SUPPORT AND SUPERVISION GUIDANCE DOCUMENT FOR INTEGRATION OF MENTAL HEALTH (MH) INTO PRIMARY HEALTH CARE (PHC) AT THE NATIONAL LEVEL

Suggested Guidance and Model Developed by International Medical Corps, in support of the National Mental Health Program in Lebanon

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Note from Author: This guidance document and suggested model for scaling up mental health services in Lebanon is in full compliance with Inter agency and WHO standards for training and supervision.
BACKGROUND

In developing countries with acute shortages of mental health professionals, the delivery of mental health services through general health care is the most viable strategy for increasing access of underserved populations to mental health care. Furthermore, mental disorders and physical health problems are closely associated and often influence each other. For example, people with common mental disorders such as depression and anxiety frequently present with somatic symptoms for treatment in general health care services.

An integrated service encourages the early identification and treatment of mental disorders and thus reduces disability. It also helps to reduce the stigma associated with seeking help from an independent mental health service. Other potential benefits include possibilities for the provision of care within the community and opportunities for community involvement in care (WHO, 2003).

Integrating the services has multiple implications for human resources (HR), mainly the following:
> General health staff require training in basic mental health competencies in order to detect mental disorders, provide basic care and refer complex cases to specialist services; and
> Mental health specialists need to be equipped to work collaboratively with general health workers, and provide supervision and support.

For countries with limited HR for mental health, delivering mental health services through primary health care is one of the most effective and viable routes for improving access to mental health care.

Examples of professionals working at this level include general practitioners, general nurses, midwives, nursing assistants and community health workers.

(i) Functions
- Identifying mental disorders
- Providing first line medication and psychosocial interventions
- Referrals to specialist mental health services
- Family and community psycho-education
- Psychological First Aid
- Prevention of mental disorders and mental health promotion.

(ii) Competencies required
- Diagnosis and treatment of mental disorders
- Counseling, support and psycho-education
- Advocacy
- Crisis intervention
- Mental health promotion and prevention of disorders

(INTERNATIONAL MEDICAL CORPS (IMC) IN LEBANON)

General
In Lebanon, IMC’s strategy since 2006 has been to enhance mental health services at the primary health care (PHC) level while also providing a wide-range of mental health and psychosocial support activities. From 2008, IMC has been providing health, mental health, and social services to refugees and vulnerable individuals from the Lebanese population. The purpose of document is to establish a framework for support and supervision linked to integrating mental health into the PHC system at the national level, as part of IMC’s support to the National Mental Health Program at the Lebanese Ministry of Public Health (MOPH).

Starting from 2009, IMC with the collaboration of the MOPH, Lebanese Order of Physicians (LOP), and the Lebanese Psychiatric Society (LPS) has organized ‘Mental Health Trainings (MHT) for PHC Providers. The MHT cycles consist of IMC training General Practitioners (GPs), paediatricians, gynaecologists, and mid-level staff (nurses and social workers) on screening, detection of mental illnesses and providing treatment for mild-to-moderate cases, and appropriate referral of the more severe cases. The MHT are based on the World Health Organization’s (WHO) mental health Gap Action Program (mhGAP) Guidelines.
Training Details and Accreditation
MHT cycles and their corresponding Refresher MHT consist of theoretical training days as well as a minimum of three On-the-Job supervision visits to assess the practical aspect of the trainings in the community/clinic setting. The MHT are in accord with the ethical guidelines suggested and recommended by the Inter Agency Standing Committee (IASC), which states that no theoretical training is complete without having a practical component to it. In total IMC has trained 138 PHC providers from all areas of Lebanon; where 41 were physicians and 97 mid-level staff. Up until 2012, physicians who participated in the MHT received Continuing Medical Education (CME) credits from the LOP. On-going efforts are in place to re-new the agreement with LOP and provide CME credits for trained PHC doctors.

Support and Supervision
In 2011, IMC started collaborating with the Imam Sadr Foundation (ISF) in Tyre where its PHC providers received training in mental health and the very first pilot supervision unit, made up of a psychiatrist, psychologist and social worker, was established. While the supervision unit was not sustained following end of IMC’s support, IMC wishes to use lessons learned from this project to explore and implement a model for on-going support and supervision, with sustainability as a key objective of this model. (Additional Details from IMC’s pilot supervision unit is included as part of a case study in this document. See Section III, page 8).

Lebanon’s National Mental Health Program (NMHP)
Lebanon primarily depends on the private sector for the provision of mental health services. Although most social security plans cover to some extent inpatient and outpatient care, persons with no coverage can benefit from inpatient care and psychotropic medication coverage through the MoPH. Specialised mental health services are available at three private mental hospitals, and seven psychiatric units within general hospitals, which are located centrally around the capital, Beirut.

National Strategy for Mental Health
Building on this experience and that of other countries, as documented in the WHO 2013 “Building Back Better” report, Mental Health could be improved in many ways, even in times of crises and emergency. It is the will of the MOPH to build on the momentum created by the local and international mental health actors to promote mental health in Lebanon and to ensure better mental health service provision to all persons living in the country. Under the patronage of H.E. Mr. Wael Abou Faour Minister of Health, in May 2014, the MoPH launched the National Mental Health Programme with the support of WHO, UNICEF, and IMC, with the aim of reforming mental health care in Lebanon and providing services beyond medical treatment at the community level, in line with Human Rights and the latest evidence for best practices.

The programme has been working on many fronts: integration of mental health into primary care, engaging universities and scientific societies, mapping of the mental health system in Lebanon, developing key guiding documents for mental health.

One year after its launch, the NMHP is launching a Mental Health and Substance Use Prevention, Promotion, and Treatment Strategy for Lebanon for the period of 2015-2020. The vision of the strategy “All people living in Lebanon will have the opportunity to enjoy the best possible mental health and wellbeing” will be approached through ensuring the development of a sustainable mental health system that guarantees the provision and universal accessibility of high quality mental health curative and preventive services through a cost-effective, evidence-based and multidisciplinary approach, with an emphasis on community involvement, continuum of care, human rights, and cultural relevance. The Lebanon Mental Health Strategy can be downloaded here: http://www.moph.gov.lb/Media/Documents/Mentalhealthstrategy-english.pdf

As part of its priority action plan, the NMPH is working towards integrating mental health into primary health care by rolling out training on the mental health Gap Action Programme (mhGAP). Health care staff trained on mhGAP is usually non-specialized health care staff (i.e. GPs, nurses, etc.) working in primary health care centres (PHCs). The challenges of working independently on the newly acquired mhGAP skills can be overwhelming and trainees will require help via support and supervision to transfer what they have learned in the training to their clinical setting. Supervision is seen as part of the continuum of education required to create competent mhGAP health care providers.

