Impact assessment of mhGAP training
Evidence from the Ministry of Health–WHO training programme in Turkey
Abstract

Over 3300 health professionals in Turkey received training in mental health and psychosocial support topics between 2017 and 2019 in the Mental Health Gap Action Programme (mhGAP), a joint Ministry of Health and WHO initiative. Syrian and Turkish health professionals currently provide mental health and psychosocial services to over 3.6 million Syrians under temporary protection in Turkey. A multicomponent impact assessment of mhGAP training was commissioned (with European Union funding) to determine the usefulness of the training programme in preparation for further mhGAP training from 2020 onwards. The assessment comprised an online survey, pre-/post-tests for trainees, an analysis of health-care utilization by trainees, compliance of trainees with mhGAP service guidelines, and patient exit interviews. The main findings were that trainees were satisfied with mhGAP training and gained significant knowledge that was attributable to the training. Both health service utilization and quality of service provision (in most categories) were improved after training. Finally, patients were highly satisfied with the mental health and psychosocial service provision.

Keywords

MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT  
MHPSS  
SYRIANS  
REFUGEES/MIGRANTS  
TRAINING
Impact assessment of mhGAP training
Evidence from the Ministry of Health–WHO training programme in Turkey
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The conflict in the Syrian Arab Republic has caused one of the world’s largest and most dynamic displacement crises, affecting millions of lives. WHO is supporting the response to the crisis through its operations in Turkey, which comprise a cross-border response from the field office in Gaziantep and a health response to refugees in Turkey, coordinated by the WHO Country Office in Ankara. In north-western Syrian Arab Republic, WHO is implementing interventions such as the delivery of vital medicines and medical supplies and providing support for the operational costs of health facilities and capacity-building of health staff. Through the Refugee Health Programme in Turkey, efforts have been made to strengthen the national health system through integrating Syrian health workers and translators, building capacity for mental health care, providing linguistic and culturally sensitive health services, and supporting home care for older refugees and those with disabilities.

Activities of the Programme are defined within the scope of the Regional Refugee and Resilience Plan 2018–2019, a broad partnership platform for over 270 development and humanitarian partners to provide coordinated support in countries bordering the Syrian Arab Republic that are heavily impacted by the influx of refugees. This platform capitalizes on the knowledge, capacities and resources of humanitarian and development actors to provide a single strategic, multisectoral and resilience-based response. Supported by several donors, WHO’s activities are complementary to the Ministry of Health-implemented SIHHAT (Improving the health status of the Syrian population under temporary protection and related services provided by Turkish authorities) project that is funded by the European Union (EU). This project operates under the EU Facility for Refugees in Turkey and focuses on strengthening the provision of primary and secondary health-care services to Syrian refugees, building and supporting a network of migrant health centres across the country, and employing additional health personnel, including Syrian doctors and nurses.

In November 2018 the Refugee Health Programme conducted the Workshop on Refugee and Migrant Health in Turkey: Survey and Research Consultation to identify gaps in the information and evidence required for Programme development and adaptation and for informing policies on migrant health in Turkey. The Workshop brought together more than 57 national and international experts from academia, the Ministry of Health, United Nations agencies and WHO collaborating centres and led to the formulation of the Programme’s research framework. Within this framework, a series of studies was implemented in the fields of mental health, health literacy, women and child health, health workforce, and noncommunicable diseases. This study, Impact assessment of mhGAP training: evidence from the Ministry of Health–WHO training programme in Turkey, is one of the studies implemented within the Refugee Health Programme’s research framework. It was implemented within the scope of the Improved access to health services for Syrian refugees in Turkey project with funding from the EU Regional Trust Fund in Response to the Syrian Crisis.
Acknowledgements

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WHO Country Office in Turkey would also like to thank the thousands of health and social care professionals who are providing much-needed MHPSS services to millions of refugees and host population alike. You are an inspiration to us.

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Abbreviations

EU European Union
MHC migrant health centre
mhGAP Mental Health Gap Action Programme
MHPSS mental health and psychosocial support
MHTC migrant health training centre
MNS mental, neurological and substance use (disorders)
OR odds ratio
PHC primary health care
SD standard deviation
SIHHAT Improving the health status of the Syrian population under temporary protection and related services provided by Turkish authorities (project)
Executive summary

Turkey is currently hosting 3.6 million Syrian refugees. Refugees and migrants suffer a higher burden of mental disorders compared with host populations. The Ministry of Health and WHO designed and implemented Mental Health Gap Action Programme (mhGAP) training in Turkey to empower health professionals to respond to the increased unmet needs for mental health and psychosocial support (MHPSS). By the end of 2019, about 3300 Syrian and Turkish health professionals employed in the Turkish health system had graduated from the WHO-supported training course. This study aimed to measure the usefulness of mhGAP training and its impact on the utilization and quality of MHPSS services and the health status of beneficiaries.

The study comprised five separate components that describe (i) the general impression of mhGAP graduates on the training received; (ii) the amount of knowledge gained that was attributable to the mhGAP training; (iii) the increased utilization of MHPSS services by comparing the number of mental health patients diagnosed in the year before and the year after mhGAP training; (iv) compliance with the quality-of-service guidelines discussed during MHPSS training; and (v) the level of service-user satisfaction with services, as a proxy for health status impact.

Data were collected for graduates that had successfully completed the mhGAP training between November 2018 and November 2019. Although each component included different groups of respondents and collected data from different periods and for different purposes, the combined results provide strong evidence that the study’s objectives had been achieved. About 96% of the graduates surveyed reported that mhGAP training had been useful. The most useful topics were Mental health promotion and Depression. Over 80% of respondents said that they would welcome additional mhGAP training. The study confirmed that both Turkish and Syrian doctors gained knowledge from the training course: the gain of 5–9% was statistically significant and attributable to mhGAP training.

The gain in knowledge was reflected in improved practice: on average, 38 additional mental health diagnoses were made by doctors in the year after training. This increase was statistically significant and was observed for most types of mental health diagnoses (all except one) and for all age groups older than 19 years. The greatest increases were for depression, acute stress disorder, and child behavioural and emotional adverse development.

For the 12 categories of training quality guidance, rates of compliance at facility level were high for the guidelines 1–6 (range: 75–84%) and medium for guidelines 7–12 (range: 40–75%). Of the latter, only two guidelines (on emergency treatment and pharmaceutical treatment) had compliance rates of 40%.

The final, and most important, component measured service-user satisfaction with MHPSS services. Most service users were women aged 21–40 years (77%) and most were married (76%). About 95% of service users were satisfied with the quality of the MHPSS services, and 93% had had their needs met. About two thirds had attended the facility for a consultation and 32% had also been prescribed treatment. The median waiting time was five minutes. Over 97% of service users were satisfied with the level of patient confidentiality, relationship with the service provider, facility opening hours or waiting times, length or frequency of appointments, and information on their health status or treatment received. The same high percentage reported that they would return for the same service in the future and would recommend the service to family members.

These data suggest that mhGAP training was useful to Turkish and Syrian doctors and that service users are satisfied with the services provided. Nevertheless, unmet needs have been exacerbated by the 2019 Novel Coronavirus Disease (COVID-19) pandemic. Moreover, the study found that although MHPSS training for health and social care professionals has translated into increased quantity and quality of service provision, further training is needed and must be supported.

Based on the findings and the conclusions of this assessment, the Ministry of Health and WHO continued to provide mhGAP training for health personnel.
throughout the COVID-19 pandemic in 2020 via open-air face-to-face and online training sessions. With European Union (EU) funding, WHO developed a distance learning platform containing, among others, a mhGAP training module for Syrian and Turkish doctors. Preliminary results from the online training course indicate that it achieved the same level of knowledge transfer as face-to-face training.

The COVID-19 pandemic has worsened the mental health status of both host and refugee populations. Prolonged social distancing and frequent curfews have increased the need for MHPSS services at all levels of care. Therefore, further studies are warranted to properly understand the impact of the pandemic on the mental health of refugee and vulnerable populations.
Impact assessment of mhGAP training

Introduction

Background

Syrian refugees in Turkey

Turkey is hosting the largest refugee population of any country since the Second World War. By mid-2020, about 3.6 million Syrians were included in the temporary protection scheme in Turkey (1). The Turkish Government and Turkish people have welcomed Syrians fleeing the conflict in their home country since 2011.

In Turkey, the Foreigners and International Protection Law defines three groups of international protection status (2). Following approval of applications for international protection by foreigners, the Law defines and awards the status of:

1. refugee, under Article 61 of the Law
2. conditional refugee, under Article 62
3. subsidiary protection, under Article 63.

For foreigners who have been forced to leave their country and cannot return, the Law provides emergency and temporary protection under Article 91. Most refugees in Turkey are classified as Syrians under temporary protection. Others include Afghans, Iranians and migrants from north Africa. In Turkey, the Directorate General of Migration Management has overall responsibility for caring for refugees and the Ministry of Health has provided millions of free medical consultations to Syrians under temporary protection through the Improving the health status of the Syrian population under temporary protection and related services provided by Turkish authorities (SIHHAT) project (organized as part of primary health care (PHC)) and in hospitals in 29 provinces (3).

In Turkey, Syrians under temporary protection enjoy the same rights and access to PHC services as the host population. To receive free health care at the secondary and tertiary levels, Syrians under temporary protection must have proof of registration in the country (identity cards) and be referred by a PHC physician. Access to PHC is ensured to all Syrians under temporary protection, whereas access to secondary and tertiary care requires additional support for transportation and/or interpretation (which is not provided through the SIHHAT project) (4).

Compared with the host population, Syrians under temporary protection live in larger households and have lower health literacy.1 They prefer to receive health communication through social media and word of mouth (through friends and family); less than 10% rely on official communication from Government sources (5).

Although refugees/migrants have different demographic characteristics from the host population, previous surveys on noncommunicable diseases found that morbidity levels were similar among refugees and the host population (6). Syrians under temporary protection in Turkey are thought to smoke and drink less than the host population.

