis on the roles of communities and system changes. The eight actions that decision-makers can do are to:
  - support system changes,
  - promote integrated health care,
  - align sectoral policies for health,
  - use health care personnel more effectively,
  - centre care on individuals and families,
  - support people with MNS conditions in their communities and
  - emphasize prevention.

Integration of care for MNS conditions in existing programmes for chronic disease care

Plan

Identify a focal point on the mhGAP operations team to work with managers of chronic disease programmes to advocate for the inclusion of mhGAP as a generic component of such programmes.

When district health managers are revising plans and budget for communicable and NCDs, ensure that people with severe MNS conditions are not left behind (section 1.3).

Prepare

Adapt mhGAP tools for use in existing chronic disease programmes (section 2.1). For example, programme managers may select certain mhGAP-IG version 2.0 modules for training and supervision for priority MNS conditions that are particularly relevant to the chronic disease condition (e.g. high co-morbidity between HIV/AIDS and depression, with dementia as a potential complication).

Strengthen care pathways between specialist MNS services and programmes for chronic diseases to enhance the quality of care provided and equitable

Practical tips

- Consider integrating MNS care into programmes for chronic diseases that represent a high burden and occur with other diseases (e.g. HIV/AIDS, cardiovascular disease, diabetes).
- When the budget for mental health is small, integration of MNS care into programmes for chronic diseases can be cost-effective and improve both physical and mental health. For example, addressing the mental health of people living with HIV/AIDS improves their adherence to antiretroviral medicines *(72)*.
- Integrated care is not just care that has been moved elsewhere. It requires resources and is provided in health care organizations, in the community and in policy. This requires coordination and strengthening of links between health and social services to include social determinants.
- Health care providers must be adequately trained and supported by continuous supervision to provide and sustain an integrated system of care.

access. This includes consultation by specialists in MNS care as well as bidirectional referrals (section 2.4).

Provide

A multilevel approach is needed to provide integrated MNS and chronic disease care with individual interventions, strengthen the health system and focus on broader social determinants of health, including social support and stigmatization reduction.

Provide services in facilities that are coordinated and holistic, managing both physical and mental health care (section 3.1).

Community workers involved in awareness raising for reducing blood pressure and for diabetes can be trained to provide information on MNS conditions and suicide (2).

Raise the awareness of health and community workers in chronic disease programmes on the purpose and importance of MNS care, and where to access services.

Link people with MNS conditions and their carers to NCD awareness campaigns.

Framework for monitoring and evaluation

- Ensure that mhGAP operations indicators are included in routine data collection, analysis and use in chronic disease programmes, and include assessment and management of chronic diseases in MNS consultations and record-keeping.

Indicator: Percentage of people treated for a chronic disease who received MNS care.

Means of verification: Chronic disease programme records, health information systems and service utilization records.

The "friendship bench" project in Zimbabwe for care of MNS conditions in people living with HIV/AIDS

Zimbabwe was one of the countries hit hardest by the global HIV/AIDS pandemic. Chronic illness and the lack of, or limited access to, mental health services contributed to increasing the burden of mental illness in the country. The Government's limited resources for mental health were used almost entirely to deliver care in tertiary hospitals to people with severe MNS conditions, such as schizophrenia, while people with common mental disorders in communities did not receive care. People with HIV infection, who are at particularly high risk for common MNS conditions like depression, received only one group therapy session before and one session after starting therapy.

Zimbabwe, a resource-poor country, witnessed an expansion of HIV/AIDS treatment initiatives. Given the substantial evidence of links between mental health and chronic diseases, this expansion provided an opportunity for integrating mental health care into non-specialized health services through a project known as the "friendship bench", after the wooden benches found outside district health care facilities. The facilities are staffed by supervised lay health workers (mainly women in the community) trained to deliver problem-solving therapy and establish referral pathways to other services, including for livelihoods. These interventions by health workers were augmented by training of nurses in mhGAP-IG in order to scale up treatment of MNS conditions *(73, 74)*.

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ANNEXES

A.1 List of indicators for mhGAP operations

Section	Indicator	Means of verification
1. Plan for mhGAP implementation in the district		
1.1 Assemble an mhGAP operations team.	• An mhGAP operations team exists, with sectors represented and team members' functions defined. • Total number of mhGAP operations team meetings per year.	• Terms of reference, meeting minutes, plan and budget for the team's activities.
1.2 Conduct a situation analysis.	• The completed situation analysis indicates needs and resources at district and facility levels.	• Completed situation analysis.
1.3 Prepare an mhGAP operations plan and budget.	• MNS care is integrated into the district health plan and approved by the government. • A budget is available, which specifies the financial, human and physical resources required to implement mhGAP in the district.	• Review meeting agendas and minutes, and continually adjust the plan and budget.
1.4 Advocate for mental health.	• Number of advocacy activities completed.	• Feedback from mental and public health leaders; pre–post surveys of knowledge, attitudes and perceptions of key stakeholders; changes in mental health policies or plans.
2. Prepare by building capacity and enhancing health system readiness		
2.1 Adapt components of the mhGAP package.	• mhGAP-IG version 2.0 training and supervision materials and e-mhGAP are adapted and available for implementation in the district.	• Adaptation workshop minutes, adapted mhGAP-IG version 2.0 training and supervision materials and e-mhGAP.
2.2 Train the workforce in mhGAP.	• Number of trainers and supervisors who participated in mhGAP training of trainers and supervisors. • Proportion of non-specialist health care providers who were trained in mhGAP [number trained / number of non-specialusts in the district]. • Number of community workers trained and who meet competency standards in mhGAP.	• Training evaluation forms, (mhGAP training manuals), competency assessments.
2.3 Prepare for clinical and administrative supervision.	• Proportion of supervisors who received training in administrative and clinical mhGAP supervision [number trained / number of supervisors (or specialists) in the district]. • Frequency and adequacy of supervision as defined in the situation analysis. • Proportion of facilities in the district that provide mhGAP supervision [number of facilities that conducted at least one supervision per month / number of facilities with trained supervisors].	• Supervision notes, group supervision attendance forms, case summaries and assessment sheets from direct supervision.