Support and supervision aim to improve the knowledge and skills of health care staff; ensure adequate delivery of mental health interventions in line with the mhGAP-Intervention Guide; and assist with administrative and programmatic aspects of implementing mhGAP in PHCs.

Existing Support and Supervision Efforts
In 2015, a total of 8 supervisors (5 psychotherapists and 3 psychiatrists) were recruited to provide support and supervision sessions for 15 centers located in Beirut/Mount Lebanon, Bekaa and North areas. During the project implementation, the
Support and Supervision Guidance Document for Integration of Mental Health (MH) into Primary Health Care (PHC) at the National Level

supervisors had very busy schedules and could not complete the support and supervision sessions required from them on monthly basis. A total of 23 on-site supervision sessions were completed during a period of 3 months, with 20 sessions delivered by psychotherapists and 3 by a psychiatrist. IMC and the NMHP had difficulty communicating and coordinating with the supervisors, which resulted in delays in payments and reporting.

The current challenge in the support and supervision unit is the lack of resources to recruit full time supervisors and relying mainly on part time clinicians. In addition, the number of supervisors was not sufficient to cover all the centres trained and the centres that will be trained in 2016.

The NMHP is currently recruiting new supervisors with psychotherapy background who will be receiving intensive TOT in mhGAP in order to start implementing mhGAP support and supervision at the PHC level. Multiple candidates were interviewed but the position was reopened to receive additional applications. Multiple constraints are being expressed by the potential candidates, one of them is the means of transportation to centres.

I. INTRODUCTION

Primary health care is about providing ‘essential health care’ which is universally accessible to individuals and families in the community and provided as close as possible to where people live and work. It refers to care which is based on the needs of the population. It is decentralized and requires the active participation of the community and family (WHO, 1978: Declaration of Alma-Ata).

Providing mental health services in primary health care involves diagnosing and treating people with mental disorders; putting in place strategies to prevent mental disorders and ensuring that primary health care workers are able to apply key psychosocial and behavioral science skills, for example, interviewing, counseling and interpersonal skills, in their day to day work in order to improve overall health outcomes in primary health care (WHO, 1990).

Integrated primary mental health services are complementary with tertiary and secondary level mental health services (see the ‘optimal mix of services’ information sheet), e.g. general hospital services (short stay wards, and consultation-liaison services to other medical departments), can manage acute episodes of mental illness quite well but do not provide a solution for people with chronic disorders who end up in the admission – discharge – admission (revolving door syndrome) unless backed up by comprehensive primary health care services or community services. Integrating specialized health services - such as mental health services - into PHC is one of WHO’s most fundamental health care recommendations (WHO, 2001).

Training and capacity building are key elements to improve access to sustainable, high-quality mental health care. Four main steps are involved to develop this capacity:

- Conducting training needs assessments.
- Providing pre- and in-service education.
- Conducting supportive supervision, including continuing education.
- Monitoring and evaluating training programs.

Supportive supervision is a high priority and a critical gap in mental health training of healthcare providers. The following Support and Supervision Model as part of integration of mental health into Primary Health care, has been compiled in response to this need. It is designed to be adapted for local context to the National Mental Health Program in the Lebanese MoPH, and supporting agencies and country staff such as UNICEF and International Medical Corps to understand and include supportive supervision methodologies as part of routine health care services. The purpose of this model is to:

1. Define supportive supervision and show how it can improve mental health care at the PHC level.
2. Outline major steps that should be considered when introducing and implementing supportive supervision.
3. Provide country examples of supportive supervision, highlighting different approaches and lessons learned.
4. Identify and disseminate available tools that can be used for supportive supervision.

Supportive supervision is a process that promotes quality at all levels of the health system by strengthening relationships within the system, focusing on the identification and resolution of problems, and helping to optimize the allocation of resources, promoting high standards, teamwork, and better two-way communication. (Marquez and Kean 2002)

A cornerstone of supportive supervision is working with health staff to establish goals, monitor performance, identify and correct problems, and proactively improve the quality of service. Together, the supervisor and trained health workers in mental health identify and address weaknesses on the spot, thus preventing poor practices from becoming routine.
Supervisory visits are also an opportunity to recognize good practices and help health workers to maintain their high-level of performance. (See Table 1 for a comparison of traditional supervision and supportive supervision.)

Table 1: Comparison of traditional and supportive supervision (Marquez and Kean, 2002)

<table>
<thead>
<tr>
<th>Action</th>
<th>Traditional Supervision</th>
<th>Supportive Supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who performs supervision</td>
<td>External supervisors designated by the service delivery organization</td>
<td>External supervisors designated by the service delivery organization; staff from other facilities; colleagues from the same facility (internal supervision); community health committees; staff themselves through self-assessment</td>
</tr>
<tr>
<td>When supervision happens</td>
<td>During periodic visits by external supervisors</td>
<td>Continuously: during routine work; team meetings; and visits by external supervisors</td>
</tr>
<tr>
<td>What happens during supervision</td>
<td>Inspection of facility; review of records and supplies; supervisor makes most of the decisions; reactive problem-solving by supervisor; little feedback or discussion of supervisor observations</td>
<td>Observation of performance and comparison to standards; provision of corrective and supportive feedback on performance; discussion with clients; provision of technical updates or guidelines; onsite training; use of data and client input to identify opportunities for improvement; joint problem-solving; follow-up on previously identified problems</td>
</tr>
<tr>
<td>encounters</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What happens after supervision</td>
<td>No or irregular follow-up</td>
<td>Actions and decisions recorded; ongoing monitoring of weak areas and improvements; follow-up on prior visits and problems</td>
</tr>
<tr>
<td>encounters</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

II. UNDERSTANDING SUPPORTIVE SUPERVISION

“Supervision is an ongoing dynamic information processing, developmental and learning process. The focus is on the intervention strategies and relationships between the supervisor, supervisee and client and the interplay amongst them, within an environmental context and quality assurance system.” (Townend 2008)

Definitions

Supportive Supervision is the process of two or more professionals formally meeting to reflect and review clinical situations with the aim of supporting the trained PHC provider in their professional environment.

Objectives of Clinical Supervision

- To provide PHC providers with a confidential, safe and supportive environment, to critically reflect on professional practice in the provision of mental health services.
- To improve quality patient services by improving mental health practice, by encouraging reflection on attitudes towards people with mental health problems and disorders, their family members and carers.
- PHC providers will do this by improving their self-awareness and taking responsibility for their practice by adhering to a framework for clinical supervision. Clinical supervision is essential for quality management.