Mental health needs of refugees

Refugees and migrants have higher mental health needs compared with the host population. Refugees come from areas of conflict and many have witnessed traumatic events such as the destruction of their property and the death of family members or friends, and often suffer from mental disorders that require long-term treatment (7). The most useful mhGAP training modules were those on depression, mental health issues for adolescents and children, and stress-related disorders from adapting to life in a new country.2 A 2016 household survey commissioned by WHO found that 38% of respondents have signs and symptoms that could easily be identified as major depression.3

The mental health needs of the Syrians under temporary protection are met by the pyramid of services (Fig. 1). WHO and the Turkish Ministry of Health have jointly designed and implemented a training programme for mental health professionals, social workers and

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1 Preliminary results from WHO surveys, unpublished.
2 WHO, unpublished data.
psychologists who provide services at different levels of the pyramid (Table 1). The training courses were designed to enhance the ability of PHC professionals to identify, diagnose and treat mental disorders among refugees, based on existing WHO and Ministry of Health training programmes and tailored to the different categories of health-care professionals. In Turkey, the mental health needs of Syrians under temporary protection are reported and addressed by both Syrian and Turkish health professionals working at all levels of health care (not only in PHC) (8).

**Table 1.** Planned training courses for mental health based on the mental health pyramid

<table>
<thead>
<tr>
<th>Level</th>
<th>Planned WHO support</th>
</tr>
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<tbody>
<tr>
<td>Long-stay facilities &amp; specialist services</td>
<td>Training of translators</td>
</tr>
<tr>
<td>Community mental health services &amp; psychiatric services in general hospitals</td>
<td>Strengthen training for health-care staff on human rights and culture-specific mental health issues</td>
</tr>
<tr>
<td></td>
<td>Guidelines &amp; algorithms for health-care staff</td>
</tr>
<tr>
<td>Mental health services through PHC</td>
<td>Training for PHC staff (mhGAP training) and MHC staff (mhGAP training for doctors, early identification &amp; support programmes such as ECD project training for nurses), training for social workers and psychologists</td>
</tr>
<tr>
<td>Informal community care</td>
<td>Acculturation stress/managing the mental health effects of adaptation problems</td>
</tr>
<tr>
<td></td>
<td>Well-being programmes</td>
</tr>
</tbody>
</table>

ECD: early childhood development; MHC: migrant health centre.
Mental health in pandemics
The COVID-19 pandemic was proclaimed a public health emergency of international concern by WHO in early 2020 (10). Since then, most activities related to PHC have been reduced as part of the measures to protect PHC health staff from unnecessary contact and allow them to focus on the pandemic. A decrease of 70% in psychosocial support consultations was registered during the first six months of the pandemic. Unmet mental health needs have grown during the pandemic for two reasons: (i) the number of consultations has decreased; and (ii) anxiety levels have increased because of prolonged quarantine, working from home, social distancing and uncertainty about the future. In response, the Ministry of Health and WHO established helplines for beneficiaries seeking medical help.

Mental health services for refugees
Previous surveys indicated that almost half of Syrians under temporary protection would choose to return to their home country if conditions there improved (11). This means that access to health services should be sustainable, equitable and affordable for the remaining half.

Migrant health centres (MHCs) have been established in Turkish provinces with a high density of refugees to provide quality PHC services more effectively to Syrians under temporary protection (3). Owing to the limited workforce for mental health care in Turkey and language barriers with refugee populations, refugees are more likely to contact a general physician than a mental health specialist. Therefore, WHO mhGAP was adapted to the Turkish context and the Strengthening Mental Health Services programme was created to strengthen PHC services through the use of evidence-based mental health intervention guides and increasing the awareness of general physicians about psychosocial support and clinical treatment methods for people with mental disorders. The aim is for PHC institutions to provide psychosocial support services as well as clinical treatment for refugees with mental health problems.

In addition, psychosocial support units were established in migrant health training centres (MHTCs) and some MHCs to provide mental health services for refugees. The mental health services are provided by psychologists and social workers, supported by Arabic-speaking interpreters, assigned to these units. By January 2020, psychosocial support services were provided in 17 provinces and 41 centres in Turkey (3).

MHPSS training
Since 2016, the legal entitlement to employment in Turkey (12) has given Syrians under temporary protection hope for a new beginning in Turkey. Employment for Syrian doctors and nurses was made possible through the SIHHAT project (3), which is directly funded by the EU Facility for Refugees in Turkey (13).

By mid-2020, approximately 3300 Syrian health professionals and support staff had been employed by the SIHHAT project to work in a PHC network of 178 MHCs located in 29 Turkish provinces. The Ministry of Health is responsible for recruiting Syrian doctors, nurses, bilingual patient guides and other health professionals who have completed WHO-supported tailored adaptation training (3). The adaptation training programme consists of one week of theoretical training and six weeks of practical training. Practical training courses for Syrian doctor and nurses takes place in seven MHTCs (one in each of seven provinces: Ankara, Istanbul, Izmir, Gaziantep, Hatay, Mersin and Şanlıurfa) (14).

A long-term aim for the Ministry of Health, WHO and the donor community is the integration of Syrian health professionals into the Turkish health system. The training and recruitment of Syrian health professionals into the Turkish national health system has required a lot of resources and time. The intention is to train a well-motivated health workforce to provide quality essential health services free of charge to Syrian refugees in Turkey (15).

MHPSS training for Syrian and Turkish health professionals consists of mhGAP training for doctors and psychosocial support training (e.g. early childhood development, gender-based violence, trauma and psychological interventions) for all other staff. The mhGAP Intervention Guide was developed to train doctors, nurses or other health professionals working in non-specialized health settings on mental, neurological and substance use (MNS) disorders and

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5 Online survey on COVID-19 impact on refugees, Turkey 3RP Health Sector, unpublished data, 2020.
was first published in 2010 (16). The revised, updated and expanded version, mhGAP Intervention Guide Version 2.0 (published in 2016), was used for mhGAP training in Turkey (17). The training material was tested at the start of 2017, with minor improvements made in mid-2017. Training for trainers in early 2017 was followed by cascade training. Since then, approximately 3300 Syrian and Turkish doctors and nurses have completed MHPSS training (Table 2).

The MHPSS training programme has received over US$ 3 million of funding support from multiple donors. This makes it one of the largest training efforts related to MHPSS in Turkey in recent years: the number of professionals trained and the amount of resources used for training them is unprecedented. This reflects the large number of refugees and their considerable unmet needs. Based on its success in supporting refugee health in the country, the Ministry of Health has asked WHO to continue providing support for the training programme.

The MHPSS training partnership
MHPSS training was provided through partnership between the Turkish Ministry of Health and WHO and implementing partners. The mhGAP training manual was first translated to Turkish and Arabic and then converted into an electronic version. The joint training team consisted of Ministry of Health officials, WHO staff and experienced trainers. The training programme followed a pre-approved plan that included cohorts and training topics in different provinces. The joint training teams completed all planned training courses within the planned schedule and budget. Before initiating more training courses, the Ministry of Health and WHO wanted to measure the impact of the training and resulting improvements in the quality of service for Syrians under temporary protection. The experience of training more than 3318 Syrian and Turkish health and social care professionals prepared the way for future high-quality training courses.

Table 2. Health and social care professionals trained, by donor and training programme

<table>
<thead>
<tr>
<th>Donor</th>
<th>Syrian</th>
<th></th>
<th>Turkish</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Othera</td>
<td>mhGAP</td>
<td>Total</td>
<td>Othera</td>
</tr>
<tr>
<td>ECHO</td>
<td>100</td>
<td>301</td>
<td>401</td>
<td>811</td>
</tr>
<tr>
<td>EUTF</td>
<td>287</td>
<td>130</td>
<td>417</td>
<td>230</td>
</tr>
<tr>
<td>KfW</td>
<td>422</td>
<td>140</td>
<td>562</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>809</td>
<td>571</td>
<td>1380</td>
<td>1041</td>
</tr>
</tbody>
</table>


a Training in early childhood development, gender-based violence, and trauma and psychological interventions.
Objectives
The Ministry of Health and WHO have provided MHPSS training for thousands of Syrian and Turkish health and social care professionals at considerable human and financial cost. The aim was to better serve the unmet mental health needs of Syrian refugees by improving the ability of Syrian and Turkish health professionals to identify, diagnose and treat mental disorders and provide psychosocial support. The training programme was designed to increase the knowledge of health professionals and improve the quality of free MHPSS services for all Syrians under temporary protection. Further training needs were identified in late 2019.

However, before committing resources to provide further training courses in 2020, it was necessary to evaluate the previous training programme. This impact assessment aimed to quantify the benefits of MHPSS training and any improvements in the quality of service and service-user satisfaction (with MHPSS services) that could be attributed to the training programme.

Methodology
The study design included a set of components to specifically assess the training process, knowledge gained by health professionals, utilization of MHPSS services, quality of MHPSS services and improvements in the health of Syrians under temporary protection (Fig. 2; the number of participants is shown for each component).

Online survey
To improve mhGAP training, the Ministry of Health and WHO conducted an online survey in early 2019 to capture the overall impression of recent graduates with the training. The survey questionnaire (Annex 1) was posted online using Google Forms and administered by the Ministry of Health. A link to the survey was sent to all recent graduates of the mhGAP programme. All responses were downloaded into a Microsoft Excel spreadsheet and analysed using Stata Statistical Software: Release 16 (StataCorp).

Fig. 2. Study components and steps

Online survey
- General impressions
- Recommendations
  (211 Turkish doctors)

Pre-/post-tests
- Measured as correct answers*
  (388 Turkish doctors, 207 Syrian doctors)

Mental health patients
- Diagnosed before/after the training programme
  (188 Turkish doctors)

Direct observations
- Compliance with training modules and guidelines
  (100 doctors)

Patient exit interviews
- Self-reported perceived quality of service
  (357 patients)

* Student t-test.

The survey included questions on the following topics, with the option for Yes/No answers:

- usefulness of the training
- most useful topics
- least useful topics
- satisfaction with training format
- changes suggested to the training programme
- new topics suggested for inclusion
- satisfaction with the psychosocial support note
- satisfaction with psychoeducation
- difficulties with psychoeducation
- additional psychoeducation needed
- additional mhGAP training needed.

