2016 CLA CASE COMPETITION
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Case Story

This Case Story was submitted to the 2016 CLA Case Competition. The competition was open to individuals and organizations affiliated with USAID and gave participants an opportunity to promote their work and contribute to good practice that advances our understanding of collaborating, learning, and adapting in action.

Improving State Mental Health Service Delivery in Sri Lanka Through Peer Support

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Phychosocial Project. *Credit: The Asia Foundation.*

What is the general context in which the story takes place?

The civil war in Sri Lanka ended on May 18, 2009. This 26-year civil war between the government and the Liberation Tigers of Tamil Eelam affected the country's socio-political landscape with a significant increase in the number of war widows and women-headed families, a breakdown of social networks and infrastructures, and fundamental changes in family and community structures. Following the many traumas of the war, a generation of Sri Lankan citizens are affected by a range of mental health and psychosocial issues. Since 2005, the Asia Foundation Sri Lanka (the Foundation), with USAID support, has implemented the Reducing the Effects and Incidences of Trauma (2005-2011) and Victims of Trauma Treatment Program (2010-2017) programs, which have provided psychosocial services for survivors of war, conflict, trauma, and torture. The programs began as a partnership with two national NGOs, the Family Rehabilitation Centre and the Association for Health and Counseling (known as Shanthiham). In 2014, the Foundation made a significant shift from primarily engaging with non-government partners to engaging with government partners taking on the best practices in mental health and psychosocial support (MHPSS) from NGO partnerships to improve the service outcomes of government MHPSS providers. The importance of clinical supervision for self-care and improving service outcomes was learned through the Foundation's work with its initial NGO partnerships. This learning was adapted to the government mental health service

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providers through the use of a peer support model, which also has at its goals self-care and improved MHPSS service outcomes.

What was the main challenge or opportunity you were addressing with this CLA approach or activity?

The end of the war provided an excellent opportunity for the Foundation to collaborate with the state-run MHPSS sector. The government's MHPSS network has an island-wide reach and has the greatest potential to be a sustainable mechanism for MHPSS service delivery. However, a daunting challenge to working with the Ministry of Social Empowerment and Welfare (MSEW) and the Ministry of Women and Child Affairs (MWCA) was the lack of clear documentation on the role, scope of work, and training needs of counselling cadre positions. Following the signing of memorandums of understanding between the Foundation and the ministries, mapping studies were undertaken to better understand the role, scope of work, and training needs of counselling assistants and counselling officers of the MSEW and MWCA. These mapping studies, among other issues, highlighted the fact that there was no system for clinical supervision available for the counselling assistants and officers.

The main challenge of setting up a clinical supervision model for the counselling assistants and officers was the dearth of clinical psychologists in Sri Lanka. In the absence of the necessary technical supervision cadre and infrastructure, the Foundation reviewed alternative models that promote self-care and improve service outcomes. Accordingly, the following eight-step peer support model adapted from Felician Francis[1] and Guusvander Veer was introduced to the MSEW and MWCA counsellors:

- Step 1: A counsellor presents a case that they found difficult to handle or proceed with further.
- Step 2: Clarifying questions: The rest of the group asks two types of questions.
    - A question to enhance their own understanding of the problem, presented by the client
    - A question to clarify or understand the problem faced by the counsellor
- Step 3: Empathetic understanding insight into the feelings of the client.
- Step 4: Clarification from the presenter.
    - The presenter identifies and names the feelings that s/he found in his/her client that have been mentioned by the rest of the members, as well as those that they did not mention.
- Step 5: Empathic Understanding: Insight into the feelings/ experience of the service provider.
- Step 6: Acknowledgement by the Presenter.
    - The presenter acknowledges the feelings that s/he experienced as a counsellor supporting this client and handling this particular case.
- Step 7: Acknowledging the positive/effective interventions and responses taken by the Service Provider.
- Step 8: Suggestions to move the case forward.

[1] Field report: Peer support supervision as a procedure for learning from practical experience in a mental health setting, Intervention 2011, Volume 9, Number 2, pp. 154-158.

The introduction of the peer support model to ministry counselors also presented a strategic opportunity to enhance the profile of longstanding NGO partnerships garnering lessons learned from the Foundation's Psychosocial Program to inform new partnerships with the government MHPSS providers. This paved the way for consistency in approaches between the state and NGO sectors to be instilled and sustained, as well as to enhance the profile of NGO partners as a resource to the state sector.

Describe the CLA approach or activity, explaining how the activity integrated collaborating, learning, adapting culture, processes, and/or resources as applicable.