Type of Supervision

- **Group supervision** is a situation of more than two or more clinicians in a clinical supervision process. Everyone in the group should agree to the model and processes used.
- **Individual supervision** is the one-on-one clinical supervision meeting.
- **Cross discipline supervision** is a one-on-one or group clinical supervision situation with more than one professional discipline involved (e.g. trained doctors and nurses in one group)
- **Peer group supervision** is a group without a chair. Participants confer with one another by discussing key topics of their professional everyday lives, in order to provide solutions for difficult situations with colleagues or clients. The participants learn better or alternative ways to manage professional problems and reduce stress. This results in the group members’ increased professionalism within their work environments.
Clinical Supervisor

The clinical supervisor
- Is a person trained/experienced with clinical supervision and should have a minimum of two years experience in the mental health field
- Is preferably from the same professional group
- Is from the same or another worksite
- Can give feedback at the supervisee's level of experience
- Has at least the same or higher level of practice skills, in the areas being addressed.

Qualities of clinical supervisor
Motivated, open, honest, aware of own strengths and weaknesses, self-reflecting, able to give and receive constructive feedback, empathize, support, challenge and has internal review skills.

Responsibility of the supervisor
- Personal availability
- Record-keeping
- Confidentiality
- Awareness of limitations in knowledge
- Commitment to the process of clinical supervision
- Be accountable to the employing organization by promoting safe clinical practice.
- To accept responsibility for own professional development by seeking out additional resources for professional development and training as necessary

Supervisee

The supervisee
Is any trained health provider trained and working within mental health at the PHC level, and is willing to:
- Learn and to be proactive
- Talk about challenges and “mistakes”
- Self-reflect
- Focus on problem-solving and avoiding blame
- Prepare for supervision

Qualities of clinical supervisee
Motivated, open, honest, aware of own strengths and weaknesses, self reflecting, able to generate ideas for action, able to accept responsibility for own practice and able to give and receive constructive feedback.

Planning for supervision
- Take time to reflect on what you may need most from your supervisor and be ready to ask for particular support
- Come prepared with an agenda for the meeting, yet be flexible for changing the plan with your supervisor if needed
- Address critical cases first so that any immediate emergency or need can be addressed before continuing supervision
- If you have particular questions, prepare them in advance

Responsibility of the supervisee
- To ensure venue and mode availability
- Personal availability
- Preparing issues to discuss
- Record-keeping
- Confidentiality
- Commitment to the process of clinical supervision
Code of Ethics and Practice for Supervisors

The below are a set of conventional (and adaptable) principles and expectations required for everyone and anyone involved in the training and supervision of PHC providers.

A. Code of Ethics

A1 The purpose of this Code is to establish and maintain standards for Supervisors in their Supervision work with trained PHC providers, hereinafter referred to as Supervisees, and to inform and protect Supervisees seeking Supervision.

A1.1 Ethical standards comprise such values as integrity, responsibility, competence and confidentiality.

A1.2 Supervisors in assenting to this Code reaffirm their assent to all other Codes and accept their responsibilities to Supervisees and their Clients, their colleagues, the wider community.

A1.3 There are various models of Supervision. This Code applies to all Supervision arrangements.

A2 Issues of Responsibility

A2.1 Given that the primary purpose of Supervision is to ensure that the Supervisee is addressing the needs of the Client:
   a. Supervisees are responsible for their work with the Client, and for presenting and exploring as honestly as possible that work with their Supervisor.
   b. Supervisors are responsible for helping Supervisees reflect critically upon that work.

A2.2 Supervisors and Supervisees are both responsible for setting and maintaining clear boundaries between working relationships and friendships or other relationships, and making explicit the boundaries between Supervision, training, and clinical care.

A2.3 Supervisors and Supervisees must distinguish between Supervising and Counseling the Supervisee.

A2.4 Supervisors are responsible for adhering to the principles embodied in this Code of Ethics and Practice for the Supervision of trained PHC providers.

A2.5 Supervisors must recognize the value and dignity of Supervisees and Clients as people, irrespective of origin, status, sex, sexual orientation, age or belief.

A2.6 Supervisors should not exploit Supervisees financially, sexually, emotionally or in any other way.

A2.7 Supervisors are responsible for establishing clear working agreements, which indicate the responsibility of Supervisees for their own continued learning and self-monitoring.

A2.8 Both are responsible for regularly reviewing the effectiveness of the Supervision arrangement, and changing it when appropriate.

A2.9 The Supervisor and Supervisee should consider their respective legal liabilities to each other, the employing or training organization, if any, and to the Client.

A3 Issues of Competence

A3.1 Supervisors should continually seek ways of increasing their own professional development, including, wherever possible, specific training in the development of Supervision skills.

A3.2 Supervisors are expected to make arrangements for their own consultancy and support to help them monitor and evaluate their Supervision. This includes having supervision of their supervision work.

A3.3 Supervisors have a responsibility to monitor and maintain their own effectiveness. There may be a need to seek help and/or withdraw from the practice of Supervision, whether temporary or permanently.
A3.4 All Supervisors should maintain a practice in provision of mental health services in line with their area of profession (i.e. psychiatry, psychotherapy, social work, etc.)

**B. Code of Practice**

This Code of Practice is intended to give more specific information and guidance regarding the implementation of the principles embodied in the Code of Ethics for Supervision.

**B.1 The Management of the Supervision Work.**

B1.1 Supervisors should ensure that their Supervisees subscribe and adhere to the Code of Ethics and Practice for PHC providers or an equivalent code.

B1.2 Supervisors should be explicit regarding practical arrangements for Supervision, paying particular regard to the length of contact time, the frequency of contact and the privacy and safety of the venue.

B1.3 Fees required should be agreed in advance and any increase in fees should be negotiated.

B1.4 Supervisors and Supervisees should make explicit the expectations and requirements they have of each other. This should include the manner in which any formal assessment of the Supervisee’s work will be conducted. Each party should assess the value of working with the other and review this regularly.

B1.5 Supervisors should ensure that their Supervisees are aware of the Supervisor’s qualifications, approach and method of working.

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**III. A CASE STUDY: SUPPORT AND SUPERVISION UNIT WITH IMAM SADR FOUNDATION IN SOUTH LEBANON**

In 2011, IMC started collaborating with the Imam Sadr Foundation (ISF) in Tyre where its PHC providers received training in mental health and the very first pilot supervision unit, made up of a psychiatrist, psychologist and social worker, was established and aimed to:

- Provide ongoing supervision and technical support to PHC staff trained to identify, treat and refer mental health disorders and will also implement additional cycles of the mental health training to new groups, or refresher trainings to already trained PHC providers.
- Provide technical support and ongoing supervision to PHC doctors and mid level staff that were trained to effectively identify, manage, and refer cases with mental health problems.
- Strengthen communication and consultation among trained PHC staff and mental health specialists, with the unit also serving as referral point for severe cases needing more specialized support.
- Strengthen the capacity of staff where the supervision unit will be established, through orientation sessions on the importance of integrating mental health services into PHC and mental health training of PHC staff.