Data were not collected on the demographic or other characteristics of respondents. As the survey was anonymous, it is impossible to assess potential differences between respondents and non-respondents. The feedback provided an insight into the respondents’ perception of mhGAP training and the need for any changes.

**Knowledge gained**

Pre-/post-testing of the mhGAP training module (questions shown in Annex 2) was conducted as part of the standard activities of all WHO-supported training in Turkey in 2008 and 2019. This was done by administering the same set of questions before the start of mhGAP training and one week after its completion (performed jointly with the Ministry of Health). Responses to the 25 questions were converted into a success rate (for each trainee) and the gain in knowledge (if any) was measured using a paired Student t-test (separately for Syrian and Turkish health professionals). The questions were related to the clinical topics covered by the mhGAP programme. A statistical significance level of \( P < 0.05 \) indicated that the gain in knowledge was attributable to MHPSS training. The average percentage gain in knowledge is reported separately for each group.

It was not possible to conduct pre-/post-testing for all graduates of mhGAP training. As no data on demographic or other characteristics of respondents were collected, nor was it possible to identify groups with lower/higher knowledge gains or any differences between respondents versus non-respondents. All hard copies of pre-/post-tests were anonymous and responses to survey questions were entered into a Microsoft Excel spreadsheet and analysed using Stata. Correct answers were assigned a value of 1 and incorrect answers a value of 0 using the Correct Answers template in Stata. Results obtained from each trainee before and after training were converted into the percentage correct score and analysed using the paired Student t-test.

**MHPSS service utilization**

The purpose of training was to improve the ability of doctors to recognize, diagnose, treat and refer patients who need mental health or psychosocial support. The practical application of knowledge gained by training was assessed using a proxy measure: the number of mental health and psychosocial patients seen and reported by doctors in clinics before and after training. For this, the Ministry of Health supplied service utilization data for 184 doctors who had reported cases to the national health information system (managed by the Ministry of Health) for one year before and one year after their training. This included the number of consultations for each doctor and the number of patients diagnosed/treated. Data included the type of consultation, based on the 11th revision of the International Classification of Diseases (ICD-11) codes (18) related to the following Diagnostic and Statistical Manual of Mental Disorders, fifth edition (19), diagnostic categories:

- Acute stress disorders
- Bipolar disorders
- Child adverse development – behavioural/ emotional
- Child development
- Delirium
- Dementia
- Depression
- Psychoses
- Self-harm.

Data on patient age were grouped as follows:

- 0–19 years
- 20–64 years
- 65 years and over.

**Quality of service**

To assess the quality of MHPSS services provided by mhGAP trainees, four MHPSS trainers assessed the
level of compliance in graduates with mhGAP training guidance and guidelines. For this, they observed the practices of 40 doctors in five provinces (Ankara, Gaziantep, Hatay, Izmir and Istanbul) for a week and assessed their competency in 12 key categories (each with several subcategories). Annex 3 shows the form used to assess compliance with mhGAP guidance in the 12 key categories and subcategories (extracted from mhGAP training manuals (20)).

No data were collected on demographic or other characteristics of the doctors observed, so it was not possible to compare the performance or characteristics of graduates with those who had received training but had not been observed providing services or with underperforming groups. Compliance with each category and subcategory was recorded as Yes/No in Google Forms. The final raw dataset was transferred to a Microsoft Excel spreadsheet and the compliance rate (i.e. the percentage of graduates who complied with each sub/category) was calculated in Stata.

Service-user perspective
All efforts to train health providers to improve health-care utilization and health service quality would mean little if they did not result in improved health for service users. As improvements in health status would take years to measure, the study instead measured self-reported user satisfaction with MHPSS services in seven provinces. For this, patient exit interviews were conducted in seven MHTCs where WHO provides operational support to health services. Interviewers were selected from a group of bilingual patient guides who were fluent in both Arabic and Turkish and had a working knowledge of how the centres operate. They were stationed outside the MHTC and interviewed patients leaving after a consultation.

Interviewers received one day of training and field testing was done in Ankara. Patient exit interviews were conducted for a month in late 2019 (mid-October–mid-November) and data were collected using Google Forms. All data were exported to Excel and analysed using Stata. Information collected from respondents included demographic data (gender, age) and other characteristics (marital status, occupation, income, residence, religion, education level and province), as well as their level of satisfaction with the MHPSS services and with specific features of the services (e.g. quality of service, treatment, waiting time, confidentiality, relationship with providers, availability of service, facility opening hours, length and frequency of appointments, and provision of information on the condition and treatment). Patients were also asked whether they would be happy to return for the same service or recommend the service to family members. Patient satisfaction was recorded using a 10-point Likert-like scale and later recoded to Yes/No answers using a cut-off point of 7. These measurements are generally ordinal and do not satisfy the requirements of parametric testing.

Data collected on demographics and other characteristics enabled the profile of MHPSS users to be determined, along with user and service characteristics that would predict service-user satisfaction with MHPSS services.

Data analysis
For all components, data cleaning and preparation for analysis was completed between late 2018 and late 2019. Data analysis included univariate and bivariate analysis, where possible. Simple percentages were calculated for the online survey, pre-/post-tests and direct observation data. Analysis of service utilization data and patient exit interview data also included bivariate analysis, where possible, as well as chi-squared tests for association between numerical and categorical variables. Multivariate analysis of patient exit interview data using multiple and logistic regression was conducted to determine the service-user profile and determinants of satisfaction with MHPSS services.
Results

The results of the impact assessment are presented in the same order as the Methodology section.

**Online survey**
A total of 211 respondents submitted answers to the online survey. However, the number of respondents differed among questions because of missing answers.

Approximately 96% of respondents (203 out of 211) reported that mhGAP training was useful (Fig. 3). Promotion of mental health and Depression were considered the most useful modules (Fig. 4). In all, 58% of respondents (116 out of 201) considered the module Promotion of mental health to be the most useful, 78 respondents considered Depression the most useful (39%) and seven considered Psychoses the most useful (3%).

**Fig. 3. Usefulness of mhGAP training**

![Bar chart showing percentages of respondents who found mhGAP training useful]

Notes: \(n=211\). Scores: 1–5 = No; 6–10 = Yes.

Surprisingly, 46% of respondents considered Psychoses to be one of the least useful modules (Fig. 5; 93 out of 201 respondents) for field practice, followed by Promotion of mental health (61 respondents; 30%) and Self-harm/suicide (48 respondents; 24%).

**Fig. 4. Three most useful modules in mhGAP training**

![Bar chart showing percentages of respondents who found specific modules useful]

Note: \(n=201\).

When asked to consider different aspects of mhGAP training, 95% (200 out of 211) of respondents said that the training format was useful (Fig. 6).

**Fig. 5. Three least useful modules in mhGAP training**

![Bar chart showing percentages of respondents who found specific modules least useful]

Note: \(n=201\).
Fig. 6. Was the training format useful?

Note: \( n = 211 \).

The total duration of mhGAP training is 25.5 hours. Approximately 43% of respondents (90 out of 211) wanted a longer training programme (Fig. 7). However, only 7% indicated they would like changes made to the training methods. The modules included in mhGAP training are revised according to the needs of each country. For Turkey, two modules were removed (Disorders due to substance use and Epilepsy) because they are covered by other training programmes delivered by Ministry of Health. Two additional modules were added because of emerging needs in the country: Promotion of mental health and Anxiety disorders. Most respondents were happy with the content of the mhGAP programme: only 22% wanted changes to the modules (Fig. 7).

Fig. 7. What aspect of mhGAP training should be changed?

Note: \( n = 211 \).

When asked whether new topics should be added to the mhGAP programme, only 29% responded that new subjects were needed (Fig. 8).

Fig. 8. Would you like new subjects to be added to mhGAP training?

Note: \( n = 211 \).

In all, 62 respondents suggested that new topics should be included: 25 suggested adding a module on addiction, 21 suggested adding a module on child psychiatry, and eight each suggested adding modules on ageing and mental health and pharmaceutical treatment (Fig. 9).

Fig. 9. Which new topics would you like to be added to mhGAP training?

Note: \( n = 211 \).

The modified mhGAP modules emphasize the importance of psychosocial support. Since provision of comprehensive psychosocial support needs the involvement of different sectors, a detailed note on the roles of different sectors was prepared and given to trainees. The note also included contact details for the institutions to be used for referral. In all, 70% of respondents (148 out of 211) considered that the psychosocial support note gives sufficient information (Fig. 10).
Psychoeducation is a widely used intervention that was developed to provide service users with a better understanding of their mental health condition. A psychoeducation component was included in the module on Intervention methods and gave basic information and guidance on the delivery of psychoeducation. Approximately 87% of respondents (184 out of 211) indicated that this information was useful (Fig. 11). In the training session, trainers emphasize the importance of psychoeducation to help patients to understand more about their condition and to empower them by increasing their coping skills and improve their general well-being.

Fig. 10. Did the psychosocial support note provide enough information?

Note: n = 211.

In all, 53% of respondents (111 out of 211) had no difficulties with the Psychoeducation component (Fig. 12). Only 11% (n = 23) indicated that not enough time was spent on this topic. In addition, 15% (n = 31) reported having difficulties in applying the concepts of psychoeducation to patient care, and only 5% (n = 10) reported difficulties in the pharmacological aspect of psychoeducation.

Approximately 59% of respondents (124 out of 211) indicated that the Psychoeducation component of the Intervention module gave sufficient information, 40% (n = 85) said that the information was partially sufficient and less than 1% (n = 2) said that it was insufficient (Fig. 13).

Fig. 11. Psychoeducation: was this useful?

Note: n = 211.

Fig. 12. Psychoeducation: did you have any difficulties with this topic?

Note: n = 211.
Despite the high level of satisfaction with the information given in many of the training modules, when asked to evaluate whether more mhGAP training is needed overall, over 83% of respondents (175 out of 211) reported that additional mhGAP training would be very welcome (Fig. 14). However, this raises issues for the administration of mhGAP training: once trainees have graduated from the programme and been certified by the Ministry of Health, they cannot re-take the course. Hence, in the future, further training needs could be addressed as part of a programme of continuous medical education training.

Knowledge gained

The amount of knowledge gained by graduates was measured by the difference in the percentage of correct scores for a test given before and one week after the theoretical component of mhGAP training. Questions were selected from the general question bank included in the mhGAP training manuals (20). Different sets of questions (with different levels of difficulty) were chosen for Turkish and Syrian doctors based on differences in the average baseline score for both groups. All questions were multiple choice and were scored equally (4 points) such that 25 correct questions would equal a correct score of 100%.

Differences in pre- and post-testing scores for Turkish and Syrian doctors were analysed using the paired Student t-test (Tables 3 and 4).

For Turkish general practitioners (n = 388), the mean (standard deviation (SD)) pre-test score was 81.7 (10.6) and the mean (SD) post-test score was 86.9 (11.0) for the post-tests. The increase in the average score for knowledge of 5% was statistically significant (P < 0.000).
Table 4. Pre-/post-test results for Syrian doctors

<table>
<thead>
<tr>
<th>Variable</th>
<th>n</th>
<th>Mean score (%)</th>
<th>SE</th>
<th>SD</th>
<th>95% CI</th>
</tr>
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<tbody>
<tr>
<td>Pre-test</td>
<td>207</td>
<td>40.1</td>
<td>1.330</td>
<td>19.130</td>
<td>37.4–42.7</td>
</tr>
<tr>
<td>Post-test</td>
<td>207</td>
<td>48.7</td>
<td>1.564</td>
<td>22.507</td>
<td>45.6–51.8</td>
</tr>
<tr>
<td>Difference</td>
<td>–</td>
<td>8.6</td>
<td>0.666</td>
<td>9.586</td>
<td>7.305–9.932</td>
</tr>
</tbody>
</table>

CI: confidence interval; SD: standard deviation; SE: standard error.

Paired Student t-test.

For Syrian general practitioners (n = 207), the mean (SD) pre-test score was 40.1 (19.1) and the mean post-test score was 48.7 (22.5). The increase of 9% in the average score for knowledge was statistically significant (P < 0.000). Therefore, there was a statistically significant increase in knowledge for both Turkish and Syrian doctors after the theoretical component of mhGAP training. These data are for the 2018 training cohorts, which represents less than half of all graduates (2017–2019). Differences between the Turkish and Syrian groups are clear, but so are the similarities. Differences in the average knowledge gain between Turkish and Syrian doctors (5% vs 9%) may be partly explained by differences in the educational backgrounds of the two groups. In addition, different questionnaires were used for Turkish and Syrian doctors.

Nonetheless, the increase in knowledge for both groups was statistically significant and was attributable to mhGAP training. However, is a 5–9% increase in knowledge a satisfactory outcome for this training course? In comparison, the general adaptation training for Syrian doctors, nurses and translators (also organized by WHO in Turkey) results in a statistically significant increase in knowledge of 24% for doctors, 32% for nurses and 39% for translator/bilingual patient guides (Fig. 15). Although the two training courses do not compare in terms of sophistication, the question remains: is a 5–9% increase in knowledge sufficient to justify the hundreds of hours taken and considerable financial costs to deliver mhGAP training?

Fig. 15. Adaptation training: knowledge gained by Syrian doctors, nurses and translators

Note: 1251 doctors (24 points), 1106 nurses (32 points), 1260 translators (39 points); P < 0.000.

Box and whisker plots show the percentile distribution of correct responses before and after mhGAP training (Figs 16 and 17). Due to the clearly visible outliers, the mean and median do not match, but the trends are very clear. For both groups, the increase in scores was statistically significant (P < 0.000) and attributable to the mhGAP training.
Impact assessment of mhGAP training

Fig. 16. mhGAP training: knowledge gained by Turkish doctors

Notes: \( n = 388 \). The means difference is statistically significant \( (P < 0.000) \).

Fig. 17. mhGAP training: knowledge gained by Syrian doctors

Notes: \( n = 207 \). The means difference is statistically significant \( (P < 0.000) \).

Utilization of MHPSS services

After the successful completion of mhGAP training, the question remains of whether the knowledge gained translates into improved practice. Well-trained and motivated health professionals should be more aware of which patients need MHPSS services and should be in a better position to identify, diagnose, treat and refer these patients.

The activity of all Syrian and Turkish doctors employed by the Turkish Ministry of Health is recorded in the national health information system. This information is analysed and used to produce reports to inform decision-making. For the impact assessment, the Ministry of Health extracted data on the ICD-11 codes for groups of mental disorders (shown in the Methodology section) included in mhGAP training courses for approximately 184 Turkish doctors who had completed one year of service after the course. These data were compared with the number of cases identified up to one year before mhGAP training (Fig. 18).

The mean (standard error of the mean (SEM)) number of cases identified was 139 (9.87) in the year before mhGAP training and 177 (12.17) in the year after. The mean increase of 27.2% in the number of cases identified after training represents 38 (3.94) additional new cases per doctor per year. The statistically significant \( (P = 0.000) \) increase in the number of cases per year indicates that after completing mhGAP training, doctors are more attentive to their patients’ mental health and diagnose mental disorders more frequently. The start and end dates for mhGAP training differed among doctors in the cohort; hence, the possible explanation for this result that more mental health cases were diagnosed in the second half of 2019 is not plausible. Next, the overall increase in the average number of cases in the year following mhGAP training was stratified by major diagnostic group and age group.

The mean (SEM) number of new cases in diagnostic groups related to Child adverse development – behavioural/emotional was 38.52 (6.89) in the year before training and 43 (8.09) in the year after training (Fig. 19; \( P < 0.044 \); statistically significant). Although the actual number of additional new cases per year was fewer than five, they represent a significant percentage increase (12.2%) for this diagnostic group. However, the presence of quite a few outliers may explain the apparent increase in new cases.
The mean (SEM) number of new cases related to child development was 3.27 (0.55) in the year before training and 6.17 (0.88) in the year after training (Fig. 20). Although this is a small increase in absolute terms (mean ± SEM: 2.90 ± 0.52), it represents a percentage increase of almost 88.6% ($P < 0.000$).
Fig. 22. Health-care utilization: depression

Notes: \( n = 184 \). Means difference = 21; \( P < 0.000 \).

The mean (SEM) number of new cases of acute stress disorder was 0.45 (0.11) in the year before mhGAP training and 0.68 (0.19) in the year after (Fig. 23). However, the mean increase of 0.24 (0.11), or 53.7%, was not statistically significant (\( P = 0.021 \)).

Fig. 23. Health-care utilization: acute stress disorder

Notes: \( n = 184 \). Means difference = 0.24; \( P = 0.021 \).

For the Self-harm diagnostic group, the mean (SEM) number of new cases was 0.07 (0.03) in the year before mhGAP training and 0.06 (0.04) in the year after (Fig. 24). The mean decrease of 0.01 (0.04), or 14.3%, was not statistically significant (\( P = 0.595 \)).

Fig. 24. Health-care utilization: self-harm

Notes: \( n = 184 \). Means difference = -0.01; \( P = 0.595 \).

The mean (SEM) number of new cases of in the psychoses category was 4.25 (0.42) in the year before mhGAP training and 5.81 (0.54) in the year after (Fig. 25). The mean increase of 1.56 (0.27), or 36.7%, was statistically significant (\( P < 0.000 \)). The mean (SEM) number of new bipolar disorder cases was 9.11 (0.72) in the year before training and 12.82 (0.88) in the year after (Fig. 26). The mean increase of 3.71 (0.38), or 40.8%, was statistically significant (\( P < 0.000 \)). Notably, although small, the mean increase in diagnosis was statistically significant for both psychoses and bipolar disorders.

Fig. 25. Health-care utilization: psychoses

Notes: \( n = 184 \). Means difference = 1.56; \( P < 0.000 \).
The mean (SEM) number of new delirium cases was 0.80 (0.14) in the year before training and 1.06 (0.22) in the year after (Fig. 27). The mean increase of 0.26 (0.12), or 31.7%, from the pre-training period is statistically significant ($P = 0.018$).

Unfortunately, there was no increase in health-care utilization for patients aged 19 years and under. The mean (SEM) number of cases in this age group was 591.97 (151.15) in the year before training and 532.34 (141.74) in the year after (Fig. 28). The mean decrease of 59.64 (65.72), or 10.0%, was not statistically significant ($P = 0.817$).

However, for the other two age groups (20–64 years and 65 years and over), the number of new cases increased after training (Figs 29 and 30). The mean (SEM) number of new diagnoses in people aged 20–64 years was 8.27 (2.42) in the year before training and 18.05 (6.58) in the year after (Fig. 29). However, the mean increase of 9.78 (4.72), or 118.3%, was statistically significant ($P = 0.019$). In people aged over 65 years, the mean (SEM) number of new diagnoses was 13.30 (1.88) in the year before training and 19.03 (2.81) in the year after (Fig. 30). The mean increase of 5.73 (1.16), or 43.0%, was statistically significant ($P < 0.000$).
Impact assessment of mhGAP training

Fig. 30. Health-care utilization: age 65 years and over

Notes: \( n = 184 \). Means difference = 6; \( P < 0.000 \).

Overall, this component of the impact assessment found a statistically significant increase in diagnosis by graduates of mhGAP training for all major mental health diagnostic categories (except for self-harm) and for all patients aged older than 19 years.

Quality of MHPSS services

Compliance with the quality guidelines discussed in mhGAP training (20) was determined by direct observation of trainees in practices related to MNS conditions. Their competencies were scored in 12 categories and 45 subcategories (described in Annex 3). Compliance rates for categories 1–6 were 75–82% (Fig. 31) and for categories 7–12 were 43–77% (Fig. 32). The lowest compliance rates were found for category 8, Assessment and management of emergency presentations, and category 9, Delivering pharmacological interventions.

Fig. 31. Compliance rates: categories 1–6

PSS: psychosocial services.

Category 1, Promote respect and dignity, is composed of three subcategories, which represent fundamental values for delivering health services. Rates of compliance with training guidelines for the three subcategories were: Treat with respect, 87%; Promote inclusion, 79%; and Protect confidentiality, 88% (Fig. 33).