Section	Indicator	Means of verification
2.4 Coordinate care pathways.	• A functioning referral system is established. • Number of health facilities, social services and community programmes that apply procedures for referring people with MNS conditions • Number of referrals and back-referrals made monthly.	• Service utilization records for monthly referrals; explicit referral criteria used to refer between primary, secondary and tertiary care and outside the health sector.
2.5 Improve access to psychotropic medicines	• Number of months per year when at least one medication in each psychotropic medication category is available in health facilities.	• Medication supply records from health facilities; service utilization records for evidence of initiation of medication for new cases.
2.6 Improve access to psychological interventions.	• Number of non-specialists in the district trained to provide psychological interventions. • Percentage of people receiving psychological interventions who report a decrease in symptoms.	• Referral of people with MNS conditions for psychological interventions; MNS symptom tools (e.g. WHO-DAS, PHQ (47, 48).
3. Provide treatment and care for MNS conditions		
3.1 Provide services at facility level.	• Proportion of people with MNS conditions identified and treated in health facilities.	• Service utilization records from health information systems; supervision records.
3.2 Provide treatment and care in the community.	• Proportion of people with MNS conditions who receive care in the community.	• Community resource maps; attendance at service user and carer support groups; service utilization records.
3.3 Raise awareness of MNS conditions and the services available.	• Number of awareness-raising activities that involve people with MNS conditions, carers and their families. • Number of people in the district reached by awareness-raising.	• Quantitative and qualitative results of a community survey on changes in knowledge, attitudes or practice on MNS conditions.
3.4 Support delivery of prevention and promotion programmes.	• Number of functioning mental health prevention and promotion programmes in the district.	• Reports of impact of prevention and promotion programmes.
4. Special events and populations		
Humanitarian emergencies.	• Percentage of the population affected by the humanitarian emergency who receive care for MNS conditions through district health services (disaggregated by age, sex and MNS condition). • Number of health facilities, social services and community programmes with staff trained to identify and support people with MNS conditions.	• District service utilization records.
MCH care.	• Number of women, children and adolescents with MNS conditions identified and treated in MCH services.	• CHW records, facility databases, plans and records from MCH services and programmes in health and social care.
Integration of mhGAP into chronic disease care.	• Percentage of people treated for a chronic disease who received MNS care.	• Chronic disease programme records, health information systems and service utilization records.

A.2 Examples of stakeholders involved in mhGAP operations

Collaborators and potential stakeholders	Potential roles
Health system. Primary health care facilities in the district, focal points in relevant health sectors, training centres in mental health, mental hospitals.	• Build capacity in mhGAP implementation and provision. • Deliver individual mhGAP interventions and support community activities. • Conduct regular M&E to assess and respond to local needs. • Identify gaps in mental health care to adapt local programme. • Foster relationships with other stakeholders, local agencies and government actors to establish comprehensive coordination and referral systems.
Individuals with MNS conditions and their carers or families.	• Provide information on services and ensure that they meet the needs and interests of people with MNS conditions. • Raise awareness about barriers to health care access for people with MNS conditions.
Community and NGOs (e.g. civil society associations, human rights groups).	• Advocate for and support mhGAP planning and implementation. • Present local interests and concerns about mhGAP programmes. • Identify activities or resources that could be provided by nongovernmental stakeholders.
Traditional healers and faith leaders.	• Advocate for and raise awareness of the rights of individuals with MNS conditions. • Assist in planning and adapting mhGAP to the local context.
Health care providers and MNS care professionals (professional associations).	• Integrate mhGAP programming into existing health care services and referral systems. • Communicate concerns and ideas for adaptation and implementation of mhGAP programmes. • Identify strengths and areas for improvement in local mental health care systems. • Advocate for the rights of individuals with MNS conditions, including effective health care. • Participate in continuous learning.
Departments in ministry of health (finance, legal office, community care, hospitals, pharmaceuticals, primary health care, human resources, personnel).	• Maintain and update patient records or IT systems. • Provide guidance on drafting mhGAP budget and costing. • Oversee M&E. • Enhance referral pathways in district health services. • Adapt essential medicines list, and improve supply to districts.
Relevant sectors in local government (social development, social services, social welfare, education, veterans' affairs).	• Social protection services can mitigate the socioeconomic impact on people living with MNS conditions and their families. • Promote accessibility of services for adults and children. • Promote the rights of people with disabilities according to the United Nations Convention on the Rights of Persons with Disabilities. • Prepare educational facilities and systems to adapt to the needs of children and young adults with MNS conditions. • Create work opportunities for people living with MNS conditions and their carers. • Design policies and strategies to promote inclusive employment (e.g. supported employment, sick and disability leave from work). • Enhance referral system between relevant disciplines and sectors. • Engage with social sectors involved in MNS care (e.g. housing, police, prison officers, protection).
Donors and financing agencies.	• Identify areas with limited financial resources. • Highlight areas of insufficient funding of mhGAP implementation and operations. • Provide constructive feedback for the mhGAP operations team on accessing financial support for programme planning and operation.
Academic sector (local public health institutes, statistics units, university faculties of medicine and nursing, academic information systems such as databases, libraries and scientific journals).	• Identify areas for research on implementation or adaptation of mhGAP programmes. • Form relationships with other stakeholders to streamline research activities. • Contribute to capacity-building of providers by pre-service and in-service education and training.
Media	• Provide responsible, accurate information about mental health issues in order to reduce stigmatization and promote awareness and support for effective health care.