As a result of the lessons learned through IMC’s previous training cycles, the focus of the mental health training was on the team approach to care, whereby the roles of various staff in supporting mental health services are stressed as is referral and coordination both within and outside the PHCs.

While the supervision unit was not sustained following end of IMC’s support, IMC wishes to use lessons learned from this project to explore and implement a model for on-going support and supervision, with sustainability as a key objective of this model.

**Overview**

In an effort to integrate MH into PHC, and develop a sustainable support system for trained PHC providers, IMC initiated the Support and Supervision unit with ISF in the South of Lebanon.

**Setting up the Supervision Unit**

In the planning phase, IMC’s aim was to strengthen communication and consultation among trained PHC staff and mental health specialists by strengthening referral networks and setting up a pilot supervision unit, made up of a psychiatrist,
psychologist and social worker. The supervision unit was stationed within ISF, a local organization that can sustain the unit following IMC’s support. Criteria for selection of partner and location of the unit, was where IMC has partner clinics and where almost no secondary mental health services are available.

The unit set up with ISF was able to provide technical support and ongoing supervision to PHC doctors and mid level staff that were trained to effectively identify, manage, and refer cases with mental health problems. The unit also served as referral point for severe cases needing more specialized support.

IMC also strengthened the capacity of ISF staff in the clinics/centres where the supervision unit was established, through orientation sessions on the importance of integrating mental health services into PHC. Per lessons learned through previous training cycles, the focus of the mental health training was on the team approach to care, whereby the roles of various staff in supporting mental health services are stressed as is referral and coordination both within and outside the PHCs.

IMC developed and utilized a mapping of free and accessible mental health services within the four geographical areas of partner clinics and produce a referral booklet to be shared with MoPH, NGO PHCs, and other service providers.

It is unknown at this time if this mapping remains to be updated, but recommendations to do so have been made by IMC in line with the NMHP’s recently concluded a 2014 4Ws (Who is doing what where and until when) mapping that maps out NGOs providing MHPSS services in the four governorates: Bekaa, Beirut and Mt. Lebanon, South Lebanon and North Lebanon.

Training Framework Components
The IMC program was implemented over a 12-month period in 2011/2012. Mental Health PHC integration trainings had been organized by IMC since 2006 with support from the MOPH and LOP. Capacity building as part of this project began in Summer of 2011, with training provided for ISF PHC doctors and nurses by Support and Supervision team members: part time Psychiatrist (1 visit per month, and as needed), and fulltime Psychologist and Psychiatric Nurse (4 days per week)

Initial training: The first training was carried out over a period of 6 days for ISF staff from 7 centers in the South of Lebanon. A pre- and post-test was used to evaluate improvement in knowledge and attitudes related to identification and management of mental health disorders.

Support and Supervision: Continuing support for trained PHC providers was provided at regularly attended individual and group supervisory sessions with the support and supervision unit. PHC providers also attended their own peer support technical group meetings, and regular refresher training organized by unit based on training needs identified.

Key Challenges
The literature suggests that MH PHC integration can improve mental health service delivery systems. In key informant interview with previous ISF Support and Supervision unit member(s), challenges of supportive supervision to trained PHC providers were identified and possible solutions that could help address those challenges were discussed. The following challenges, and corresponding solutions emerged:

<table>
<thead>
<tr>
<th>Challenges</th>
<th>Solutions</th>
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| GP as gatekeeper to MH services: Some ISF clinics presented as non-physician based, a term now used to describe PHC’s where GPs are not consistently available in a clinic, and provide services through rotation between various clinics. | • Differentiated between physician based and non-physician based PHC clinics (terms used in Lebanon’s updated WHO AIMS), determining the gatekeeper and the focus/model of training and supervision. In non-physician based clinics, the nurse was selected to take on gatekeeper role, this also applied to clinics where physicians were not able to allocate sufficient time to patients due to patient load.  
• Mental health at the PHC level was provided through an all-inclusive trained team of medical professionals and social workers (when available) working together, with long term follow up, support and supervision. Trainings were tailored to GPs, mid- level staff, and doctors from different specialties. |
### Challenges

<table>
<thead>
<tr>
<th>Supervision Team members from far locations resulting in lots of time spent on the road that can be better invested in training and supervision.</th>
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<tbody>
<tr>
<td>At the end of IMC’s support, ISF continued the comprehensive supervision unit model in 2 out of the 7 centers:</td>
</tr>
<tr>
<td>• Keeping on part time psychiatrist one day per month and on a needs basis, that provides district level:</td>
</tr>
<tr>
<td>a. Clinical supervision and support at field level and</td>
</tr>
<tr>
<td>b. Dedicated time to support and supervise other unit members,</td>
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<tr>
<td>• Setting up local psychologists that provide on-going support and supervision to trained PHC doctors within their area/village of residence</td>
</tr>
<tr>
<td>• Continuing peer level supervision organized between PHC staff.</td>
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<tr>
<th>Time was identified as an issue, with feedback from trainees expressing the short training, and the need for on-going refresher trainings based on identified training needs following the first foundational theoretical mhGAP training.</th>
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<tbody>
<tr>
<td>For better mastery of the theoretical approaches and practical skills, trainings should be longer and happen more regularly (refresher trainings), along with regular supervision. Additionally, a longer program timeline would ensure more sustainable outcomes and impacts.</td>
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<tr>
<th>During this initial pilot, monitoring and evaluation (M&amp;E) was inconsistent.</th>
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<tbody>
<tr>
<td>In future replications, M&amp;E should be developed and implemented by an M&amp;E expert at program development. Another strategy to ensure sustainability of the monitoring design would be to use a participatory approach that integrates the trained PHC providers into the process. Due to the participatory nature of the training and program, this would contribute to more robust and flexible reporting.</td>
</tr>
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</table>

### Lessons Learnt and Recommendations

The work that IMC had done since 2011 serves as one example of designing a sustainable support and supervision model as part of mental health PHC integration in close collaboration with the government and key stakeholders.

Having already established relationships with PHC clinics, MH specialists, local ministries, and government officials, IMC was able to work with WHO to gain support for the MH PHC integration program and the Support and Supervision Unit. Additionally, during the same 12-month project, other trainings provided to mental health workers helped to create a common language to be used by services providers, as well as the insight needed for service providers to be able to support and collaborate with the unit.

