A manual for checking

Mental Health Best Practices in Somalia

World Health Organization

GRT GRUPPO PER LE RELAZIONI TRANSCULTURALI

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About this manual

Purpose

This manual is an adaptation of the WHO Quality Rights Tool Kit to the Somali context. It aims at assisting policy makers and service providers in Somalia to assess and improve the quality of care and human rights conditions in mental health and social care facilities. It addresses quality care and human rights in inpatient, outpatient and community facilities by using a participatory approach involving people with mental health conditions, families and healthcare staff. All of this is in line with the United Nations Convention on the Rights of Persons with Disabilities (UN-CRPD, 2006), which ensures equal rights to people with disabilities and is a framework for countries to provide them with information on human rights standards that need to be respected, protected and fulfilled in mental health and social care facilities.

Objectives

In order to further improve the mental health situation in Somalia, the objectives of the manual are as follow:

- Improve the quality of services and human rights conditions in inpatient and outpatient mental health facilities in Somalia.
- Build capacity among Somali service users, families and health workers to understand and promote human rights and recovery from mental disabilities.
- Develop a Somali civil society movement of people with mental disabilities to provide mutual support, conduct advocacy and influence policy-making processes in line with international human rights standards.
- Continue to further reform the Somali national policies and legislation in line with best practice and international human rights standards.

Structure

Chapter 1 provides background information and a brief country overview of Somalia. Chapters 2 describes the mental health situation in Somalia, including how mental health patients are dealt with within the Somali culture as well as the various activities till date to improve mental health in the country. Chapter 3 outlines in detail a checklist that has been adapted in order to ensure that each and every health facility providing mental health services in Somalia meets the standards and human rights of the UN Convention on the Rights of Persons with Disabilities.

1. Introduction

1.1. Background and country overview

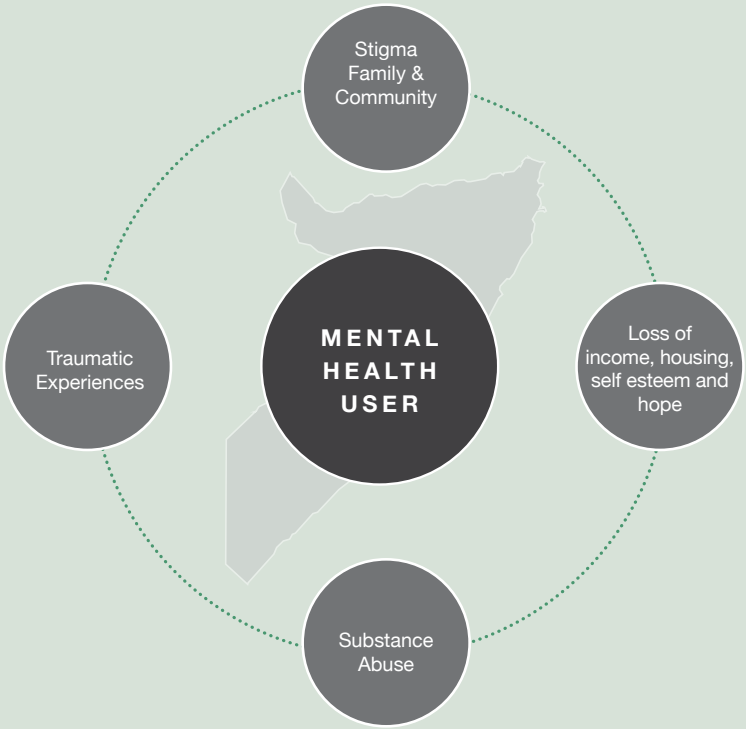
Since 1991, conflicts and statelessness profoundly affected the health care system in Somalia. After the collapse of the central government and the descent into civil war, many efforts to restore a central government were unsuccessful. Powerful internal forces and regional dynamics resulted in a state of chaos. The impact of lack of governance has resulted in a generation without adequate access to social services and the collapse of public institutions for health and welfare.

The country of Somalia is geographically and politically divided into the three zones of South Central Somalia, Somaliland (the north-west) and Puntland (the northeast). These zones are further divided into a total of 18 administrative regions. According to estimates, one third of the population lives in urban areas and two thirds in rural areas.