A.3 mhGAP tools for situation analyses

mhGAP situation analysis tool at district level

Instructions: This tool is to be completed with data from districts only. A "district" is defined as an administrative division in a country that is smaller than a region. This document is the generic version of the situation analysis, and addition of a local context and specific local issues might be required. The goal of the tool is to provide details for each district that plans to implement mhGAP and the factors that affect general health and MNS conditions in the area.

Please add rows as needed.

D.1 Socio-demographic and economic factors

District name	Ethnicities and religions	Languages

Population size (millions)

Total	Urban %	Rural %

Socio-economic context

- HHousing types, % with sanitation, % with electricity
- Major economic activity in district. Other indicators of socioeconomic status of district (e.g. roads, transport, availability of television/ radio/ Internet/ mobile).

Overview of common social problems in the district that might affect MNS conditions and distress (e.g. domestic violence, crime, availability of alcohol, a recent natural disaster, political unrest, conflict).

D.2 Mental health policies and plans

Existence of an officially approved mental health policy / strategy? Year last revised; in how much of the district has it been implemented; decentralization or integration into non-specialized health services and/or special population programmes; address issues of equity (gender, low socioeconomic status).

☐ Yes ☐ No Year:

Please describe

Mental health budget as percentage of total health budget

Dedicated mental health legislation? Year last revised; in how much of the district has it been implemented; inclusion of protocols for managing people with MNS conditions who require treatment against their will; social welfare benefits.

☐ Yes ☐ No Year:

Please describe

D.3 Overview of health facilities

Overview of health facilities. Give the total number of health facilities and whether public, private or NGO. Include both inpatient and outpatient facilities..

Number of facilities that provide mental health care

Public (primary, secondary, tertiary)	Private	NGO

Facilities

Name of facility	Type of facility	Location

Key stakeholders in the district (individuals and organizations)

Name	Position	Contact	Comments

D.4 Mental health information systems

Data sources used in the district: Clinical / patient records; facility reports / records; facility survey; household survey; vital registration system; administrative data

Data collection mechanisms: Data are collected routinely; data are collected periodically (e.g. quarterly, annually); data are collected occasionally (e.g. every 3 or 5 years); data are never or not collected

Data reporting to central level: automatic and/or continuous; periodic / regular; occasional; not reported

Data disaggregation by: age, gender, diagnosis (Yes/No)

Mental health outcomes/indicators:

1. Health status and outcome indicators: prevalence of mental disorders; suicide mortality rate; mental health status or outcomes of people who use mental health services
2. Health system indicators: number of beds in mental hospitals; number of beds in psychiatric units of general hospitals; number of admissions to mental hospitals; number of admissions to psychiatric units of general hospitals; number of involuntary hospital admissions; number of people with mental disorders who use mental health outpatient services; number of people with mental disorders who use primary health care services; number of primary and general health workers who receive in-service training

D.5 Health service delivery systems

Health workforce in the district. (Total number / number in public sector / number in private sector) For example: psychiatrists, psychologists, general physicians, nurses, health educators, social workers.

	/ /	
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	/ /	
	/ /	
	/ /	

Number of people with MNS conditions who received medical (psychiatric or primary care) services in the past year. Specify incidence by MNS condition.

Primary? Yes/No	Diagnosis	Number

Number of people with MNS conditions who received mental health interventions in the past year. Give type of intervention and number of people.

Intervention	Number

D.5 Health service delivery systems, continued

Which medicines for specified MNS conditions are available in primary care clinics? (Add the list of essential medicines; refer to WHO and national lists)

Formulation oral, liquid, injection	**Strength** (e.g. tablet contains 15 mg active ingredient)	**Level of availability** Facilities in which most medicines are found (%)			
		Public	Private	Pharmacy	NGO

Are there any planned community or recreation activities or support groups for people with MNS conditions? Describe any activities designed to help this group.