Recommendations to be considered in the replication of IMC’s support and supervision project with ISF include:

- Establishing coordination: Establishing a coordinated network of peer support and communication among trained PHC providers, identifying a core group per area and supporting regular meetings.
- Identifying needed resources: Identifying and allocating resources to cover costs for regular support and supervision to trained PHC providers (e.g. phone communication, phone cards, transportation).
- Defining roles: Defining roles of Supervision unit including how they interact with supervisees, PHC management, and the formal mental health service provision system.
- Defining activities: Developing agreed upon activities of supportive supervision in line with supportive supervision model (e.g. supervision sites, types and frequency of visits and activities, group and individual meetings, etc.).
- Defining steps and criteria for selecting senior PHC providers to engage in supportive supervision: Offering peer support works in line with setting up effective and sustainable supportive mechanism for those trained.
- Code of conduct: Developing a code of conduct for Supervision unit.
- Connections to other services and organizations: Facilitating more formalized connections with mental health service providers and clinics as well as community-based organizations in each governorate.
IV. MOVING TOWARD A NATIONAL SUPPORTIVE SUPERVISION MODEL

The integration of mental health into primary care has been a policy objective in Lebanon since 2012, adopting a national mental health strategy in 2014 that recognizes the importance of the mental dimension of health. However, there is still no specific allocation of resources to implement the action plan within this national strategy, and no continuing professional development on mental health for staff at the community and health care level. Indeed, this is a common problem across low-income countries, which give low status and few resources to national mental health programs. Detailed information about the Lebanon health system levels, mental health staffing and resource allocation, can be found in the soon to be published 2015 World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS).

A. Key Elements of National Roll Out of MH PHC Training to assist impact and sustainability

Key elements assist with impact and sustainability; mainly conducting efforts to train front-line health workers in partnership with the MOPH, in the context of the country’s health and mental health policies, in Lebanon’s case this would be the National Mental Health Strategy being rolled out by the NMHP. The project should agree with the MOPH the appropriate local training institution for Continuing Medical Education (CME) and Continuing Professional Development (CPD) for primary care, and work through that organization to train local trainers who are likely to remain in post for a long time. Call up of participants should be through the MOPH to ensure that appropriate people attend for training. Continuous policy dialogue is necessary throughout the project to solve a variety of issues such as the supply of medicine, supervision, and annual planning.

<table>
<thead>
<tr>
<th>Training Course Delivery</th>
<th>In conjunction with training institution relevant for CME /CPD for primary care using local Trainers.</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>[In Lebanon, The Lebanese Order of Physicians, and Syndicate for Nurses are the appropriate institutions for CME.]</td>
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<tr>
<td>Training course materials</td>
<td>Distributed to training institutions for integration into basic, post-basic and CME curricula</td>
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<tr>
<td></td>
<td>[In Lebanon, a good example of such an institution is Université Saint-Joseph de Beyrouth, (USJ), due to affiliation of local trainers with this university.]</td>
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<tr>
<td>Accreditation of the course materials for Lebanon</td>
<td>By MOPH, Lebanese Order of Physicians, and Nursing, Social Worker syndicates</td>
</tr>
<tr>
<td>Regular support and supervision</td>
<td>By local support and supervision teams that may or may not include the following (depending on local capacity and human resources): local psychiatrist, and local psychologist, psychiatric nurses, and/or social workers and public health doctors</td>
</tr>
<tr>
<td>Continuous policy dialogue with MOPH</td>
<td>Integration of mental health into Lebanon Essential Package of Health, medicine supply, Health management information System (HMIS), support and supervision to primary care, Local Accreditation of Training.</td>
</tr>
<tr>
<td>Linkage to local planning</td>
<td>Orientation workshops for ministry and other relevant health staff and decision makers to encourage inclusion of mental health in national health plans and budgets</td>
</tr>
<tr>
<td>Training content</td>
<td>Comprehensive, interdependent modules, consistent with local health policy and health sector reforms, and tailored to local health priorities</td>
</tr>
<tr>
<td>Training methods</td>
<td>Multi-method, active, participatory, assessed</td>
</tr>
<tr>
<td>Reinforced by</td>
<td>Distribution of Lebanon adaptation of WHO mental health primary care guidelines (mhGAP), teaching materials, regular supervision</td>
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</table>

B. Structure and content of the training program

A partnership and Memoranda of Understanding should be re-established between the MOPH and the LOP, and relevant syndicates for trained PHC providers, including nurses and social workers. Additionally, a formal partnership needs to be developed with universities, to develop a training course, together with the adapted WHO Primary Care Guidelines, including sections prioritized by the national mental health strategy and action plan, such as child health, reproductive health, and substance use.
Module | Content
--- | ---
Core concepts & content | Management of Mental, neurological and substance use disorders [Using the Lebanon adaptation of the WHO mental health primary care guidelines (mhGAP)]

Core skills | - Identifying mental disorders  
- Providing basic medication and psychosocial interventions  
- Referrals to specialist mental health services  
- Family and community psycho-education  
- Crisis intervention  
- Prevention of mental disorders and mental health promotion.

Health and non health sector policy and practice issues | General health policy, mental health strategy, linkages between mental health and child health, reproductive health and other sectors in line with National MH strategy; roles and responsibilities for each level in the health system, health management information system and the value of data collection, working with community health workers and with traditional healers and integration of mental health into annual operational plans.

C. Suggested Supportive Supervision Model

Strategies are needed to develop specialists, to manage and treat complex cases, to provide ongoing supervision and support to non-specialists, and to teach and train other health professionals. In Lebanon, district level supervision teams cannot be set up due to limitations in capacity and human resources across the country, and particularly in remote areas where integration of MH into PHC is most needed. Accordingly, the above model is implemented through a central coordination mechanism lead by the NMHP of the MOPH. Master trainers (stage 1) will train fulltime trainers and supervisors (stage 2) employed by INGO and UN partner agencies, and are then dispatched through the NMHP training unit to different districts in accordance with number of MOPH trainees, and frequency for supportive supervision sessions (stage 3) required for trained PHC providers to meet competency standards.

In conjunction, national efforts exist to strengthen communication and consultation among trained PHC staff and mental health specialists, through a referral system that ensures comprehensive MHPSS services, and referral points for severe cases needing more specialized support.
Components specific to Apprenticeship in Mental Health Intervention Provision
(In compliance with WHO’s mhGAP Support and Supervision Guide)

A) Orientation for Master Trainers, local psychiatrists, on mhGAP and scaling up mental health services in country through an overview of the importance of integration of MH into PHC.

B) Training of trainers (TO Ts) Trainers and Supervisors, local training and supervision teams of psychologists, psychiatric nurses, and social workers per district.

In the ToTs training and supervision team members are trained to conduct the mhGAP Training course and to provide supportive supervision. So, in the ToTS, master trainers build capacity of national facilitators to be able to conduct mhGAP training to non-specialist health care providers.

The role of the master trainer in the ToT workshop is to teach training and supervision team members on:
- Essential mhGAP-IG content
- Modern interactive teaching methodologies
- Support and supervision skills

C) Selection of PHC providers who demonstrate interest and aptitude for the profession Initial theoretical training for PHC providers and supervisors.