The country borders Kenya in the south, Ethiopia in the west, Djibouti in the north, and in the east it faces the Gulf of Aden and the Indian Ocean. Its multiple borders and extensive coastline, with numerous ports, have meant that Somalia has long been an important trade hub for the import and export of goods, including cross border smuggling. Regulation and control of the flow of goods have always been very difficult, particularly with the current lack of any functioning authority.

The Somali population is of nomadic heritage and even today a large proportion of the population is essentially nomadic. The pastoralists primarily practice this nomadic life-style, as they follow their cattle to new grazing areas. The rural population can be divided, partly based on their livelihood, into pastoralists, agro-pastoralists and riverine populations (settled in more fertile conditions and mainly growing crops). In addition, some one third of the population is made up of urban residents and a large number of internally displaced people (IDPs), victims of many conflicts in the country.

2. Mental Health in the Somali context



2.1. Overview

The term 'Mental Illness' is used to refer to a broad category of disabilities, such as affective disorders (major depression, and dysthymia) and different anxiety disorders (such as generalized anxiety disorders, and post-traumatic stress disorder). Their essential features are disturbances in emotions, often accompanied by cognitive distortions such as excessive worry, negative thinking and by somatic expressions (unexplained medical symptoms that are often the presenting complaints in primary health care settings).

Mental illness is generally denied and discriminated against by Somalis. What's more considering hospitalization because of mental illness is highly stigmatized in the Somali culture. Usually it is not until someone becomes ill and, for example, is struck by a Psychosis and cannot take care of him/herself that Psychiatric or Biomedical Health Care is considered.

According to the Somali culture, a person is more likely to report physical pain rather than psychosocial symptoms when they are experiencing sorrow

Mental Health users receiving education lessons thus stimulating the thinking process
(© GRT/Julie Taylor)

or sadness. These psychological symptoms are often explained in the form of physiological complaints such as headaches, chest pain, sweating, forgetfulness combined with sleep deprivation and nightmares.

New concepts such as mental health complaints (caafimaadka maskaxda) together with its treatment (daawayn) are somewhat unknown among the Somali population. The word 'depression' has no translation in the Af-Somali language, but is rather described as: qalbi-jab which means in the strict sense and literal translation- 'a broken heart.' When discussing mental health illnesses, the Somali mental health service providers often describe the recognized physiological symptoms rather than referring to the diagnosis, such as 'depression' (GRT Rapid Assessment 2012).

2.2. Response activities

Due to the long neglect of mental health issues in Somalia, not many health partners do operate in this area of work. Since 1996, the NGO Gruppo per le Relazione Transculturali (GRT) has worked in mental health, starting with the Mental Health hospital in Berbera. From there they expanded to Bossaso General hospital in 2003 where a 10-bed mental health ward was constructed. Following the construction, various expats worked with the staff in order to create and scale up quality service delivery for the many mental health patients. Back in 2005 and 2009, the World Health Organization (WHO) organized specific three-month trainings on mental health for mental health practitioners coming from all the regions of Somalia. Participants' knowledge, skills, and attitude towards mental disorders were generally poor even if the majority of them have been exposed to mental health issues for a long time. During 2011, a joint induction/refresher course in collaboration with GRT was given to 48 mental health workers in Hargeisa and Garowe. These activities not only increased the technical and management skills of the health workers, but also raised their sensitivity towards the mentally ill and their skills to work with families. This aspect sensitized the training participants on the necessary process of setting up community based mental health care at the same time as secondary mental health care. In the same year, with support of GRT and the European Commission, the Hargeisa Group Hospital mental health ward as well as the Bossaso mental health ward were rehabilitated.

WHO showed further commitment in improving the mental health services in Somalia through public education on mental health and awareness of the rights of the mentally ill through the *Chain-free initiative*, which was launched initially

in Mogadishu, and later on expanded to Somaliland. Its overall purpose was to develop, implement and evaluate a model for quality mental health services. The initiative focused on improvement of the quality of life of patients with mental disorders through combating the stigma, providing them with equal opportunity to access basic humanitarian treatment in hospitals, homes and the environment in which they live. With support of GRT, various awareness campaigns have been conducted and many users and families have been supported and educated on how to better care for their family members with a mental health illness. WHO's chain-free initiative involved the following three phases:

- Phase 1 - Chain-free hospitals: removing the chains, reforming the hospital into a patient friendly and humane place with minimum restraints.
- Phase 2 - Chain-free homes: removing the chains, providing family psycho-education, training family members on a realistic, recovery-oriented approach, provision of home visits.
- Phase 3 - Chain-free environment: removing the "invisible chains" of stigma and restrictions to human rights of persons with mental illness, the right to universal access to all opportunities with and for persons with mental illness.

Enjoying physical rehabilitation activities promotes a sense of realization
(© GRT/Julie Taylor)

In order to have a better understanding of the mental health situation in the country and to put mental health - a highly neglected area in Somalia - on the health agenda, WHO country office produced a mental health situation analysis in 2010. This publication revealed that one in three Somalis has been affected by some kind of mental illnsess, a prevalence which is higher than in other low-income and war-torn countries.

Following increased media attention to mental health issues in Somalia, new funding was received in 2011 from the Common Humanitarian Fund to support a total of five mental health facilities with medical supplies, including Marka, Mogadishu, Jalalaqsi, Gaalkacyo and Johwar. After successful negotiations, other donors pledged a contribution for additional procurement of mental health medicines.

From 30 July to 4 August 2012, the WHO country office in Somalia, in collaboration with WHO Regional Office, the WHO country office in Ethiopia and the Ministries of Health in Somalia organized a training of trainers workshop on the mental health gap action programme (mhGAP) intervention guide in Addis Ababa, Ethiopia. A total of 18 mental health professionals (doctors, psychiatric nurses, mental health officers), academics from medical schools/nursing schools, as well as public health officers and primary health care supervisors attended the training. The pre- and post-training assessment, as well as structured feedback on individual sessions indicated significant improvement in knowledge and skills of participants to conduct training of non-specialists in their respective regions during the next phase of mhGAP implementation programme for Somalia. This training was organized following an initial workshop held in Nairobi in April 2012 with Somali senior professionals representing Ministries of Health, educational institutions and health service providers to adapt the mhGAP training material and intervention guide to the Somali context. WHO launched mhGAP in 2008 to bridge the gap in services between what is available and what is needed. The mhGAP intervention guide was developed in 2010 to provide evidence diagnostic and treatment algorithms for a limited number of priority mental health conditions.

Checklist for mental health best practices in Somalia

This manual is an adaptation of the WHO Quality Rights Toolkit to the Somali context, which aims to improve the quality and human rights conditions in mental health and social care facilities and empower civil society organization to advocate for the rights of people with mental and psychosocial disabilities.

The care available from mental health facilities in Somalia is not only of poor quality but in many instances hinders recovery. Training of staff is minimal and out-dated, and the level of knowledge and understanding about the human rights of persons with mental disabilities is very poor. It is common for people to be locked away in small, prison-like cells with no human contact, or to be chained to their beds, unable to move. Inhuman and degrading treatment practices are common, and people in facilities are often stripped of their dignity and treated with contempt. Violations are not restricted to inpatient and residential facilities. Many people seeking care from outpatient and community care services are disempowered and also experience extensive restrictions in their basic human rights.

Since the Toolkit uses the UN-CRPD, listed below are a set of themes that illustrate the Human Rights required within a Mental Health Facility and all that needs to be address.

This manual will assist the service provider and policy makers to deliver proper Mental Health Care in line with the UN-CRPD. The Convention intends to ensure equal rights to people with disabilities. This is done by elaborating in detail the rights of persons with disabilities and setting out a code of implementation. A total of eight principles and articles form the base for the Convention. They include:

- Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons
- Non-discrimination
- Full and effective participation and inclusion in society

- Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity
- Equality of opportunity
- Accessibility
- Equality between men and women
- Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities

Based upon the guiding principles and articles of the Convention, a checklist has been developed in order to ensure that each and every health facility providing mental health services meets the standards and human rights within each theme (see below).

Theme 1: The right to an adequate standard of living
(Article 28 of the CRPD)


'Chaining' is a Human Rights violation
(© WHO/Pieter Desloovere)

Standard 1.1 The building is in good physical condition
Example: The building is well ventilated, windows are intact, good general condition of the building, the paint on the walls is intact

ACHIEVED | NOT ACHIEVED

Standard 1.2 The sleeping conditions of service users are comfortable and allow for sufficient privacy
Example: Are there enough beds for each user?
If more than one user in the room is there sufficient space for them to change their clothes? Can the door be locked from the inside?

ACHIEVED | NOT ACHIEVED

Standard 1.3 The facility meets hygiene and sanitary requirements
Example: Are there your bathing and toilet facilities clean and working properly?
Are there separate bathing and toilet facilities for men and women?

ACHIEVED | NOT ACHIEVED

Standard 1.4 Service users are provided with food, safe drinking water and clothing that meets their needs and preferences.
Example: Does your facility provide to the user three nourishing meals and safe drinking water a day
Does your facility provide any type of clothing to meet the needs of your user?

ACHIEVED | NOT ACHIEVED

Standard 1.5 Service users are able to communicate freely and their right to privacy is respected
Example: Is there a telephone available for the user to call home?
Is there an allocated room for the user to speak privately with family and/or staff?

ACHIEVED | NOT ACHIEVED

Standard 1.6 The facility provides a welcoming, comfortable and stimulating environment conducive to active participation and interaction
Example: Is there comfortable, furniture available in a good condition (e.g. chairs)?
Is there an entertainment room available?

ACHIEVED | NOT ACHIEVED

Standard 1.7 Service users are able to enjoy a fulfilling social and personal life and remain engaged in community life and activities.
Example: Are the users allowed to attend weddings, funerals and prays at the mosque?
Is the user allowed to visit the family home once a week?

ACHIEVED | NOT ACHIEVED

Funk, M. & Drew, N. (2011) 'WHO QUALITY RIGHTS TOOL KIT' to assess and improve quality and Human Rights in Mental Health and Social Care Facilities', Geneva

Theme 2: The right to the enjoyment of the highest attainable standard of physical and mental health (Article 25 of the CRPD)

Standard 2.1 Facilities are available to everyone who requires treatment and support
Example: Do you admit all users that need acute care?
Do you provide care without discrimination among users?

ACHIEVED | NOT ACHIEVED

Standard 2.2 Staff is skilled and able to provide good quality mental health services
Example: Is your staff aware about the human rights of the user?
Is your staffs' trained and professionally competent to deal with mental health users?

ACHIEVED | NOT ACHIEVED

Standard 2.3 Treatment, rehabilitation and linkages to support networks and other services are elements of a service user driven treatment plan, and contribute to a service user's ability to live independently in the community
Example: Are the service user involved in their personal treatment plan?
Are the service users having access to psychosocial programmes and rehabilitation?

ACHIEVED | NOT ACHIEVED

Standard 2.4 Psychotropic medication is available, affordable, and utilized appropriately
Example: Do you provide the medication to suit the user's disability?
Is your service free of charge?

ACHIEVED | NOT ACHIEVED

Standard 2.5 Adequate services are available for general and reproductive health
Example: Do you refer to other disciplines?
Do you liaise with other departments on behalf of your service user?

ACHIEVED | NOT ACHIEVED

Participating in football enhances co-ordination and sensory skills
(© WHO/Pieter Desloovere)

Funk, M. & Drew, N. (2011) 'WHO QUALITY RIGHTS TOOL KIT' to assess and improve quality and Human Rights in Mental Health and Social Care Facilities', Geneva.

Theme 3: The right to exercise legal capacity and to personal liberty and the security of person (Articles 12 and 14 of the CRPD)

Standard 3.1 Independent living in the community is always prioritized when decisions are made regarding admission to hospital and methods of treatment

Example: Do your staff encourage and support service networks?
Does your facility promote and encourage the service user to return to the community after treatment?

ACHIEVED | NOT ACHIEVED

Standard 3.2 Procedures and safeguards are in place to prevent detention and treatment without informed consent

Example: Does your facility respect the rights of the service user in relation to treatment?
Does your facility discuss the user's care and treatment?

ACHIEVED | NOT ACHIEVED

Standard 3.3 Service users are able to exercise their legal capacity and are provided the support they may require to exercise their legal capacity

Example: Does your facility provide access to legal aid when needed?
Does your facility support the user in his/her need for legal assistance?

ACHIEVED | NOT ACHIEVED

Standard 3.4 Service users of facilities have the right to confidentiality and access to personal health information

Example: Does your facility provide treatment interventions in a private and confidential place?
Does your facility provide access to the users file when asked?

ACHIEVED | NOT ACHIEVED

Male users being taught skills about nurturing and caring for something he produced (© GRT/Julie Taylor)

Funk, M. & Drew, N. (2011) 'WHO QUALITY RIGHTS TOOL KIT' to assess and improve quality and Human Rights in Mental Health and Social Care Facilities', Geneva.

Theme 4: Freedom from torture or cruel, inhuman or degrading treatment or punishment and from exploitation, violence and abuse (Article 15 and Article 16 of the CRPD)

Standard 4.1 Service users have the right to be free from verbal, mental, physical and sexual abuse, and physical and emotional neglect

Example: Are the service user provided information about s/he's rights?
Do your staffs ensure by observation and completion of a chart that a user is always safe and free of harm from self or others?

ACHIEVED | NOT ACHIEVED

Standard 4.2 Alternative methods are used in place of seclusion and restraint as means of de-escalating potential crisis situations

Example: Are your service users chained?
Do you provide a comfort room for aggressive users?

ACHIEVED | NOT ACHIEVED

Standard 4.3 Elector-convulsive therapy (ECT), psychosurgery, or other medical procedures that have permanent and irreversible effects, whether performed at the facility or referred out to another facility, must not be abused and can only be administered with the free and informed consent of the person

Example: Not applicable

ACHIEVED | NOT ACHIEVED

Standard 4.4 No service user is subject to medical or scientific experimentation without their consent

Example: Not applicable

ACHIEVED | NOT ACHIEVED

Standard 4.5 Safeguards are in place to prevent torture or cruel, inhuman or degrading treatment or other forms of ill-treatment and abuse

Example: Do you have an observational tool in place for monitoring the treatment of the user?
Do you have a complaint procedure in place?

ACHIEVED | NOT ACHIEVED

A user enjoying the fruits of his labor (© GRT/Julie Taylor)

Funk, M. & Drew, N. (2011) 'WHO QUALITY RIGHTS TOOL KIT' to assess and improve quality and Human Rights in Mental Health and Social Care Facilities', Geneva.

Theme 5: The right to live independently and be included in the community (Article 19 of the CRPD)

Standard 5.1 Service users are supported to have access to a place to live and have the financial resources necessary to live in the community.

Example: Do the staff lobby and speak to the Ministry of Health and Interior Affairs in relation to housing?
Do the staffs assist, provide and document information in relation to financial matters?

ACHIEVED | NOT ACHIEVED

Standard 5.2 Service users are able to access education and employment opportunities

Example: Do the staff provide verbal information on any opportunities in relation to education and employment opportunities?
Do the staff document such provided information?

ACHIEVED | NOT ACHIEVED

Standard 5.3 Participation of service users fully in political and public life and the enjoyment of their freedom to associate are supported

Example: Do the staff provide information on political and public life participation?
Do the staff document such provided information?
Are the service users assisted with voting?

ACHIEVED | NOT ACHIEVED

Standard 5.4 Service users are supported to take part in social, cultural, religious, and leisure activities

Example: Are the users allowed to visit the mosques?
Are the service users provided with cultural activities and if so, what are they?
What leisure activities are provided to the user?

ACHIEVED | NOT ACHIEVED

Group activities encouraged to foster team spirit and a sense of belonging to a community (© GRT/Julie Taylor)

Funk, M. & Drew, N. (2011) 'WHO QUALITY RIGHTS TOOL KIT' to assess and improve quality and Human Rights in Mental Health and Social Care Facilities', Geneva.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