Are NGOs providing services for people with MNS conditions in the district? (Including advocacy)

Name	Type (professional, lay or self-help)	Services provided	Number of people involved in the past year

D.6 MNS conditions care training

Were there specific training programmes in MNS care provision for health care providers in the past year? Describe the training, frequency and extent of the programme for each type of health care provider. What proportion of the district's care providers received training? Does training require re-certification or refreshing? Include pre-service and in-service training.

Type of health worker	Type of training	Frequency of training	Other comments, re-certifications, etc.	Supervision (length and by whom)

Describe the district health supervision system for the mental health workforce.

D.7 Awareness-raising, prevention and promotion programmes

Are the knowledge, attitude and behaviour towards MNS conditions and its treatment different in the district from those at regional level? Describe strategies to reduce stigmatization of MNS conditions (e.g. everyday social or professional activities). Describe differences in this district and between rural and urban areas or other sociodemographic factors.

Is an awareness-raising programme about MNS conditions implemented at district level? If yes, specify the target audience: general public, people with epilepsy and their families, other. Describe the programme (e.g. billboards, booklets, television, health fairs).

D.8 Pathway of care

What alternative treatments are used by people with MNS conditions? Specify the type of treatment (home remedy, faith-healer, traditional or other community methods).

What is the usual pathway by which an individual seeks care? Specify who is the first point of contact and then the others in order (e.g. first faith healer, second medical professional, etc.). Specify whether contact is made for complex cases or for common MNS presentations.

First
Second
Third

Describe the referral system for the care of people with [specified MNS condition].

What barriers do people with MNS conditions face in accessing treatment?

D.9 Sociocultural factors

Evidence of help seeking for MNS conditions. Extent of use of traditional/religious healers; stigma & discrimination; what is known of abusive practices (e.g. chaining, restraining); family burden.

What is known about explanatory models of MNS conditions?

mhGAP situation analysis tool at facility level

Instructions: This tool is to be completed for each health facility or clinic in the public or private sector that will be planning mhGAP implementation. It is the generic version of the situation analysis, and specific local issues might have to be added. For items "in the past year", please report data for the past 12 months. **Please add rows as necessary.**

F.1 Administration and services

Facility name	Location	Distance from residential area

Working days and opening hours. By appointment only, drop-in or emergency.

Types of services	Type of facility
☐ Primary ☐ Secondary ☐ Tertiary	☐ Public ☐ Private ☐ Community/NGO

Care services

☐ Inpatient ☐ Outpatient ☐ MNS conditions care ☐ Other

Population served. Approximate number of people covered (in past month):

Number of individuals with MNS conditions served in the last year

Average per month	New MNS cases	Total MNS cases

Availability of medicines. Does the facility have sustainable access to mhGAP-IG-suggested MNS medicines? If no, how far is the closest facility with medicines? If yes, does the facility dispense medicine for MNS conditions? Which one(s)?

Access to smartphone and IT literacy (relevant for e-mhGAP): What percentage of the staff, if has access to a smartphone or tablet devices? What operating system is used: iOS Android, desktop computer? Is there regular access to the Internet?

Staff. Indicate the total number and types of staff. Indicate whether they received training in care for MNS conditions in the past year.

Type of health worker	MNS training

F.2 MNS conditions services, referrals and supervision

Does the facility have psychosocial services for people with MNS conditions and their families? Describe interventions (e.g. counselling, psychoeducation), and state the number of referrals to psychosocial interventions per year.

Are there outreach services for people with MNS conditions? Describe the type of service (e.g. mobile clinic). Specify the number of people visited daily and by whom.

Service follow-up and drop out. Describe any system for managing people with an MNS condition who discontinue services (e.g. incentives, appointment systems).

Can people be seen in a private room? Describe the consultation room.

How many MNS conditions referrals were made in the past month? (In- or outpatient)
What is the typical route for referral of patients with MNS conditions? Describe the referral mechanism (assessment, follow-up and discharge) and source of referral to the facility (e.g. self-referral, from which formal or informal provider) or destination out of the facility (e.g. district hospital, MNS outpatient service).

Into the facility	**Out of** the facility
Number (In/out):	Number (In/out):
Mechanism:	Mechanism:
Source:	Destination:

Do staff know how and where to report safety or abuse issues? Would staff be able to report child abuse, elder abuse, high-risk or criminal behaviour or human rights abuses to the relevant agency or system?

How many episodes of physical restraint or seclusion occurred in the past year?

Is there a supervisory system for care of MNS conditions? Describe who supervises, the number of supervisors, how they supervise, where they supervise and the frequency of supervision. Does supervision follow training?

Does the facility use any guideline, assessment or treatment protocol for care of MNS conditions? If so, describe its content, including assessment, management and referral for priority MNS conditions. How is the guideline or protocol implemented? How is compliance monitored?

F.3 Community involvement in care for people with MNS conditions

List and describe facility links with the community. Specify the type of group (e.g. volunteers, faith organizations, family groups, traditional healers, schools).