D) Application of knowledge “on the job” under direct supervision and coaching Practice groups with local supervision and master trainer consultation.

E) Ongoing expansion of knowledge and skills under supervision
- Supervisors: additional coaching on supervision techniques by master trainers.
- PHC providers: Supervision groups for expanded number of cases facilitated by district training & supervision team.

Note: As the scaling up happens, you will need more supervisors than the trainers; trainers can train non-specialists as many times as needed but supervisors cannot supervise infinite number of trainees. In that case you will need to conduct Training of the Supervisors Training.

Recruitment of Trainees: Trainees across all areas of training (Master trainers, training and supervision team members, and PHC providers) should be selected through a formal recruitment process, approved by the government, using specific criteria relevant to skills, knowledge, commitment and dedication to the scaling up of mental health. These criteria include:

☐ Professional level (Must be PHC Doctor, nurse, social worker)
☐ Expected post-training functions
☐ Must have had 2 years and more of experience at the Primary Health Care Level
☐ Willing to attend the X days of theoretical training organized on weekly basis; over the course of Y weeks.
☐ Willing to commit to 3 mandatory On the Job Training sessions, and ongoing supportive supervision.

It is important that the application process be initiated through a public announcement of the upcoming mhGAP training. A checklist for standard announcements can be found below:

<table>
<thead>
<tr>
<th>Training Event Information:</th>
<th>Standard Information:</th>
<th>Application Information:</th>
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</thead>
<tbody>
<tr>
<td>☐ Title of Training</td>
<td>☐ Free (incentives if any)</td>
<td>☐ Where to pick up applications</td>
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<tr>
<td>☐ Start Date</td>
<td>☐ Priority groups/areas</td>
<td>☐ Where to submit applications</td>
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<tr>
<td>☐ End Date</td>
<td>☐ Organizers/Funding agency</td>
<td>☐ Application deadline</td>
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<td>☐ Total number of hours</td>
<td>☐ Contact Person, Contact Number</td>
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</table>
Ensuring Sustainability
The key step to ensuring sustainability of supportive supervision is to institutionalize it within the government system. This can be done in several ways:

- Incorporate supervision into the national budget and work plan or into the district-level micro-plans. This helps make supervision a recurring, funded cost.
- Increase decision maker and manager awareness of the benefits of supportive supervision by:
  - Collecting data on positive results gained from supportive supervision, such as improved performance of health workers, improved mental health coverage, or positive patient outcomes.
  - Lobbying government officials and decision makers on the benefits and effectiveness of supportive supervision. Show data on improved quality, cost-effectiveness, and increased coverage.
  - Continually advocating for supportive supervision at the central-, district-, and health center-levels to maintain visibility of supportive supervision as a key element to quality service delivery.
- Develop a team approach to increase supportive supervision at a health facility and make it a routine procedure, with or without frequent visits from the central or district level. Health facility staff can develop supervision plans that fit their structures and conduct regular self-assessments to monitor their performance.

However, in Lebanon, national efforts for mental health have been almost entirely funded and supported by International Medical Corps, and UNICEF, as key partners of the MOPH’s NMHP. Institutionalization of supportive supervision within the government is contingent on the commitment of its current partners to continue supporting national efforts, and work towards a phased handover process that would allow the government to gradually take more ownership and responsibility.

Accordingly, the first step towards sustainability is to have a joint Memorandum of Understanding between the MOPH, World Health Organization, International Medical Corps, UNICEF, and other potential supporting partners, that delineates roles, responsibilities, commitments and ownership, with a clear multi-year timeline for handover to the MOPH.

D. Suggested One Year Work Plan for National Supportive Supervision

Process
This document suggests a 1-year work plan for scaling up mental health services in Lebanon, in line with suggested supportive supervision model in the same report, and has been developed in accordance with the below process for setting up a supportive supervision system.

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<thead>
<tr>
<th>Setting up a supportive supervision system</th>
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<tbody>
<tr>
<td>Training a core set of supervisors</td>
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<td>(1 training &amp; supervision team per district)</td>
</tr>
<tr>
<td>Creating/adapting checklists and recording forms</td>
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<tr>
<td>Ensuring appropriate resources are available- vehicles, per diem, areas for collaboration with other programs</td>
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</table>

<table>
<thead>
<tr>
<th>Planning regular supervisory visits</th>
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<tbody>
<tr>
<td>Where: using data to decide priority supervision sites</td>
</tr>
<tr>
<td>When: Schedule supervision visits using a workplan</td>
</tr>
<tr>
<td>What subjects to train: identifying training needs and skills that need updating</td>
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</tbody>
</table>

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<thead>
<tr>
<th>Conducting supportive supervision visits</th>
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<tbody>
<tr>
<td>Observation &amp; Case Discussions</td>
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<tr>
<td>Use of data</td>
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<td>Problem-solving</td>
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<td>On-the-job training</td>
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<td>Recording observations and feedback</td>
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<th>Follow-up</th>
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<tr>
<td>Follow up on agreed actions by supervisors and supervised PHC staff</td>
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<td>Regular data analysis</td>
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<tr>
<td>Consolidated monthly Feedback/report to stakeholders: MOH, WHO, IMC</td>
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</table>

Source (adapted from): Module 4. Supportive supervision Training for mid-level managers (MLM) - WHO/IVB/08.04
**Stages, Objectives and Activities in Supervision**

<table>
<thead>
<tr>
<th>Stages</th>
<th>Objectives</th>
<th>Activities</th>
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</table>
| Stage 1     | Preparation for Supervision | • Set goals and priorities for supervision (e.g. regular review of caseload, assistance with difficult cases, ongoing development of clinical competencies)  
• Prepare a supervision schedule (e.g. once every two weeks for one hour) |
| Stage 2     | Conducting Supervision     | • Establish contact with those being supervised  
• Review objectives and norms  
• Observe workers as they carry out tasks  
• Provide feedback and discuss observed tasks  
• Discuss any other outstanding issues or concerns |
| Stage 3     | Follow-up of Supervision   | • Formalize feedback in reports or evaluation forms  
• Organize training program, if necessary  
• Make changes to organization or logistical support, if necessary  
• Reorganize scheduling, goals and priorities, if necessary |

**Setting Up Levels And Frequency Of Supervision**

The team is developing a system to identify high performing, lesser performing, and poor performing health centers. Each center would receive more or less frequent supervision visits according to their status. The status of the centers would be regularly evaluated based on service improvements or declines and performance levels and status would change accordingly. The criteria for each of the three levels would continually increase, encouraging the centers to improve their performance when compared to their colleagues in other health centers.