The enhanced collaboration between state MHPSS providers and the Foundation after the war was a great opportunity to introduce best practices in MHPSS to the state sector. The learning from the Foundation's NGO partnerships for psychosocial service provision highlighted the importance of practice supervision as a measure for quality control of the counselling service and self-care of the practitioner. The Foundation's work with the government's counselling and psychosocial service has focused on two areas: to develop an awareness of the value of practice supervision and how it influences service quality and professional competency; and to introduce and equip point persons involved in provision of counselling services with knowledge and skills to train their teams and facilitate regular peer support mechanisms within their respective districts.

The Foundation introduced peer support to MSEW and MWCA in 2014. This provided the space for case discussion and self-care of the service provider as provided for within a clinical supervision setup. This methodology allowed peers to take on this role, which was an innovative response to the dearth of clinical psychologists in the country. Peer support helps the counsellor to gain perspective of their work and how they interpret situations. The uses and usefulness of the model is further illustrated by the quotes below:

> "The usefulness of regularly meeting, having a file that documents proceedings, the opportunity to plan for team activity to work on one thematic area as a group, when we set up as a team for the peer support is when we began to realize the things we could do together. Even when there is a medical referral in a district that is far from us we can refer it to a colleague". —*Counseling assistant in Uva province*

> "When I try to step into the client's shoes to empathize with them, I may still be seeing the situation the way *I* would see and feel things. Because we are unique, we may not quite understand someone else's experience exactly the way they do. Peer support allows us access to multiple perspectives on an issue, which broadens the possible ways we see and experience a situation. It reduces my errors and helps me think beyond my personal values and experiences. —*Clinical psychologist*

> "A good opportunity to meet/understand the mistakes we have made and improve ourselves … was an excellent opportunity to strengthen ourselves as a team and get mutual support … excellent for self-care and motivation/standardization of the services." —*Counseling assistant, Central Province*

> "We get a new view of the client and we don't feel so isolated anymore." —
> *Counseling Assistant, North Central Province*

Counselors have found the model extremely useful. For the first time, they have an opportunity for case discussion and self-care. In 2015/2016, MSEW and MWCA issued circulars directing that peer support be practiced at the monthly review meetings, ensuring that this methodology for high-quality care has been institutionalized.

Were there any special considerations during implementation (e.g., necessary resources, implementation challenges or obstacles, and enabling factors)?

The peer support model was introduced to MSEW and MWCA though a training-of-trainers model and one-on-one capacity building of the core group (i.e., trainers) by a clinical psychologist with a technical committee set up to review and advice on outcomes. The training-of-trainers group/core group was identified by both ministries, and monthly capacity building programs were conducted separately for each ministry with the support of a clinical psychologist. These meetings were important to build the knowledge, skills, and attitudes of the core group on best practices in MHPSS. It was also useful to develop the group's general clinical skills.

During the course of a year, the following capacity building work was conducted with the core group: building the resilience of the counsellor; ethics (identify key ethical principles); working with and facilitating groups/group therapy (elders/youth, teenagers/women); drafting monthly progress report formats; strategies to support staff/ primary caregivers working with children with behavioral problems to understand and support children positively; forming and using circular questions; developing an intervention plan; substance misuse and challenging areas; sexual problems (further interventions, basic principles of trauma or crisis counselling, and domestic violence); and men as fathers. These monthly capacity building programs were essential for the professional development of the core group and for the purpose of equipping them as trainers of the peer support model.

The core group was trained on the peer support model though the means of several training-of-trainers programs over the course of 3 years (2014-2016). In turn, the core group trained counselling assistants in the districts. Once the model was introduced across the country, several refresher training programs were conducted to ensure that it was understood and working well. One of the challengers faced in this process was institutionalizing the model in the MSEW and MWCA. While the benefits of the model were apparent to the counselling cadre, it took some time to advocate for its use and usefulness with the ministries' administrative staff, who are in charge of the counselling cadre. Although the model was introduced in 2014, the circulars mandating its use every month came out in 2015 for MSEW and in early 2016 for MWCA.

A rough estimate of the financial cost of the program:

	Estimated Cost (USD)
Training programs	$36,800
Technical input	$14,200
Total	**$51,000**
Percentage of total program cost (estimate)	3.5%

With your initial challenge/opportunity in mind, what have been the most significant outcomes, results, or impacts of the activity or approach to date?

The initial challenge faced was the dearth of psychologists available for one-on-one clinical supervision. The response was to find an alternative mechanism for such supervision. The best fit was the peer support model, which provided for the benefits of one-on-one supervision that could be practiced with peers. This provided the space for case discussion and self-care of the service provider, as provided for within a clinical supervision setup.

The next challenge was institutionalizing the model at ministry level. This was tackled through a three-pronged approach:

1. Advocacy with decision-makers
2. Ongoing capacity building of the training-of-trainers/core group
3. Establishment of a Technical Support Committee

While the benefits of the model were apparent to the counselling cadre, the Foundation needed to spend time with administrators at the ministry level who do not have a background in MHPSS to advocate for the institutionalizing of the peer support model. The advocacy also included ensuring that decision-makers participated in the many capacity building programs, which helped build their awareness of the MHPSS sector. The Technical Support Committee kept decision-makers informed of the direction of the work and sought their concurrence moving forward.

As a result of these efforts, the peer support model that was first introduced to the ministries in 2014 was institutionalized through circulars mandating the use of the model on a monthly basis. The circular for the MSEW came out in 2015; the one for MWCA came out in early 2016.

If your project or activity is in the development phase or just recently underway (less than 1 year into implementation), how do you intend to track results and impact? What outcomes do you anticipate?

In 2016 approximately 2 years after the peer support model was introduced to MSEW and MWCA, indicators were developed that would measure the its impact for improving self-care and service outcomes. Separate workshops were held for each ministry to develop indicators to assess the use and usefulness of the model. The following indicators were developed:

- Client outcome: Has the peer support model had an impact on improving the quality of service provision to clients?
- Counselling assistants' wellbeing, confidence, and cooperation (team spirit): Has the peer support model supported the self-care of the counselling assistants?
- Counselling assistants' skills & knowledge: Has the peer support model facilitated the development of knowldge, skillls, and attitudes of the counselling assistants?
- Accountability/Commitment (attendance): Has the peer support model iniciated better attendence by the counselling assistants for monthly meetings?
- Coordination & Logistics: Has the peer support model improved networking and referral?

These indicators were developed in a participatory manner with the input of the counselling assistants. In order for the assistants to give this feedback, the model had to be used and practiced for a while. It will take a further 1-2 years to collect data on the indicators, which is not within the life span of the current source of USAID funding. However, as the indicators have been developed and introduced to counselling assistants island-wide, the ministries could take on the task of data collection for the indicators going forward.

What were the most important lessons learned?

One of the most important lessons learned from the introduction of the peer support model is that when adapting a concept like clinical supervision to a local setting, the concept needs to be contextualized to suit that setting's needs, resources, and culture. While one-on-one clinical supervision was not possible within the Sri Lankan context, where more than 400 counsellors work in both the MSEW and MWCA, the peer support model was adapted to take the place of clinical supervision. Similarly, it was learned that when introducing a new concept, it is important to advocate its use and usefulness at many different levels. With the introduction of the peer support model, this advocacy was done at the following levels: service users/providers, administrators, and donors. Another key learning was the importance of identifying a core group that can take on new learning, retain it, and train others. Both partner ministries appointed a core group to work with a clinical psychologist on a monthly basis. Another learning was identifying the importance of having a Technical Support Committee with a representation of decision-makers to steer and guide the work.

A crucial lesson learned was that the Foundation needed to have ongoing, one-on-one relationships with the different stakeholders in order for the work to go forward. Above all, the Foundation needed to establish and maintain good relationships to introduce the new model to the state sector. This involved adapting available resources to respond to needs, advocating with decision-makers,

identifying a core group for long-term capacity building, and establishing the Technical Support Committee for advocacy purposes. Fostering change within the government required a high level of diplomatic engagement with the key decision-makers.

Any other critical information you'd like to share?

Taking on the lessons learned in introducing the peer support model to the counselling cadre of the MSEW and MWCA, the Foundation has identified that the model could be used for other MHPSS cadres. It has initiated the introduction of the model to Ministry of Health nurses attached to acute psychiatry wards, who often operate within a bio-medical model where their scope of work involves the use of a psychosocial model. The nursing cadre is expected to provide a patient-friendly service and needs to gradually move away from a disease-oriented service and limiting of their services to the administration of drugs. A peer supervision model could be used to build the skill of nurses to engage with their clients. A nurse could bring in cases for peer support that s/he may find difficult, and the peer support process could provide support by building the nurse's skills to improve communication with patients and build empathetic understanding. In introducing a peer support model to nurses in acute psychiatry wards, some principles of psychiatric nursing that could be actively put to use include accepting the patient as he/she is, using self-understanding, using consistent behavior, giving reassurance, changing a patient's behavior though emotional experience, and avoiding unnecessary increases in a patient's anxiety.