Does the facility have a formal collaborative programme with other public services? Public awareness and education providers, social, housing or vocational services, schools or criminal justice services, etc. Describe level of interagency work.

mhGAP situation analysis reporting checklist

☑ Suggested reporting checklist for a situation analysis

- ☐ Context
- ☐ Health background related to MNS conditions, including prevalence, burden of disease and treatment gaps
- ☐ Current capacity in terms of health infrastructure and systems (including M&E and IT systems)
- ☐ Current capacity in terms of human resources
- ☐ Coverage and quality of essential interventions and any reasons for low or ineffective coverage
- ☐ Community resources available to people living with MNS conditions
- ☐ Current policies that are relevant to MNS conditions and their implementation, current spending on these conditions and the principal partners involved
- ☐ Conclusion that synthesizes all information and identifies barriers to implementation of the mhGAP programme
- ☐ Recommendations, listed in order of priority

A.4 mhGAP operations plan

Checklist of a minimum set of activities

☑ 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.

Sample mhGAP operations plan

Activity	Timing	Responsible officer or agency	Resources required
Meetings of mhGAP operations team to oversee programme activities and discuss collaboration among stakeholders.	Continuous	District mental health officer	Meeting venue. Transport costs for operations team.
Meeting with procurement department of ministry of health to ensure availability of essential psychotropic medicines at centres.	January	Medical supplies unit	District mental health budget to include essential psychotropic medicines.
Training of all general practitioners and all nurses in mhGAP-IG version 2.0 to provide services for people with epilepsy, psychoses and depression.	February–April	Mental health unit at local university and ministry of health training department	Training costs.
Continuous supervision by specialists at centres.	February– December	Mental health unit at local university and ministry of health training department	Supervision costs.
Information on indicators reported monthly from centres and dissemination of analyses every 3 months to monitor progress.	February– December	National health information centre	National health information system to include data on mental health.

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

Module: _____

Section	Page	Adaptations
Common presentations Is there robust evidence of the common presentation of MNS conditions in the local setting? What idioms are used to describe the signs and symptoms of MNS disorders? [DEP 21-24; PSY 35-36; EPI 58; CMH 71-72; DEM 95; SUB 114; SUI-; OTH 143]		
Physical illness In view of the epidemiology in the district, should the examples of physical diseases for differential diagnosis be revised? [DEP 23; PSY 35; EPI 59; CMH 75-79; DEM 95; SUB 112; SUI-; OTH-]		
Management "Consult a specialist". What does "consult" mean for this condition (telephone, refer)? What specialist should be consulted for this condition (psychiatric nurse, psychiatrist)?		
Psychosocial interventions Review the interventions listed in the module and determine whether they are available now or are expected to be within the next few years. If they are, list the available services by location (as an annex), and indicate how people are referred to them. If they are not, consider which should be retained or removed from some or all of the current text. Consider adding basic principles of problem-solving counselling to training materials. [DEP 27; PSY 40; EPI 64; CMH 87; DEM 101; SUB 123; SUI-; OTH-]		
Pharmacological interventions Review the medicines listed. If other psychotropic medicines are widely available, accessible and affordable and are in accordance with national protocols or guidelines, they may be added for use in adults (but not in children or adolescents, for whom fluoxetine remains the only medicine). [DEP 28; PSY 41; EPI 65; CMH-; DEM-; SUB 126; SUI-; OTH-]		
Follow-up Review the recommendations on frequency of contact, and adapt them if necessary to the local context. If relevant, identify the venue of and health personnel involved in follow-up. [DEP 29; PSY 46; EPI 67; CMH 90; DEM 103; SUB 128; SUI-; OTH 48]		
Other module-specific adaptations Essential care and practice module [p. 7] Include relevant articles or clauses from national or regional mental health legislation or regulations. Epilepsy module [p. 64] To the text "Local driving laws related to epilepsy should be observed", consider adding relevant text from national law. Child and adolescent disorders module [p. 73]. Include local developmental milestones in training, if available, and provide as a hand-out. Substance use disorders module [p. 115]. Review the list of psychoactive substances in the table, and consider adding substances used in the national context.		

Other comments:

A.6 Suggested training schedules

Training of trainers and supervisors

Time	Day 1	Day 2	Day 3	Day 4	Day 5
9:00–10:45	• Welcome and introduction to mhGAP • Importance of integrating mental health into non-specialized health settings	• Introduction to mhGAP-IG 2.0 training methods and competencies to be acquired	• Training skills: Using mhGAP-IG 2.0 • First-person accounts • Video demonstrations	• Participant facilitation exercise and feedback	• Supervision: theory and practice
11:00–12:30	• Familiarization with implementation of mhGAP-IG version 2.0	• Preparing and evaluating a training course (assessment of training required)	• Training skills: role play	• Participant facilitation exercise and feedback	• Supervision: theory and practice
1:15–3:00	• Essential care and practice	• Training: Presentation skills	• Assessment of competency and feedback	• Participant facilitation exercise and feedback	• Individual feedback and plan for running own course
3:15-5:00	• Essential care and practice (continued)	• Training: • Facilitating group discussions • Demonstrations	• Participant facilitation exercise: Participants are given time to prepare deliver mhGAP-IG training	• Review of training and other interactive training techniques	• Individual feedback and plan for running own course (continued) • End

Training of health care providers

The complete mhGAP-IG course comprises nine modules; however, they can be taught as appropriate in the local context. Suggested schedules are:

- delivery of all nine modules over a minimum of 5–6 consecutive days;
- delivery of the nine modules in three segments, e.g. over three weekends; or
- delivery of the essential care and practice module for the MNS conditions most relevant to the local context. Participants may then learn the other modules by themselves or by e-learning.

Schedule for training in priority conditions

Priority conditions	Duration
INTRO Introduction to mhGAP	1.75 hours
ECP Essential care and practice	5.5 hours
DEP Depression	4.5 hours
PSY Psychoses	4.5 hours
EPI Epilepsy	4.5 hours
CMH Child and adolescent mental and behavioural disorders	6.5 hours
DEM Dementia	4.5 hours
SUB Disorders due to substance use	6 hours
SUI Self-harm/suicide	4 hours
OTH Other significant mental health complaints	4.5 hours

A.7 Interventions for priority MNS conditions in mhGAP 2.0

Individual and population interventions for priority MNS conditions

Priority condition	Individual interventions		Population interventions
	Pharmacological element	Psychosocial, including evidence-based psychological interventions	Prevention and promotion
DEP Depression	• Amitriptyline (a tricyclic antidepressant), for use in adults only • Fluoxetine (a selective serotonin re-uptake interventions: inhibitor)	• Psychoeducation • Promote functioning in daily activities and community life (e.g. physical activity) • Psychological behavioural activation, relaxation training, problem-solving treatment, CBT, IPT	• Activities to improve community attitudes towards people with MNS conditions
PSY Psychoses	• Haloperidol or chlorpromazine • Second-generation antipsychotics (with the exception of clozapine) may be considered for individuals with appropriate psychotic disorders as an alternative to haloperidol or chlorpromazine if availability can be assured and cost is not a constraint. • Lithium, valproate or carbamazepine for bipolar mania	• Psychoeducation • Strengthening social support, reducing stress, teaching life skills • Psychological interventions: CBT, family counselling or therapy	• Activities to improve community attitudes towards people with MNS conditions • Facilitation of assisted living, independent living and supported housing that is culturally and contextually
EPI Epilepsy	• Essential antiepileptic drugs: Carbamazepine, phenobarbital, phenytoin and valproic acid • Newer Antieplieptic medicines (Lamotrigine, Levetiracetam and Topiramate) as add-on therapy in people with medicine resistant convulsive epilepsy.	• Psychoeducation that is culturally and contextually appropriate	• Activities to improve community attitudes towards people with MNS conditions
SUB Disorders due to substance use	• Benzodiazepines for alcohol withdrawal • Thiamine for Wernick encephalopathy • Baclofen to prevent relapse • Methadone and buprenorphine for opioid maintenance and detoxification	• Psychoeducation, including stigmatization discrimination • Psychological interventions: CBT, contingency management therapy, family counselling or therapy, motivational enhancement therapy	• Activities to improve community attitudes towards people with MNS conditions • Mutual help groups • Provision of sterile injection equipment and retrieval of used equipment in primary care centres, involving community pharmacies or through outreach programmes

Priority condition	Individual interventions		Population interventions
	Pharmacological element	Psychosocial, including evidence-based psychological interventions	Prevention and promotion
CMH Child and adolescent mental and behavioural disorders	• Methylphenidate for attention deficit hyperactivity disorder after consultation with a specialist • Fluoxetine but no other selective serotonin re-uptake inhibitor or tricyclic antidepressant for adolescents with depression	• Psychoeducation for person and carers and parenting advice • Guidance to caregivers on improving child and adolescent behaviour • Promote child and adolescent well-being and functioning (including social and peer connections, physical activity and self-care) • Psychological interventions: CBT, training in parenting skills	• Activities to improve community attitudes towards people with MNS conditions
DEM Dementia	• Cholinesterase inhibitors and memantine (not first-line treatment)	• Psychoeducation • Carer support (self-care, stress management)	• Activities to improve community attitudes towards people with MNS conditions
STR Conditions related to stress	• Selective serotonin re-uptake inhibitor (fluoxetine) and tricyclic antidepressant (amitriptyline) as second-line treatment	• Psychoeducation (e.g. on post-traumatic stress disorder) • Psychological first aid • Support in dealing with psychosocial stressors with problem-solving techniques • Stress management • Strengthening of positive coping methods and social support • Psychological interventions: CBT focused on trauma, eye movement desensitization and reprocessing[1]	• Activities to improve community attitudes towards people with MNS conditions
SUI Self-harm and suicide	• In line with treatment of concurrent mhGAP priority condition	• Remove means of self-harm, and ensure follow-up after self-harming episode • Psychoeducation • Carer support • Activate psychosocial support networks (e.g. peers, family, community) • Psychological interventions: CBT	• Reduce access to means of self-harm. • Suicide prevention programmes in schools that include training in mental health awareness and skills • Policies to reduce harmful use of alcohol should be a component of a comprehensive suicide prevention strategy. • Encourage the media to report responsibly about suicidal behavior • Activities to improve community attitudes towards people with MNS conditions
OTH Other significant mental health complaints	• In line with treatment of concurrent mhGAP priority condition	• Psychoeducation • Support in reducing psychosocial stressors by problem-solving techniques • Psychological Interventions: in line with treatment of concurrent mhGAP priority condition	• Activities to improve community attitudes towards people with MNS conditions • Reduce access to means of self-harm. • Suicide prevention programmes in schools that include training in mental health awareness and skills • Policies to reduce harmful use of alcohol should be a component of a comprehensive suicide prevention strategy. • Encourage the media to report responsibly about suicidal behaviour

[1] Like CBT for trauma, the aim of eye movement desensitization and reprocessing is to reduce subjective distress and strengthen adaptive beliefs related to the traumatic event. Unlike CBT for trauma, eye movement desensitization and reprocessing does not involve detailed descriptions of the event, direct challenging of beliefs, extended exposure or homework.

See relevant modules in mhGAP-IG version 2.0 for important considerations in the prescription of psychotropic medications, with particular attention to children, adolescents, pregnant or breastfeeding women, older adults, people with cardiovascular disease and adults with thoughts or plans of suicide.

The evidence-based psychological interventions recommended in the mhGAP-IG version 2.0 are described below.

Psychological Intervention	Abbreviation in mhGAP-IG 2.0 module	Description
Behavioural activation	DEP	Psychological treatment to improve mood by re-engaging in activities that are task-oriented and used to be enjoyable, in spite of current low mood. It may be used as a stand-alone treatment and is also a component of CBT.
Relaxation training	DEP	Involves training in techniques such as breathing exercises to elicit a relaxation response
Problem-solving treatment	DEP, SUI	Psychological treatment that involves systematic use of problem identification and problem-solving techniques in a number of sessions.
Cognitive behavioural therapy (CBT)	DEP, CMH, SUB, PSY, SUI	Psychological treatment that combines cognitive components (for thinking differently, for example, by identifying and challenging unrealistic negative thoughts) and behavioural components (doing things differently, for example helping the person to do more rewarding activities).
CBT for trauma	STR	CBT for trauma usually includes exposure (in images or in vivo) and/or direct challenge to unhelpful trauma-related thoughts and beliefs.
Contingency management therapy	SUB	A structured method of rewarding certain desired behaviour, such as attending treatment and avoiding harmful substance use. Rewards for desired behaviour are reduced over time as natural rewards become established.
Family counselling or therapy	PSY, SUB	Counselling is usually given in more than six planned sessions over a period of months. It should be delivered to individual families or groups of families and should include the person living with mental illness, if feasible. It has supportive and educational or treatment functions. It often includes negotiated problem-solving or crisis management.
Interpersonal therapy (IPT)	DEP	Psychological treatment through the link between depressive symptoms and interpersonal problems, especially those involving grief, disputes, life changes and social isolation. Also known as "interpersonal psychotherapy".
Motivational enhancement therapy	SUB	Structured therapy (four sessions or fewer) to help people with substance use disorders. The approach to motivating change is motivational interviewing, i.e. engaging people in a discussion about their substance use, including perceived benefits and harms in relation to the person's values, avoiding argument if there is resistance, encouraging people to decide on their goal for themselves
Parenting skills training	CMH	A group of treatment programmes to change parenting behaviour and strengthen confidence in adopting effective parenting strategies. It involves teaching parents emotional communication, positive parent–child interaction skills and positive reinforcement methods to improve the behaviour and functioning of children and adolescents.
Eye movement desensitization and reprocessing[1]	STR	Based on the idea that negative thoughts, feelings and behaviour are the result of unprocessed memories. Treatment involves standardized procedures that include focusing simultaneously on (i) spontaneous associations of traumatic images, thoughts, emotions and bodily sensations and (ii) bilateral stimulation, most commonly in the form of repeated eye movements

[1] Like CBT for trauma, the aim of eye movement desensitization and reprocessing is to reduce subjective distress and strengthen adaptive beliefs about the traumatic event. Unlike CBT for trauma, eye movement desensitization and reprocessing do not involve detailed descriptions of the event, direct challenging of beliefs, extended exposure or homework.

Examples of community interventions are listed below.

Prevention and promotion	Awareness-raising	Identification	Interventions (psychosocial support)	Recovery (user mobilization and peer-support groups)	Human resources
• Life skills training, • Parenting skills, • Promotion of physical activity and healthy eating	• Increase awareness of MNS conditions. • Reduce stigmatization, discrimination and abuse. • Protect human rights.	• Increase identification of people with MNS conditions and their referral and service use. • Establish contact, interact with and assess individuals' symptoms and behaviour with the adapted community version of the mhGAP.	• Provide psychological first aid in acute traumatic events. • Provide psychoeducation with emphasis on self-care strategies, especially for depression. • Provide brief psychological interventions (section 2.5). • Strengthen social support, including family interventions and enhancing social networks. • Link to community resources. • Assess risk for self-harm or suicide, and intervene preventively. • Facilitate referral to a facility by accompanying the individual, if possible.	• Mobilize the community to ensure social inclusion and involvement in community activities and support for families (financial, alimentary, and practical). • Ensure multisectoral collaboration to access opportunities for skill development and livelihood support. • Provide regular follow-up and advice on adhering to treatment. • Link individuals to self-help and peer-support groups.	• Front-line workers • Community integration by intersectoral linkages • Continuing care

A.8 Forms for non-specialist health care providers of mhGAP

mhGAP intake form

This form is designed to assist health care providers in recording important information about the people they see in their facilities. The form is in line with the Essential care and practice module of mhGAP-IG version 2.0. The mhGAP operations team may wish to adapt the form to suit the needs of their district population.

Facility name:	Facility location:	Name of provider:	Date intake:
Personal details			
Full name:	Date of birth: Age:	Occupation:	Gender: ☐ Male ☐ Female
Address:		Telephone:	
Carer's details			
Carer's name:	Address:	Telephone:	Relationship to patient:
I. Assess physical health (refer to mhGAP-IG version 2.0 p. 8)			
1. Assessment of physical health			
2. Management of physical health			
II. Conduct an MNS assessment (refer to mhGAP-IG version 2.0 p. 9)			
1. Presenting complaint			
2. General health history			
3. MNS history			
4. Family history of MNS conditions			
III. Manage MNS conditions (refer to mhGAP-IG version 2.0 p. 11)			
1. Treatment plan			
2. Psychosocial interventions			
3. Pharmacological interventions			
4. Referrals			
5. Follow-up plan			
6. Carer and family			
7. Link (employment, education, social services, housing, others)			
8. Special populations ☐ Children and adolescents ☐ Older adults ☐ Pregnant or breastfeeding women			
IIII. Assess for self-harm or suicide and substance use disorders			

mhGAP follow-up form

This form is designed to assist health care providers in recording important information about the people they see in their facilities. The form is in line with the follow-up sections of mhGAP-IG version 2.0. The mhGAP operations team may wish to adapt the form to suit the needs of their district population.

Facility name:	Facility location:	Name of provider:	Date of follow-up:
Personal details			
Full name:	Date of birth: Age:	Occupation:	Gender: ☐ Male ☐ Female
Address:		Telephone:	
Carer's details			
Carer's name:	Address:	Telephone:	Relationship to patient:
Follow-up from first visit			
Date of first assessment:	Name of provider:	Referrals:	
Priority MNS conditions (tick all that apply, then provide details of diagnosis)	DEP, PSY, EPI, CMH, DEM, SUB, SUI, OTH		
Management protocol			
Psychosocial interventions			
Pharmacological interventions			
Links to other sectors/service:			
Assess for improvement (refer to appropriate follow-up section for MNS condition in mhGAP-IG version 2.0)			
1. Is the person improving?	Yes / No		
2. Which symptoms are persisting and how do they affect daily functioning?			
II. Monitor treatment			
1. Is the person taking medication?	Yes / No		
2. Assess for adverse effects of medication			
III. Revise treatment as appropriate			
1. For how long has the person been symptom free?			
Recommendations			
Frequency of contact			

Referral form

Name of facility			**Original / copy**
Referred by:	Name:		Position:
Initiating facility (name and address):			Date of referral:
Telephone arrangements made:	☐ Yes ☐ No		Facility Tel No.
Referred to facility (name and address):			
Service user name			
Identity number			Age: Sex: ☐ M ☐ F
Address			
Mental and physical health history (*include substance use, medical history, family history*)			
Assessment findings			
Any treatment provided			
Reason for referral			
Documents accompanying referral			
Print name, sign and date	Name:	Signature:	Date:

Back-referral from facility (name)			Tel. No.
Reply from (person completing form)	Name:		Date:
	Position:		Specialty:
To initiating facility: (*name and address*)			
Service user name			
Identity number			Age: Sex: ☐ M ☐ F
Address			
This person was seen by: (*name and position*)			on date:
Mental and physical health history (*include substance use, medical history, family history*)			
Assessment findings			
Diagnosis			
Treatment plan and follow-up			
Medication prescribed			
Psychological intervention recommended			
Please continue with: (*medications, prescriptions, psychosocial care, follow-up*)			
Refer back to:			On (date):
Print name, sign and date	Name:	Signature:	Date:

Referral register OUT								
Date referral made	**Name (M or F)**	**Identity No.**	**Referred to** (facility / specialty)	**Referred for**	**Date back-referral received**	Follow-up required YES / NO	Follow-up completed YES / NO	**Appropriate referral** YES / NO

Referral register IN							
Date referral made	**Name (M or F)**	**Identity No.**	**Referred from** (facility / specialty)	**Referred for**	**Appropriate referral** YES / NO	Summary of treatment provided	**Date back-referral sent**

List of mhGAP operations team members:

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2. .....
3. .....
4. .....
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List of facilities currently implementing mhGAP at district level:

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10. .....

Notes

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