**Frequency of clinical supervision**

The following table provides recommendations for determining the frequency of clinical and supportive supervision. It is expected that additional factors, such as the availability of supervisors, may further impact frequency. The below guidance is meant to help draw out supervision visits, and should be considered in parallel to ongoing availability of supervisors’ support either by telephone or field visit as requested by supervised PHC providers.

<table>
<thead>
<tr>
<th>Level of Clinical Supervision</th>
<th>Weighting Factors</th>
<th>Minimum Expected Frequency(^1)</th>
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</thead>
</table>
| Level 1                       | Novice practitioner (PHC doctor or nurse):  
• With limited practice experience in mental health.  
• Have not completed minimum of 3 on the job training sessions since completion of theoretical mhGAP training.  
• Showing low competency levels as documented through on the job-training checklist. | Four hours of individual or group supervision monthly. At least 50 per cent of supervision should be on an individual basis. |
| Level 2                       | Completed requirements for on the job training (3 sessions following completion of theoretical training)*  
• Showing low competency levels as documented through on the job-training checklist. | Two (2) hours of individual or group supervision monthly. At least 50 per cent of supervision should be on an individual basis. |

\(^1\) Number of supervision hours to revised based on number of supervisors available as part of national supervision plan, and number of supervision units established.
## Level of Clinical Supervision | Weighting Factors | Minimum Expected Frequency
---|---|---
### Level 3
Low frequency clinical and supportive supervision
- Experienced PHC providers with more than 1 year of practice providing mental health through the PHC
- Completed requirements for on the job training (3 sessions following completion of theoretical training)\(^*\)
- Showing medium to high competency levels as documented through on the job-training checklist.
One (1) hour of individual or group supervision bi-monthly. At least 50 per cent of supervision should be on an individual basis.

* Note: Completion of the required 3 job training sessions, determines the frequency of ongoing supportive supervision sessions needed for trained PHC providers, based on competency levels assessed (these are frequency levels 2 or 3). The required 3 on the job training sessions are not sufficient for successful integration, and used here only to determine frequency of ongoing supportive supervision needed.

## Frequency of Supervision for Supervisors/Master Trainers
Supervision of supervision should be provided only by a Mental Health expert (a Master Trainer) who has a high level of demonstrated competence in the provision of practice supervision.

<table>
<thead>
<tr>
<th>Level of Clinical Supervision</th>
<th>Weighting Factors</th>
<th>Minimum Expected Frequency</th>
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</thead>
</table>
| **Level 1**
High frequency supervision of supervision | Novice supervisor with less than five (5) years of supervisory experience | One (1) hour of individual or group supervision fortnightly |
| **Level 2**
Low frequency supervision of supervision | Experienced supervisors | One (1) hour of individual or group supervision monthly |

* Adapted from: Clinical Supervision Guidelines for Mental Health Services, Queensland Health (2009)
### Table 2: Suggested Work-Plan

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<thead>
<tr>
<th>Months:</th>
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<tbody>
<tr>
<td><strong>Trainers and Supervisors</strong></td>
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<tr>
<td># Orientation for Master Trainers</td>
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<tr>
<td>1</td>
<td>Set up national training for local psychiatrists, on mhGAP and scaling up mental health services in country.</td>
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<td>2</td>
<td>Identify Core Master trainers to be utilized for rolling out TOT for district training and supervision teams, and who will provide ongoing support and supervision to these teams through monthly or quarterly follow up training (to be identified based on supervision frequency determination guidance)</td>
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<tr>
<td><strong># Training and Supervision Teams</strong></td>
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<td>1</td>
<td>Carry out TOT for training and supervision</td>
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<td>2</td>
<td>Establish training and supervision teams consisting of: Psychologist, and psychiatric nurse OR social worker, that can be dispatched to different districts based on supportive supervision needs.</td>
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<td>3</td>
<td>Identify 1 psychiatrist per district to serve as referral point for clinical support and management, and consultation on complicated and emergency cases. (In line with existing national efforts for developing a MHPSS referral system)</td>
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<td>4</td>
<td>Select Senior PHC provider per area to engage in supportive supervision</td>
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<td>5</td>
<td>Establish peer level supervision organized between PHC staff</td>
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<td><strong>Training for PHC providers</strong></td>
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<td># Recruitment and theoretical training</td>
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<td>1</td>
<td>Orientation for PHC managers and key government staff on importance of integration of MH into PHC</td>
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<td>2</td>
<td>Set up and carry out formal recruitment process of PHC providers</td>
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<td>3</td>
<td>Assess organizational level integration of MH in PHC (WHO tool) for PHC clinics who nominate PHC providers for training.</td>
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<td>4</td>
<td>Carry out Theoretical Training for PHC providers per district in 4 stages</td>
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<tr>
<td># Core on the job training and supervision</td>
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<tr>
<td>1</td>
<td>Develop supervision plan, including type of supervision (one on one, group, etc.)</td>
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<td>2</td>
<td>Carry out a minimum of 3 on the job training and supervision sessions for each trainee.</td>
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<td>3</td>
<td>Develop comprehensive and individualized trainee competency reports as part of M&amp;E, which will inform frequency of ongoing supportive sessions per trainee.</td>
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<td><strong>Ongoing Supportive Supervision</strong></td>
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<tr>
<td># Organize regular visits per district using frequency determination criteria</td>
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<td>1</td>
<td>Develop a supervision plan indicating frequency and type of visits per district based on identified training needs (see frequency determination guidance in this document)</td>
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<td>2</td>
<td>Carry out Supportive Supervision</td>
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### Monthly Monitoring and Evaluation

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<th>Months:</th>
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<tbody>
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<td><strong>Monitoring and Evaluation</strong></td>
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<td>1</td>
<td>Identify M&amp;E focal point/expert to help set up M&amp;E system, support and follow up on its implementation, and develop bi-monthly reports that should inform the project components of training, supervision, and data collection.</td>
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<td>2</td>
<td>Set up a system for monitoring and evaluation including what data to collect, those involved in collecting and consolidating data for analysis.</td>
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### Ongoing Supportive Supervision

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<th>Months:</th>
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<td><strong>Ongoing Supportive Supervision</strong></td>
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<td>1</td>
<td>Develop a signed agreement (continuation of previous MOU agreement) with MOPH and LOP for accreditation of mhGAP foundational training and ongoing supportive supervision hours.</td>
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<td>2</td>
<td>Establish clear plan for a continuing policy dialogue with MOPH</td>
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<td>3</td>
<td>Advocate for the integration of MH into the Lebanon essential package of health, medicine supply, Health management information System (HMIS), support and supervision to primary care, Local Accreditation of Training.</td>
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<td>4</td>
<td>Identify local training institution relevant for CME and CPD for primary care</td>
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<td>5</td>
<td>Distribute training course materials to training institutions for integration into basic, post basic and CPD curricula.</td>
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**E. Suggested System for Monitoring and Evaluation**

A system for monitoring and evaluation needs to be in place, one which assesses: Knowledge and clinical competencies among trainees, client service provision (identification, management, and referral), client satisfaction with services, client outcomes, and organizational level change in collaboration with select clinics and work of the supervision unit.