Fig. 32. Compliance rates: categories 7–12

Compliance rates with training guidance for category 2, Know common presentations, were at least 77% for both subcategories: Know common presentations of priority MNS conditions, 78%; and Know other symptoms that may present as part of priority MNS conditions, 79% (Fig. 34).
mhGAP training also aims to develop competencies in category 3, Know the principles of assessment, which has three subcategories: Steps in history-taking, Assessment principles and Key points of assessment principles. Compliance with training guidance in this category was 73–79% (Fig. 35). For the three subcategories, 79% of trainees demonstrated compliance with guidance on Key points of assessment, 76% with guidance on Assessment principles and 74% with Steps in history-taking.

Management of common psychiatric disorders at PHC level is essential to reduce the treatment gap. Compliance with training guidance for category 4, Know the principles of management, was 64–82% (Fig. 36). Of the three subcategories, the lowest level of competency was observed for Naming the management principles for priority MNS conditions.

Use of effective communication skills is a core competency for all health-care staff at all stages of care from history-taking to increasing treatment adherence. Communication is specifically important for mental health care because of the vulnerability of service users and the stigmatizing behaviours of social groups, including health-care professionals. Therefore, compliance with guidance for category 5, Use effective communication skills, needs to be evaluated very carefully. Compliance rates in the six subcategories were 79–88% (Fig. 37). The highest compliance rate was with the subcategory related to friendly interaction with service users (88%). Although these numbers show that there is room for further improvement, the finding that at least 79% of trainees were competent in all subcategories is highly encouraging. PHC workers have an important role in the early diagnosis and treatment of people with mental health conditions, especially in low-resourced areas. Performing an assessment (category 6) includes assessment of the specific diagnostic area along with a collateral assessment (of the carer and school) and identification of concurrent medical (MNS and physical) conditions. Compliance rates with training guidance for this competency were slightly lower than for the previous five categories, at 73–80% (Fig. 38).
Assessing and managing underlying or concurrent physical conditions (category 7) will enhance the effectiveness of mental health interventions. Most physical conditions can be recognized and managed at PHC level. Therefore, assessors observed the skills of trainees in four subcategories: Recognize the importance of assessing physical conditions, Take a detailed history, Perform a physical examination, and Manage physical conditions to evaluate this competency. Compliance rates for these four subcategories were 73–81% (Fig. 39). Assessment and management of emergency presentations (category 8) may be lifesaving. Unfortunately, compliance rates for all four subcategories were low, at 28–53%. Trainees had the lowest competency in Managing emergency presentations of priority MNS conditions using pharmacological interventions (Fig. 40).

Note: the subcategories are Recognize emergency presentations; Perform an emergency assessment; Manage emergency presentations using non-pharmacological interventions; and Manage emergency presentations of priority MNS conditions using pharmacological interventions, as appropriate and available.

The provision of psychosocial services at PHC level in Turkey is very limited. mhGAP training is one of only a few in-service training programmes (if not, the only one) related to mental health. Compliance rates with training guidance on category 9, Provide psychosocial interventions, ranged from 61% to 74% (Fig. 41). mhGAP training does not provide extensive information on pharmacological treatments for mental disorders. Therefore, the assessment of category 10, Deliver pharmacological interventions as needed, was included to identify future training needs. The subcategories were to Identify a need for medication...
in priority MNS conditions, Work collaboratively to educate with people with a priority MNS condition; Select and prescribe medication for priority MNS conditions; Consider the needs of special populations when prescribing for priority MNS conditions; and Follow-up of medications for priority MNS conditions, including monitoring any side-effects. Compliance rates on delivery of pharmacology interventions ranged from 13% to 74% (Fig. 42). Competency was lowest for two subcategories (Select/prescribe medicine and Consider the needs of special populations), and low for a third (Follow-up on medications).

Fig. 41. Compliance rates: provide psychosocial interventions

Given that mental disorders may have a long duration, mhGAP training emphasizes planning and performing follow-up (category 11). Trainees are expected to Understand the importance of follow-up for priority MNS conditions; Know when and how to plan for follow-up for priority MNS conditions; Perform a follow-up assessment for priority MNS conditions to determine ongoing management; and Manage crisis presentations and deviations from the treatment plan for priority MNS conditions. Compliance rates in these subcategories ranged from 61% to 82% (Fig. 43). The highest competency was in Understanding the importance of follow-up, while the lowest was for Management of crisis presentations.

Fig. 42. Compliance rates: deliver pharmacological interventions

Fig. 43. Compliance rates: plan and perform follow-up

Mental health is a multisectoral area, and a considerable number of patients need referral to other specialized mental health services or social services. Therefore, Knowing when to refer to a specialist or Link with other services and outside agencies (category 12) is important for the delivery of mental health services at PHC level. Compliance with referral procedures ranged from 71% to 79% (Fig. 44).
Patient exit interviews
Patient exit interviews generated more detailed information on patient demographics (Figs 45 and 46). Most interviewees (77%; 276 out of 357) were women aged 20–40 years ($n = 246$). Only 25 respondents were aged under 20 years; of these 23 were female. The mean (SD) age was 33 years (10.38) for female respondents and 38 years (12.67) for male respondents.

Note: $n = 357$.

A total of 271 respondents were married; of these, 214 were women and 57 were men (Fig. 47). The remaining 24 men and 62 women were single, divorced or widowed. Only 40% of those aged under 20 years were married; about 78% in other age groups were married.

About 85% of respondents were Arabs (Fig. 48). The sex ratio was similar between ethnic groups: 78% were female in the Arab group and 71% in the other groups. The chi-squared test showed no significant association between ethnicity and gender in respondents ($P = 0.251$).
Most respondents had received no education (18%) or only primary school education (42%; Fig. 49). About 29% were educated to secondary level (middle/high school) and 11% to university level. Logistic regression analysis indicated that female respondents were more likely to have received primary education only compared with men (odds ratio (OR) = 2.23; 95% CI: 0.946–2.254; \( P = 0.067 \)), whereas men were more likely to have been educated to middle/high school (OR = 1.18; 95% CI: 0.518–2.716; \( P = 0.686 \)) or university level (OR = 1.78; 95% CI: 0.650–4.865; \( P = 0.261 \)). However, the differences between genders were not statistically significant.

In all, 96% of respondents had completed registration (Fig. 51). Registration status was not significantly associated with any other demographic or social variable, even though female respondents were 1.54 times more likely to be registered compared with men (\( P = 0.482 \)). Although only 4% of all respondents had not registered, this finding indicates that health services in Turkey are not restricted to those with registration.
Of all respondents, 91% (231 out of 253) said that they received psychosocial support that day from a social worker or psychologist (Fig. 52). Of the 22 respondents who had received MHPSS from a doctor, 21 were female. The average age of female respondents who had received MHPSS from psychosocial services was 34.4 years; for those who had received MHPSS from a doctor, the average age was 32.2 years.

**Fig. 52.** Patient exit interview: MHPSS service provider

The level of satisfaction with MHPSS services was scored on a 10-point scale (1 = least satisfied; 10 = most satisfied; Fig. 53). When the scores were then recoded into satisfied/not satisfied with a cut-off point of 7, the satisfaction rate with services provided that day was 95% (i.e. 95% of respondents (n = 253) reported a satisfaction level of 7 or more; Fig. 54). Logistic regression analysis indicated that men were more likely to be satisfied with MHPSS services (OR = 1.49; 95% CI: 0.421–5.290; P = 0.534).

**Fig. 53.** Patient exit interview: how do you score the quality of MHPSS services you received today?

When respondents were asked whether their needs had been met that day, their responses were again initially scored on a 1–10 scale (1 = not met, 10 = fully met; Fig. 55). The responses were later recoded into met/not met with a cut-off point of 7 (Fig. 56). In all, 93% of respondents (n = 253) reported that their needs had been met. Logistic regression analysis indicated that men were more likely to have had their needs met by MHPSS services (OR = 2.36; 95% CI: 0.691–8.083; P = 0.170). An important finding of the survey is that respondents were 2.11 times more likely to have had their needs met if MHPSS services were provided by psychosocial support staff (P = 0.210).

**Fig. 54.** Patient exit interview: how do you rate the quality of MHPSS services you received today (pooled)?

Note: n = 253.

**Fig. 55.** Patient exit interview: were your MHPSS needs met today?

Notes: n = 253. 1 = not met; 10 = fully met.
**Fig. 56.** Patient exit interview: were your MHPSS needs met today (pooled)?

Note: \( n = 253 \).

Out of all respondents, 67\% (\( n = 169 \)) had received a consultation on the survey day and only 1\% (\( n = 3 \)) had received a prescription only; the remaining 32\% (\( n = 81 \)) had received both (Fig. 57).

**Fig. 57.** Patient exit interview: what kind of treatment did you receive today?

Note: \( n = 253 \).

Fig. 58 shows the waiting times for all respondents. The median waiting time was five minutes and the mean waiting time was 11 minutes (due to outliers). The waiting time for the 75th percentile was 10 minutes. Two groups experienced the highest mean waiting time (15 minutes): female respondents aged under 20 years and female respondents aged over 40 years. Overall, the average waiting time was 12 minutes for female respondents and eight minutes for male respondents.

**Fig. 58.** Patient exit interview: what was your waiting time today?

Note: \( n = 253 \).

In all, 99\% of respondents (\( n = 250 \)) were happy with the level of confidentiality in MHPSS services (Fig. 59). Women were more likely to be satisfied with the level of confidentiality (OR = 1.61; 95\% CI: 0.144–18.169; \( P = 0.696 \)). Arab respondents were also more likely to be satisfied with the level of confidentiality (OR = 3.67; 95\% CI: 0.322–41.673; \( P = 0.295 \)).

**Fig. 59.** Patient exit interview: are you happy with the confidentiality in MHPSS services?

Note: \( n = 253 \).

In all, 99\% of respondents (250 out of 253) were happy with their relationship with the service provider (Fig. 60). Moreover, most respondents (98\%, \( n = 249 \)) were happy with the availability of the MHPSS services (Fig. 61). Respondents of Arab ethnicity were more likely to be satisfied with the availability of such services (OR = 2.43; 95\% CI: 0.243–24.214; \( P = 0.449 \)); however, there was no difference in the likelihood of being satisfied with the availability of MHPSS services between genders or among age groups.
**Fig. 60.** Patient exit interview: are you happy with your relationship with the MHPSS service provider?

![Pie chart showing 99% Yes and 1% No](image1)

Note: $n = 253$.

**Fig. 61.** Patient exit interview: are you happy with the availability of MHPSS services?

![Pie chart showing 98% Yes and 2% No](image2)

Note: $n = 253$. 

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In all, 96% of respondents (242 out of 253) were happy with the facility opening hours (Fig. 62). Female respondents were 2.8 times more likely than male respondents to be happy with the facility opening hours (OR = 2.83; 95% CI: 0.832–9.638; \( P = 0.095 \)); however, no differences in the level of satisfaction with facility opening hours was observed among the different age groups.

Most respondents were happy with the length of the appointment (98%, \( n = 247 \); Fig. 63) and most were happy with the frequency of the appointments (97%, 246 out of 253; Fig. 64). Female respondents were 1.3 times more likely than male respondents to be happy with the appointment frequency (OR = 1.30; 95% CI: 0.245–6.860; \( P = 0.760 \)). Respondents in the 20–40-year age group were more likely than those aged under 20 years to be satisfied with the appointment frequency (OR = 4.29; 95% CI: 0.766–24.050; \( P = 0.097 \)).

Fig. 62. Patient exit interview: are you happy with the facility opening hours?

Note: \( n = 253 \).

Fig. 63. Patient exit interview: are you happy with the length of the appointment?

Note: \( n = 253 \).

Almost all respondents (96%; 240 out of 253) were happy with the length of waiting time before the appointment (Fig. 65). Male respondents were 3.45 times more likely than female respondents to be happy with the length of waiting time (OR = 3.26; 95% CI: 0.409–26.001; \( P = 0.265 \)). Respondents aged 20–40 years were more likely than those aged under 20 years to be satisfied with the length of waiting time (OR = 1.41; 95% CI: 0.163–12.201; \( P = 0.755 \)); respondents aged over 40 years were also more likely to be satisfied with the length of waiting time compared with those aged under 20 years (OR = 1.38; 95% CI: 0.134–14.106; \( P = 0.789 \)).

Fig. 65. Patient exit interview: are you happy with waiting time for the appointment?

Note: \( n = 253 \).
Most respondents (98%, 247 out of 253) were also happy with the information they had received about their health status (Fig. 66). Differences between genders and among age groups were not statistically significant. Most respondents (97%, \( n = 245 \)) were also happy with the information they had received about their treatment (Fig. 67). Again, there were no significant associations with gender or age group for this measure.

**Fig. 66.** Patient exit interview: are you happy with information received on health status?

![Graph showing 98% Yes, 2% No](image1)

Note: \( n = 253 \).

**Fig. 67.** Patient exit interview: are you happy with information received on treatment?

![Graph showing 97% Yes, 3% No](image2)

Note: \( n = 253 \).

Most respondents (98%, \( n = 249 \)) said they would return to the facility for a similar service (Fig. 68). Female respondents were 3.29 times more likely than male respondents to be happy with frequency of their check-up appointments (OR = 3.29; 95% CI: 0.453–23.896; \( P = 0.239 \)). Respondents aged 20–40 years were more likely than those aged under 20 years to return for the same service (OR = 3.39; 95% CI: 0.333–34.579; \( P = 0.302 \)).

**Fig. 68.** Patient exit interview: would you come back for a similar service?

![Graph showing 98% Yes, 2% No](image3)

Note: \( n = 253 \).

The same percentage of respondents (98%, \( n = 249 \)) who reported they would return for the same treatment said that they would also recommend the service to family members (Fig. 69). Female respondents were more likely than male respondents to recommend the service to family members (OR = 3.29; 95% CI: 0.453–23.896; \( P = 0.239 \)). Respondents aged 20–40 years were more likely than those aged under 20 years to recommend the service to family members (OR = 3.39; 95% CI: 0.333–34.579; \( P = 0.302 \)).

**Fig. 69.** Patient exit interview: would you recommend this service to a family member?

![Graph showing 98% Yes, 2% No](image4)

Note: \( n = 253 \).
Discussion

Strengths and limitations
A strength of this study is that although each stand-alone component can be reported as a separate assessment, the combined findings form a comprehensive picture of the usefulness of mhGAP training and its impact on the health status of end beneficiaries.

Regarding service users, limitations related to how they were selected and/or the quantity of information. The selection was not random because of the difficulty in constructing a sampling frame for Syrians under temporary protection who seek services in MHTCs. In addition, information was only collected from service users for the late-2019 period, and it is not possible to determine how the findings would differ for other MHPSS users in other periods. However, a strength is that all respondents were anonymous and the authors made no attempt to identify or influence the respondents.

Regarding mhGAP graduates, limitations are that it is difficult to extrapolate the findings from each component to the whole population of trainees. As data were collected from all components between late 2018 and late 2019, they are specific to that period and also to mhGAP graduates trained by Ministry of Health and WHO and serving in the seven MHTCs where WHO provides operational support. Since the start of the COVID-19 pandemic, most face-to-face training has been transferred online using distance learning platforms. Therefore, it would be interesting to observe the impact of online mhGAP training compared with traditional training.

Another limitation is that implementation of the components of this assessment relied heavily on mobile technology and the Internet. Google Forms is an efficient, free tool, but is not a professional online survey data collection and reporting tool. However, it was an efficient and reliable platform for this study. Low-level analysis of response frequencies was performed in Google Forms, with additional analysis performed using professional statistical software.

Overall, the evidence generated is limited to the groups studied: it cannot be generalized because it was not based on all doctors who have graduated from mhGAP training nor on a random selection of doctors followed from training to service provision. In addition, the different components of the assessment were completed at different times and no control groups were included. Often, information was only collected on the topic in question, and not on demographics or other characteristics that would allow a more in-depth analysis of the results. As such, lack of a representative sample of the entire population of doctors who have undergone mhGAP training may limit the findings and conclusions to those trainees who were actually included in the assessment. Nonetheless, these respondents comprise a reasonable percentage of the total cohort of trainees. Improved planning could ensure that future studies include a random sample of all graduates of mhGAP training, along with an analysis of their knowledge gained and number of new cases identified following training.

mhGAP training: benefits for both trainees and service users
This impact assessment was the first of its kind and has generated evidence on the usefulness of mhGAP training in Turkey. However, these findings would not be useful without a discussion of their relevance and importance to the training programme.

The online survey indicated that trainees were highly satisfied with mhGAP training and would like further training. These findings were based on responses from 211 Turkish doctors. Unfortunately, no additional (demographic or other) information was available to determine whether those who responded to the survey were representative of the entire cohort. Nonetheless, the respondents comprised 23.5% of all Turkish graduates of mhGAP training, which is a considerable proportion of the pool of Turkish doctors providing health services for Syrians under temporary protection.

In order to improve the amount of feedback, we plan to conduct annual online surveys to continuously monitor
trainee satisfaction with the programme. An important finding was the need for more mhGAP training. Once a doctor has successfully completed the five days of training and pre-/post-tests, mhGAP training is certified as complete by the Ministry of Health. This means that any future mhGAP-related training needs to be in the form of continuous medical education. Another argument in favour of continuous medical education is that the overall score for Syrian doctors remains low. Since the start of the COVID-19 pandemic, the Turkish Ministry of Health and WHO have been working together to establish an online training platform, with mhGAP training as one of the core courses. If EU funded, the platform is expected to provide continuous medical education for hundreds of Syrian and Turkish doctors.

A knowledge gain of 5–9% was attributable to mhGAP training. However, the pre-/post-tests did not yield information to determine which types of doctors gained more (or less) knowledge from the training programme (and why). Data were collected for 43.3% of Turkish and 36.3% of Syrian doctors who completed the training course. In future, it is planned to include pre-/post-tests as part of the online mhGAP training via the distant learning platform and, eventually, compare the amount of knowledge gained from online training and face-to-face training. Demographic and service-related information will also be included in the online pre-/post-test. This information might be useful to further tailor the training modules to the needs of health service provider.

Data on health service utilization extracted from the Ministry of Health’s health information system confirmed that the average annual number of new cases identified by Turkish doctors increased after the training (compared with before training). Although a control group was not included in this study, results from data for 188 Turkish doctors (or 21% of all Turkish doctors trained) indicate that the increased diagnosis of mental disorders was attributable to mhGAP training. In future, a similar study is needed for mental health-care services provided by Syrian doctors. Steps will be taken to compensate for factors that might influence the findings, such as improvements of the national health information system for Syrian doctors.

and conditions on prescriptions by foreign doctors in Turkey.

Compliance rates with service quality guidelines were 75–85% for categories 1–6 and 43–77% for categories 7–12. Only two categories had compliance rates of less than 50%. Assess and manage emergency presentations and Deliver pharmacological interventions as needed and appropriate. These important findings indicate future areas for improvement, in terms of both mhGAP training and the organization of mental health services provided by general practitioners. Future mhGAP training should include improved modules on psychiatric emergencies and pharmacological treatment. Further investigations are warranted to determine the reasons for low compliance in these areas.

The patient exit interviews identified very high levels of user satisfaction with MHPSS services. Interestingly, user feedback from this survey was more positive compared with other WHO surveys on general PHC services provided to refugees/migrants. A possible explanation is the low satisfaction threshold of Syrians under temporary protection. Studies conducted in other countries have indicated that mental health service users often inflate their satisfaction level either because of their lower health literacy or because they are afraid that negative feedback will affect their access to health services. The present study collected feedback from 357 beneficiaries. An analysis of pre-COVID-19 health service utilization indicated 83 000 MHPSS consultations in seven MHTCs over 24 months. Assuming four consultations per month (one per week) per beneficiary, the respondents in this survey represent slightly more than 40% of the monthly MHPSS consultations, which is a reasonable sample for analysis.

Overall, the findings of this study indicate that mhGAP training:

- was useful, as confirmed by feedback from graduates; and
- had a positive impact on both service utilization by beneficiaries and their satisfaction level with MHPSS, as confirmed by the increased number

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7 The current module on health information system for Syrians under temporary protection is currently undergoing improvements for some additional functionality.

8 In addition, prescriptions related to mental health diagnoses are issued by general practitioners and confirmed by psychiatrists after the first issue, for continued use.
of new cases identified by doctors after mhGAP training and data from patient exit interviews.

This information will be used by the Ministry of Health and WHO to continue their capacity strengthening efforts. Better planning and more resources are needed for mhGAP training of Syrian and Turkish doctors. The mental health gap is considerable, and PHC providers are expected to respond to the unmet health needs of Syrians under temporary protection, which have been exacerbated by the COVID-19 pandemic. Feedback from Turkey’s health sector partners in the Regional Refugee and Resilience Plan (3RP) indicates that health needs for noncommunicable diseases (including mental health) have been exacerbated by the pandemic, during which the attention of health providers has focused on COVID-19 (21). Social distancing and fear of infection have hindered service provision and increased the gap for routine health services.

The COVID-19 pandemic is a public health emergency of international concern, but the most vulnerable population groups are being hit the hardest. Other WHO surveys have indicated that refugees/migrants have larger households and smaller living spaces compared with host populations. They also have lower health literacy and have suffered more job losses and economic hardships as a consequence of the pandemic. The resulting income loss has increased the hardship for food and shelter, as well as for health and sanitation. The additional anxiety and daily stressors have exacerbated mental health problems in a population that is already vulnerable and very fragile.

As a final point, the value of this report should be emphasized. Sceptics would argue that WHO and Ministry of Health would regard their training activities as useful, so why spend additional resources to prove that. The response is that the evidence was generated from anonymous respondents who do not share the interests of WHO or the Ministry of Health. The data are available in the original format and the results have only one purpose: to inform on the quality and impact of the extraordinary training effort undertaken in Turkey. Overall, the evidence indicates that implementation of the mhGAP training tool by WHO and the Ministry of Health has greatly improved the quality of health care for Syrians under temporary protection in Turkey.

The lessons learnt during the last three years could be useful to other countries and/or humanitarian actors facing similar challenges as the Turkish health system.

**Online mhGAP training in 2021**

The findings of this assessment helped the Ministry of Health and WHO to continue mhGAP training in late 2020 and 2021 via a distance learning platform. The online training course combined face-to-face and self-paced training. The first two cohorts had completed the online training course by early February 2021. Preliminary results indicated that the knowledge gained was attributable to mhGAP training. However, further analysis is needed to determine whether the amount of knowledge gained differed according to the delivery methods.

**Recommendations**

Based on the overall findings of this study, the Ministry of Health–WHO training team recommend to:

- organize more mhGAP training, in line with the positive experiences identified in this report;
- improve monitoring of the training process and strengthen training quality for future cohorts to increase the quantity and quality of information collected from mhGAP trainees;
- advocate for more resources for future mhGAP training (from the Ministry of Health, WHO and national donors) to ensure that the current standards of training are maintained in the long-term;
- increase the amount of evidence on the mhGAP training and its impact on quantity and quality of services provided and on service-user satisfaction, as a proxy for health status – this evidence will be useful for other countries and/or agencies implementing similar MHPSS services for vulnerable populations; and
- organize additional training for psychosocial support staff (psychologists, social workers and other categories) who shoulder the major burden of mental health services at PHC level.

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Conclusions

The clear conclusion of this report is that the activities of the Ministry of Health–WHO on mhGAP training in Turkey have been useful. The gain in knowledge was attributable to the training course and has translated into increased utilization of MHPSS services. Although there is room for improvement, service users are happy with the quality of the services provided and would return for the same service.

This study was implemented within the scope of the Improved access to health services for Syrian refugees in Turkey project with funding from the EU Regional Trust Fund in Response to the Syrian Crisis.
References


### Annex 1. Outline of mhGAP training

Table A1 shows the type and duration of mhGAP training modules delivered in Turkey.

**Table A1. mhGAP training modules**

<table>
<thead>
<tr>
<th>Module</th>
<th>Duration of teaching (hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Promotion of mental health</td>
<td>2.0</td>
</tr>
<tr>
<td>Essential care and practice</td>
<td>3.5</td>
</tr>
<tr>
<td>Depression</td>
<td>3.0</td>
</tr>
<tr>
<td>Psychoses</td>
<td>3.0</td>
</tr>
<tr>
<td>Anxiety disorders and stress-related disorders</td>
<td>3.0</td>
</tr>
<tr>
<td>Self-harm/suicide</td>
<td>2.0</td>
</tr>
<tr>
<td>Dementia</td>
<td>3.0</td>
</tr>
<tr>
<td>Child and adolescent mental and behavioural disorders</td>
<td>3.0</td>
</tr>
<tr>
<td>Other significant mental health complaints</td>
<td>3.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>25.5</strong></td>
</tr>
</tbody>
</table>

The training modules are delivered by a team of peer trainers (general practitioners) and psychiatrists. All trainers underwent five days of training for trainers, in addition to mhGAP training. At least three trainers per 25 participants were present in each session to support role-playing and other group activities.
Annex 2. mhGAP pre-/post-test questions

1. Which of the following cluster of symptoms best fits with an episode of depression?
   Choose only one answer.
   a. Marked behavioural change, agitated or aggressive behaviour, fixed false beliefs
   b. Decline in memory, poor orientation, loss of emotional control
   c. Inattentive, overactive, aggressive behaviour
   d. Low energy, sleep problems, loss of interest in daily activities.

2. Which of the following is a good combination therapy for depression?
   a. Vitamin injections and increased exercise
   b. Psychosocial interventions and an antidepressant
   c. An antipsychotic and a mood stabilizer
   d. Hypnotherapy and relaxation.

3. Which of the following cluster of symptoms fits best with an acute manic episode?
   Choose only one answer.
   a. Confusion, disorientation to time, place and person; marked functional decline
   b. Admits to consuming alcohol, has slurred speech and uninhibited behaviour
   c. Has recently stopped taking regular benzodiazepines and presents with agitation, sweating and poor sleep
   d. Decreased need for sleep, increased activity level, reckless behaviour.

4. Which of the following statements concerning psychosis and bipolar disorder is correct?
   Choose the best answer.
   a. People with psychosis or bipolar disorder do not need evaluation for medical conditions.
   b. People with psychosis or bipolar disorder are best cared for with long-term hospitalization.
   c. People with psychosis or bipolar disorder are unlikely to be able to work or contribute to society.
   d. People with psychosis or bipolar disorder are at a high risk of stigmatization and discrimination.

5. Which of the following is part of a psychosocial intervention in psychoses?
   Choose the best answer.
   a. Promote functional daily activities but recommend against work or serious relationships as they may be too stressful.
   b. Discuss with the caregiver and family whether long-term institutionalization may be appropriate.
   c. Provide psychoeducation, especially to avoid sleep deprivation, stress, drugs and alcohol.
   d. Discuss with the caregiver different ways that they might be able to challenge the person’s delusions.

6. Which of the following is the best description of child developmental disorders?
   Choose only one answer.
   a. Child development disorders have a relapsing and remitting course.
   b. Child development disorders are always associated with abuse and neglect.
   c. The child developmental disorders category includes attention deficit hyperactivity disorder and conduct disorder.
   d. Child development disorders involve impaired or delayed functions related to central nervous system maturation.
7. Which of the following is good advice for any child and adolescent mental and behavioural disorder?

**Choose the best answer.**
- a. The carer can use threats or physical punishment if a child has problematic behaviour.
- b. The carer should remove the child from mainstream school as soon as possible.
- c. The carer can use other aids such as television or computer games instead of spending time with the child.
- d. The carer should give loving attention to the child every day and look for opportunities to spend time with them.

8. A 42-year-old man comes to your establishment. He lost his wife and child a week ago. His friends say he was suddenly unable to walk properly, and he looked tired and depressed all the time. You do a physical examination and find that his medical symptoms cannot be explained by any physical condition. Further test results are also normal. You make sure that his symptoms do not have a physical cause. Friends say that the client was a happy, joyful person until his wife and child died, and he has no health problems.

**Which of the following is the most likely diagnosis?**
- a. Depression
- b. Epilepsy
- c. Dementia
- d. Mourning/loss.

9. Which of the following is the best first-line treatment for child and adolescent developmental disorder?

**Choose only one answer.**
- a. Psychosocial intervention
- b. Pharmacological treatment
- c. Referral to a specialist
- d. Referral to an outside agency.

10. Which of the following should be given as advice to an adolescent with a mental or behavioural disorder?

**Choose the best answer.**
- a. They should avoid community and social activities as much as possible.
- b. They should avoid using drugs, alcohol and nicotine.
- c. They should avoid school if it makes them anxious.
- d. They should avoid being physically active for more than 30 minutes per day.

11. Which of the following is a common presentation of dementia?

**Choose the best answer.**
- a. Low mood and loss of enjoyment in daily activities
- b. Fixed false beliefs and hearing voices
- c. Excessive hyperactivity and inattention
- d. Decline or problems with memory and orientation.

12. Which of the following is a common presentation of dementia?

**Choose the best answer.**
- a. Severe forgetfulness and difficulties in carrying out usual work, domestic or social activities.
- b. Drowsiness and weakness down one side of the body.
- c. Fluctuating mental state characterized by disturbed attention that develops over a short period of time.
- d. Low mood in the context of major loss or bereavement.
13. Which of the following is the best description of dementia?

**Choose only one answer.**

a. Dementia can have a large impact on the person, their caregiver and family, and society in general.
b. Dementia can be cured through pharmacological interventions.
c. Dementia does not interfere with activities of daily living such as washing, dressing, eating, personal hygiene and toilet activities.
d. Dementia is a normal part of ageing.

14. Which of the following statements best describes treatment options in dementia?

**Choose only one answer.**

a. All people with dementia should have access to pharmacological interventions, regardless of the availability of a specialist.
b. Pharmacological interventions, if started early enough, can cure dementia.
c. With early recognition and support, the lives of people with dementia and their carers can be significantly improved.
d. Psychosocial interventions for dementia should only be provided by a specialist owing to their complexity.

15. Which of the following should you tell the carer of someone who has had an episode of self-harm or a suicide attempt?

**Choose the best answer.**

a. Medication will be made available so that they can keep the person sedated.
b. Restrict the person’s contact with family, friends and other concerned individuals in case it is too overwhelming.
c. Remove access to any means of self-harm and try to provide extra supervision for the person.
d. Forced vomiting as an emergency treatment option if they suspect self-harm or suicide attempt.

16. Which of the following is part of a psychosocial intervention where the person seeking help witnessed the death of a loved one to violence?

**Choose the best answer.**

a. They should talk about the incident as much as possible, even if they do not want to.
b. It is normal to grieve for any major loss in different ways and, in most cases, grief will diminish over time.
c. Avoid discussing any mourning process, such as culturally appropriate ceremonies/rituals, as it may upset them further.
d. Refer to a specialist within one week of the incident if they are still experiencing symptoms.

17. Which of the following is true about psychological treatment (e.g. cognitive behavioural therapy, interpersonal therapy)?

**Choose the best answer.**

a. They should only be provided by specialists who have been trained to provide them.
b. These are single-session therapies that do not require significant time.
c. Interpersonal therapy should be offered to all people with a MNS condition.
d. Non-specialist workers can be trained to deliver these interventions.

18. Which of the following is true about pharmacological interventions?

**Choose the best answer.**

a. They should always be offered to people with MNS conditions.
b. The side-effect profile and efficacy of past treatments should be considered.
c. They should be determined based on the preference of the health-care provider.
d. Drug–drug interactions are not relevant in MNS conditions.
19. A 42-year-old man presents with gastrointestinal problems and low energy. An examination shows no cause for his physical symptoms, but he also reports a low mood, not sleeping or eating properly, and not enjoying time with his family as much as he used to for over two months.

**Which of the following is the most likely diagnosis?**

a. Depression
b. Epilepsy
c. Dementia
d. Other significant mental health complaint.

20. Metin is a 14-year-old boy who is referred to you by his school teacher. The teacher tells you that Metin has always been in trouble at school and is very disruptive to the other students. He seems unable to concentrate on anything for very long. The teacher wants you to see him in case something can be done. You meet Metin, who does not want to sit down to talk to you. In the brief time that you talk, he tells you that he hates school and finds it boring. In your assessment, you do not think that he is depressed, or that he has delusions or hallucinations. He denies using any substances. A physical examination is normal. You meet Metin's parents, who tell you that they have had trouble with Metin for years. He can never sit still when they take him somewhere, such as a church or a friend's house, is always getting bad reports at school, and wants to constantly be moving around the house and doing something.

**Which of the following is the most likely diagnosis (select only one)?**

a. Depression
b. Psychosis
c. Epilepsy
d. Childhood and adolescence mental and behavioural disorder
e. Dementia
f. Disorder due to substance use
g. Self-harm/suicide
h. No illness – normal behaviour for his age.

21. A 31-year-old woman is brought in by her husband. He reports that she has not been sleeping for the last two weeks and has been talking very fast and spending lots of money. On review, she is irritable and tells you she is writing a book that will make her famous. You perform a physical examination and blood tests, which are normal. She tells you she does not use drugs or alcohol, and her husband agrees with that. Her last menses was two weeks ago.

**Which of the following is most likely diagnosis?**

a. Alcohol poisoning
b. Mania
c. Early pregnancy complication
d. Epilepsy.

22. A 6-year-old girl is seen in your clinic. Her parents have brought her in because they are worried about her. She has not been able to start school because she does not talk and her mother has to help her with eating, dressing and self-care. When you ask about her early years, her father tells you that she learnt to walk much later than her brothers and sisters and does not interact with other children her own age.

**Which is the most likely condition?**

a. Developmental disorder
b. Behavioural disorder
c. Mood disorder
d. Psychosis.
23. A 63-year-old man is brought in by his daughter, who is worried about him. He was always a very quiet and kind man, but lately seems more irritable and is having uncontrollable emotional outbursts. He seems to be more forgetful than usual. She tells you that he has never had depression and is otherwise healthy. When you talk to him, you do not think he has any hallucinations or delusions, although he does not know what the date is.  

**Which is the most likely condition?**  

a. Depression  
b. Psychosis  
c. Epilepsy  
d. Dementia.

24. Which of the following psychosocial interventions might you work on with a person with depression?  

**Choose the best answer.**  

a. Avoid telling them too much about depression in case they get even more depressed.  
b. Suggest they take some time off work if they can afford to.  
c. Work with them to reduce stress and mobilize support, including involving carers.  
d. None of the above: better just to refer them to a specialist for interpersonal therapy or cognitive behavioural therapy.

25. Which of the following might you say to a carer for someone with psychosis?  

**Choose the best answer.**  

a. The patient needs to take the medications regularly and return for follow-up.  
b. The person will learn that their delusions are wrong if family members are critical when they discuss their unusual beliefs.  
c. The person can be settled down when they are agitated by giving them a small amount of alcohol.  
d. The person can be settled down when they are agitated by reducing the amount of food they are given.
Annex 3. Competency after mhGAP training: compliance with guidance

The form used to assess compliance with mhGAP guidance in the 12 key categories and subcategories is shown below.

<table>
<thead>
<tr>
<th>Category/subcategory (only those that apply to the task)</th>
<th>Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Needs work</td>
<td>Achieved</td>
</tr>
</tbody>
</table>

1. **Promote respect and dignity**
   - Treats all persons with MNS conditions with respect and dignity in a culturally appropriate manner
   - Promotes inclusion and collaborative care for people with MNS conditions and their carers
   - Protects the confidentiality and consent of people with MNS conditions

2. **Know common presentations**
   - Knows common presentations of priority MNS conditions
   - Knows other symptoms that may present as part of priority MNS conditions

3. **Know the principles of assessment**
   - Can name the steps in history-taking for an MNS assessment, and the key features of each step: the presenting complaint, past MNS history, general health history, family history of MNS conditions and psychosocial history
   - Can name the assessment principles for MNS conditions: physical examination, mental status examination, differential diagnosis, basic laboratory tests, identify the MNS condition
   - Can name two or three key points under each assessment principle for MNS conditions
<table>
<thead>
<tr>
<th>Category/subcategory (only those that apply to the task)</th>
<th>Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Needs work</td>
<td>Achieved</td>
</tr>
</tbody>
</table>

4. **Know the principles of management**

   Understands the importance of integrating care for priority MNS conditions into primary practice

   Can name the management principles for priority MNS conditions: develop a collaborative treatment plan, psychosocial interventions, pharmacological interventions when indicated, refer to a specialist, develop an appropriate plan for follow-up, work together with the carer and family, foster strong links with other services, and modify treatment plans for special populations

   Can name one or two key points under each of the management principles for priority MNS conditions

5. **Use effective communication skills**

   Creates an environment that facilitates open communication about priority MNS conditions

   Involves the person (and their carer, where appropriate) in all aspects of the assessment and management of priority MNS conditions

   Actively listens to the person with a MNS condition

   Is friendly, respectful and non-judgemental at all times in interactions with a person with a MNS condition

   Uses good verbal communication skills in interactions with a person with a MNS condition

   Responds with sensitivity when people with a MNS condition disclose difficult experiences

6. **Perform assessments**

   Performs a MNS assessment using history-taking, including the presenting complaint, past MNS history, general health history, family history of MNS conditions and psychosocial history

   Considers and excludes conditions other than priority MNS conditions

   Performs a collateral assessment (i.e. carer, school), as appropriate, of priority MNS conditions

   Considers other concurrent conditions, both MNS and physical conditions
<table>
<thead>
<tr>
<th>Category/subcategory (only those that apply to the task)</th>
<th>Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Needs work</td>
<td>Achieved N/A</td>
</tr>
</tbody>
</table>

7. **Assess and manage physical conditions**
   - Understands the importance of assessing physical health in assessments of priority MNS conditions
   - Takes a detailed history of physical health, including asking about physical risk factors, from people with priority MNS conditions
   - Performs a physical examination and investigations for priority MNS conditions, as appropriate and available
   - Manages physical health conditions and risk factors or refers to a specialist (if needed) in people with MNS conditions

8. **Assess and manage emergency presentations**
   - Recognizes emergency presentations of priority MNS conditions
   - Performs an emergency assessment of priority MNS conditions, including a risk-assessment
   - Manages emergency presentations of priority MNS conditions using non-pharmacological interventions
   - Manages emergency presentations of priority MNS conditions using pharmacological interventions, as appropriate and available

9. **Provide psychosocial interventions**
   - Provides psychoeducation, including about the priority MNS condition and available treatment
   - Addresses current psychosocial stressors to reduce stress and strengthen social supports, as appropriate for the priority MNS condition
   - Promotes function in daily activities, as appropriate to the priority MNS condition
   - Involves carers and others in psychosocial intervention for priority MNS conditions, as appropriate
   - Recognizes a role for other psychological treatments in priority MNS conditions, and either provides these or refers to a specialist, as appropriate, (i.e. short psychological treatments for depression; specific advice on child and adolescent mental and behavioural disorders; interventions to improve cognitive function in dementia; motivational interview for disorders of substance use; relaxation training for other significant mental health complaints)
10. Deliver pharmacological interventions as needed and appropriate

Identifies whether medication is needed for priority MNS conditions
Works collaboratively with people with priority MNS conditions to educate them about the risks and benefits of treatment, potential side-effects, duration of treatment and importance of adherence
Selects and prescribes medication for priority MNS conditions (if has prescribing rights), as appropriate and available
Considers the needs of special populations when prescribing for priority MNS conditions
Follows up on medications for priority MNS conditions, including monitoring for side-effects and adherence, considering special populations, and knowing when medications can be safely reduced and/or stopped

11. Plan and perform follow-up

Understands the importance of follow-up for priority MNS conditions
Knows when and how to plan for follow-up for priority MNS conditions
Performs a follow-up assessment for priority MNS conditions to determine management based on progress of the priority MNS condition
Manages crisis presentations and deviations from the treatment plan for priority MNS conditions

12. Refer to a specialist and link with outside agencies

Knows when to refer to a specialist at any stage of assessment or management of a priority MNS condition, as appropriate and available
Links with other services and outside agencies for priority MNS conditions, as appropriate and available
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