The following tools are examples of what should be employed:

**1. Service provision (log tracking form)**
Trainees will track cases with mental health problems using daily log sheets which include identification and diagnosis, management (what type of intervention was employed, including pharmacological and non-pharmacological intervention) and referral (type of service provider referred to)

**Sampling & Recruitment Plan:** All patients with mental health problems seen at the clinics

**2. Mental health knowledge (pre-post training KAP test) and competencies (on the job evaluation checklist)**
Increase in mental health knowledge will be assessed utilizing KAP tests administered before and after completion of the theoretical training. Clinical skills and competencies will be assessed by trainers administering on the job evaluation checklists to each trainee during the on-the-job supervision. The checklist measures key competencies such as appropriate assessment and diagnosis, management, clinical record keeping, communication and professionalism.

**Sampling & Recruitment Plan:** All trainees receiving training in mental health.

**Selection of Instruments:** Instruments developed locally by country team in coordination with local trainers who develop the training material based on the WHO (2010). mhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized health settings. Version 1.0. WHO, Geneva, Switzerland.

**3. Client feedback and satisfaction with services (pre-post client satisfaction survey)**
Client feedback and satisfaction with services will be assessed among samples of clients visiting PHC clinics throughout the program period. Satisfaction surveys will assess the clients satisfaction with the clinical encounter and perceived quality of service provision.

**Sampling & Recruitment Plan:** All patients receiving services at the PHC clinics.
Variables: NA

Selection of Instruments: IMC has developed a set of satisfaction surveys in the Middle East region. Instrument will be selected in coordination with local mental health team.

Adaptation: instrument will be adapted for use in Lebanon through focus group discussions with patients.

4. Client Outcomes
Client outcomes including improvement in functioning, and access to services will be measured among those clients referred to social workers at the PHC level.

Sampling & Recruitment Plan: All patients diagnosed with depression at the PHC level by case management team.

Selection of Instruments: IMC has a locally developed and culturally appropriate functioning scale, based on the Bolton method for developing a functioning scale. The scale has been validated, and is administered at 0, 3, and 6 months for MH cases diagnosed at PHC clinics where PHC providers were trained in the South of Lebanon. The scale has also been adapted for use in Syria and Turkey with Syrians. Further adaptation may be needed for use across all districts in Lebanon.

5. Mental health integration at the organizational level (PHC integration checklist)
PHC clinics will be selected based on commitment to integrating mental health into clinical services. A PHC MH integration checklist will be administered to each PHC clinic before and after completion of the training to track organizational level change. Criteria include information on roles and responsibilities in addressing mental health problems, tracking of mental health as part of the Health Information System, referral pathways, multi-disciplinary coordination and communication, and availability and use of psychotropic medications. Those standards and criteria will be monitored and shared with PHC clinics heads, with the goal of facilitating integration at the organizational level and sharing results and lessons learned with other relevant stakeholders and organizations (e.g. WHO, MOPH).

INDICATORS
Following the first use of the PHC integration checklist at the PHC level, agreement on indicators for successful integration of MH into PHC will need to be finalized in accordance with the below structure:

a. Training indicators
i. X PHC providers complete mental health training and/or orientation sessions on importance of MH [indicator # to be developed in accordance with national plan, and capacity for training]
ii. 85% of PHC trainees who complete the theoretical training receive a minimum of 3 on-the-job supervised clinical sessions

b. Outcome indicators
i. 85% of PHC providers who complete trainings reach minimum competency standards, with 60% achieving high competency standards, in performing mental health consultations, in accordance with IMC training. (Diagnosis, management, prescription, appropriate referral to specialized services or trained PHC colleague)
ii. 85% of cases of depression [Selection of MH disorder to be in line with priority conditions and most common MH conditions managed at the PHC level in Lebanon] managed at the PHC level show an improvement in functioning as measured by a culturally appropriate scale.

c. Process indicators
i. Increase in number of peer supervision team meetings among PHC staff to discuss management of mental health cases.
ii. Increase in number of referrals between trained PHC staff (e.g. from nurses to doctors, and vice versa)
iii. Decrease in number of referrals to training and supervision team and identified local psychiatrist for clinical care.
iv. Availability of medication at the PHC clinics
v. Improvement in documentation of MH cases (HIS)
vi. Decrease in number of training and supervision team visits to clinics (nurse, psychologist, psychiatrist)
vii. Voluntarily seeking technical advice/calls to training and supervision team members by trained PHC staff

d. Performance Monitoring
The below timeframe describes expected performance of trained PHC doctors over the course of a 6 month period, for those who: 1) Complete theoretical training in mhGAP covering priority conditions, 2) Complete 3 on the job training sessions, and 3) Receive ongoing supportive supervision for a period of 6 months whereby frequency of supportive supervision sessions/visits during these 6 months is determined by competency levels assessed during the first 3 on the job training sessions completed.

2 These suggested expectancies developed with support from IMC’s regional mental health advisor, using Turkey’s integration model as a reference, and would need to be further developed, and contextually adapted, by trainers/supervisors.
CONCLUSION

Supportive supervision remains a high priority and a critical gap in mental health training of healthcare providers. The Support and Supervision Model proposed by International Medical Corps in support of the NMHP in Lebanon, has been developed in response to this need. The Model should be adapted based on local resources and capacities, and further developed and rolled out by the NMHP in the Lebanese MOPH, and supporting agencies and country staff such as WHO, UNICEF and International Medical Corps.

REFERENCES


Month 1
- Able to collect information from patient and family, including patient history.
- Able to carry out a risk assessment.

Month 2
- Able to assess for/diagnose MH priority conditions.
- Prescribe and manage conditions using medications.
  - Able to adjust dose and manage side effects.

Month 3
- Able to take on new cases, and manage those with chronic conditions or in need of regular follow up, under close supervision of trainer/supervisor.

Month 4
- Able to independently manage 60 to 65 % of cases, making appropriate referrals to specialist as needed.

Month 5
- Able to independently manage approx. 80% of cases, making appropriate referrals to specialist as needed.

Month 6
- Competent in dealing with emergency cases, and maintaining regular case flow.
- Knowledgeable and has a good understanding of community psychosocial support, and able to work collaboratively with mid level staff including caseworkers and nurses, both receiving referrals, and making referrals to them.
ANNEXES

You can open the annexes by double clicking on the following icon: