PROJECT SPECIFICS / ABSTRACT

Project name: Mental Health and Primary Care Integration and stigma reduction in St Vincent and the Grenadines

Project lead: Dr Elizabeth Medford (in-country supervisor, Senior Nursing Officer, Mental Health Rehabilitation Centre (MHRC), St. Vincent and the Grenadines

IGH Fellow: Dr Claire Carstairs (Aug 2022 – Jan 2023)

Local Partners: Ministry of Health, Wellness and the Environment, St Vincent and the Grenadines

Start Date: August 2022

Relevance to Partner's Overall Strategy: From the STAR Workshops in 2022, mental health and primary healthcare integration, as well as reduction of stigma surrounding mental health, emerged as key priorities for St. Vincent and the Grenadines. The Draft Mental Health Policy and Action Plan from the Ministry of Health, Wellness and the Environment state the following Goals: improve the mental health of the population; protect the human rights and mental health rights of the population; reduce mortality and disability related to mental health disorders. Objectives (to be attained by 2025) include: To provide well-coordinated, equitable, decentralised mental health services to the Vincentian population across all age groups at all levels of the health care system through integrated systems of health care; To provide integrated community-based mental health services with emphasis on promotion and prevention through multi-sectoral policies and partnerships; To advocate for universally standardized and specialized mental health services which are well integrated into the entire care systems to meet the needs of the population in St. Vincent and the Grenadines; To provide comprehensive, continuous mental health programme for rehabilitation and effective reintegration of clients into families and communities through community empowerment and inter-sectoral collaboration; To decrease levels of stigma and discrimination experienced by persons with mental health problems through appropriate therapeutic interventions, policies, legislation, public information and mass education.

Goal: Improve quality of mental health care and safety and dignity of patients, through improved integration of mental health and community healthcare, and reduction of stigma

Outcomes:

- Increased communication and engagement between MHRC team, District Medical Officers and District Nurses with mental health patient discharge and community support
- Improved safety on inpatient wards
- Improved attitudes and reduced stigma regarding care for mental health patients in the community

Progress:

1. **Regular discharge coordination meeting established**

- Weekly meeting for full multidisciplinary team
- Resources created: whiteboard to record patients discussed; pro-forma for documentation in patient notes
- Pilot of additional interventions: inpatient substance/alcohol use disorder counselling; early district team follow-up for selected patients

2. Discharge communication strategy developed

- Nurse "champions" for each ward identified to keep note of discharged patients, flag to doctors which patients still require discharge letters, and ensure telephone handover by ward nurse to district nurse is completed
- Discharge Communication Books produced for each ward to record patient details, discharge date and whether letter sent and telephone handover complete
- Delivery strategy developed: in-tray containing delivery folder for each district, for delivery during field clinics and other visits

3. Shared mental health team / primary care follow-up model established

- Model for shared follow-up established: DMO/DN taking over regular follow-up of stable outpatients, with MHRC input once or twice per year; early follow-up of patients recently discharged from MHRC
- Established engagement from district medical officers and district nurses in most communities to date
- Referral form (with same delivery system) developed to inform DMOs and district nurses
- First Mental Health Education Afternoon for community staff completed
- Presentations produced for use in first round of community staff sessions, based on requests from DMOs and district nurses during integration engagement meetings

Discharge / shared follow-up protocol written to encompass all above

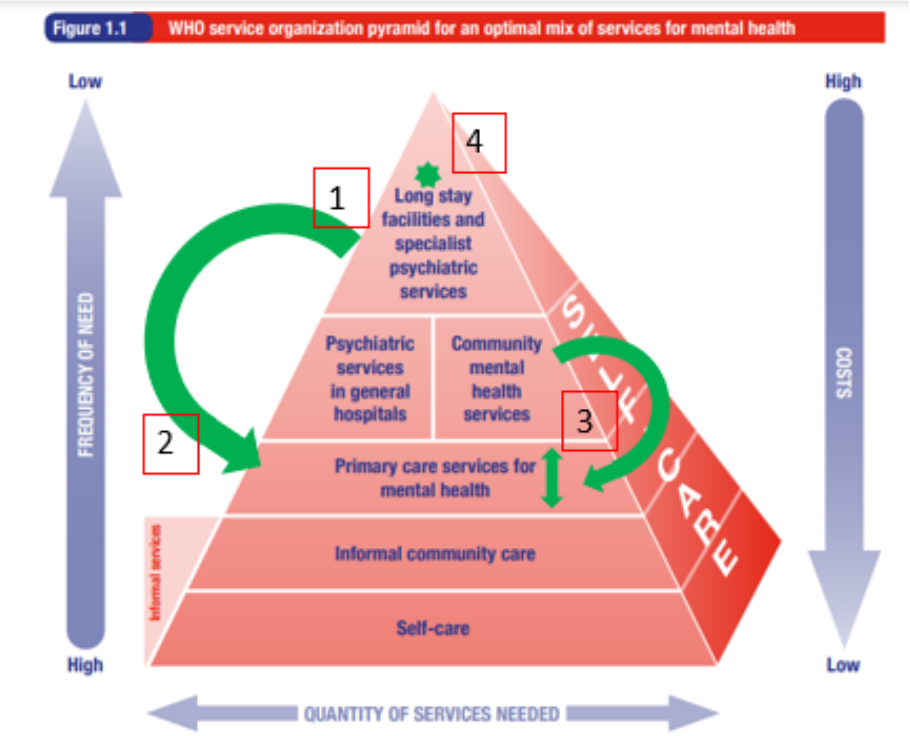
4. **Proposal discussed with PS and sent to CMO for HEE/Ministry of Health/Royal College of Psychiatrists initiative to employ UK-based consultant psychiatrist in SVG.** Ministry response pending

   For future projects: A list has been compiled of mental health and community staff who would be interested in training in substance/alcohol use disorder counselling; Dr Providence has provisionally agreed to provide this training in a structured way, if arranged by a future IGH fellow, based on her PAHO "Train the Trainers" qualification.

Handed over to:

Incoming IGH fellow/s

Illustrated approach to integration based on WHO service organisation pyramid for an optimal mix of services for mental health



1 Introduction of discharge co-ordination meeting

2 Improve communication with community primary healthcare teams at point of discharge

3 Shared primary / mental healthcare follow-up for stable patients

4 Work towards Ministry of Health / HEE / RC Psych partnership to facilitate employment of consultant psychiatrist

Project Progress

ITEMS	INDICATORS	SOURCES OF INFORMATION	PROGRESS – favourable outcomes in **bold**
GOALS			
Improve quality of mental health care and safety and dignity of patients, through improved integration of mental health and community healthcare, and reduction of stigma			
OUTCOMES			
Increased communication and engagement between MHRC team, District Medical Officers and District Nurses with mental health patient discharge and community support	Improvement in reports of documentation being received by community staff	Community staff questionnaires	*When patients are discharged from the Mental Health Centre we most often receive/d a discharge notification detailing their admission and treatment (Aug →Jan)* **Strongly agree 0% → 20%** Agree 11% → 0% **Neither agree/disagree 0% → 20%** **Disagree 44% → 30%** **Strongly disagree 44% → 30%** *It would be helpful if there was increased communication about plans for patients being discharged from, or followed up by, the mental health team* **Strongly agree 78% → 50%** Agree 22% → 50% Neither agree/disagree 0% → 0% Disagree 0% → 0% Strongly disagree 0% → 0%
		MHRC staff questionnaires	*We have adequate communication with the district medical officers and nurses* Strongly agree 0% → 0% Agree 29% → 22% Neither agree/disagree 14% → 33% Disagree 50% → 33% Strongly disagree 7%
	Discharge letters sent to 100% of patients discussed in discharge coordination meeting (compared to no discharge letters being sent direct to DMOs at outset)	Discharge coordination discussion list and regular checking of delivery folders (Sept-Nov) Discharge communication book	**Sept-Nov – 65% patients on discharge discussion list had discharge letter produced and placed in delivery folder → Nov-Jan increased to 75% of all discharged patients**

	NEW Nov-Jan Telephone handover to community for 100% of patients 100% discharges recorded in discharge communication book	Discharge communication book Discharge communication book	**36% of all discharged patients with telephone handover provided to community (compared to 0% at outset)** **100% discharges recorded in book**
	Agreement of 50% DMOs and DNs to share responsibility for follow-up of long-term stable mental health patients and of all District Nurses for early follow-up post-discharge	Outcomes from district clinic engagement meetings Community staff questionnaires	**Engagement from (Nov → Jan)** - **10/27 DMOs → 21/27 DMOs** - **21/ ~41 Nurses → 35 nurses/NAs** - **5/38 district clinics → 22/38** *I would be happy to follow-up stable mental health patients (Aug →Jan)* Strongly agree 33% → 10% Agree 56% → 70% Neither agree/disagree 11% → 10% Disagree 0% → 10% Strongly disagree 0% → 0% *I would be willing and able to follow-up patients immediately following discharge (Aug → Jan)* **Strongly agree 11% → 30%** Agree 44% → 20% **Neither agree/disagree 22% → 30%** **Disagree 22% → 20%** Strongly disagree 0% → 0%
	Follow-up partially taken over by DMOs, with reduced MHRC OPD follow up in at least 10% of MHRC OPD attenders	OPD shared follow-up referral forms Telephone follow-up of patients referred	Sept-Nov – 5 patients referred for shared follow-up **Nov-Jan – 12 patients referred for shared OPD follow-up (17 total)** Limited data (see *what went less well?)*
	Better opinions of discharge process among staff at MHRC	MHRC staff questionnaires	*We have an efficient patient discharge process (Aug →Jan)* Strongly agree 0% → 0% **Agree 7% → 40%** **Neither agree/disagree 36% → 40%** **Disagree 57% → 10%** Strongly disagree 0% → 10% *We have effective techniques to reduce RE-admissions* Strongly agree 0% → 0% **Agree 14% → 20%**

			Neither agree/disagree 0% → 20% **Disagree 79% → 40%** Strongly disagree 7% → 20%
	Improved attitudes to following up patients with mental health disorders	Community staff questionnaires	*I feel confident diagnosing / managing mental health problems in the community (Aug → Jan)* Strongly agree 22% → 0% **Agree 11% → 70%** **Neither agree/disagree 33% → 20%** **Disagree 22% →10%** Strongly disagree 11% *I have adequate resources to guide diagnosis / management of common mental health disorders, aside from direct Psychiatrist advice* Strongly agree 0% → 0% **Agree 22% → 56%** **Neither agree/disagree 0% → 22%** **Disagree 56% → 22%** **Strongly disagree 22% → 0%**
	Reduced absolute re-admission rate	Monthly ward statistics report	**Readmissions July 32 → December 29** **(32 → 24 when corrected for absconders) *** *(see graphs below for illustration)*
	Reduced re-admission rate among cohort of patients discussed in new Discharge Coordination Meeting	Male/female ward report books; discharge coordination meeting list	21 patients were discharged and re-admitted between 12/9/22 (first discharge discussion date) – 16/1/23 **Of these, 16 were not discussed in the discharge meeting during their last admission; 4 were discussed.** This may be an early indication of a favourable impact from the discharge discussion meeting
	Reduced time between admissions among cohort of patients discussed in new Discharge Coordination Meeting, in cases where readmission does occur within project timeframe	Male/female ward report books; discharge coordination meeting list	September 12th – January 16th Insufficient data – only 2 patients had dates recorded for most recent and previous 2 admissions; 1 discussed in meeting between most recent 2 admissions, 1 not discussed 21 patients discharged and readmitted 12/9/22 – 16/1/23; 8 had documented discharge date from last admission and admission date from most recent admission in report book - Discussed in meeting on last admission (N=5) – mean 31 days to readmission, median 18 days - Not discussed in meeting (N=8) – mean 31.4 days to readmission, median 31 days
Improved safety on inpatient wards	Reduced number of recorded incidents on the inpatient wards	Monthly ward statistics report	July: 5 incidents; December: 7 incidents * *(see graphs below for illustration)*
	Reduced crowding measured by absolute number of inpatients	Monthly ward statistics	Average ward census: July: 196; January: 174 * *(see graphs below for illustration)*

	at end of project compared with start		
Improved attitudes and reduced stigma regarding care for mental health patients in the community	Improved attitudes of staff and patients	Community, MHRC and patient questionnaires	Community staff *Psychiatric illnesses should be treated separately from other types of health problems (Aug → Jan)* Strongly agree 0% → 10% **Agree 33% → 30%** **Neither agree/disagree 11% → 0%** **Disagree 56% → 60%** Strongly disagree 0% -> 0% *Mental health staff are viewed positively by other healthcare workers* Strongly agree 44% → 30% **Agree 33% → 50%** Neither agree/disagree 22% → 10% Disagree 0% → 0% Strongly disagree 0% → 10% MHRC staff *Our patients regularly face stigma* Strongly agree 57% → 60% Agree 36% → 40% Neither agree/disagree 0% → 0% Disagree 0% → 0% Strongly disagree 7% → 0% *Mental health workers regularly face stigma themselves* Strongly agree 36% → 10% Agree 36% → 40% Neither agree/disagree 14% -> 10% Disagree 14% → 20% Strongly disagree 0% → 20% Patients I would attend follow-up if some of it was with my district medical officer in a local clinic Strongly agree 24% Agree 41% Neither agree/disagree 18% Disagree 12% Strongly disagree 6%

			I would feel safe attending my local clinic with a Mental Health problem Strongly agree 19% Agree 63% Disagree 13% Strongly disagree 6% I regularly experience stigma relating to my Mental Health problem Strongly agree 18% Agree 24% Neither agree/disagree 12% Disagree 24% Strongly disagree 24 % *Patient questionnaires to be repeated following focused patient engagement / stigma interventions in future project/s*
OUTPUTS			
Introduction of coordinated discharge planning	40 patients discussed in new Discharge Coordination meeting (Mondays 1pm) by project midpoint Early "bridging" follow-up provided to all for whom this is identified to be beneficial Substance abuse counselling sessions delivered to all patients assessed to be likely to benefit from this	Discharge coordination meeting list Discharge coordination meeting list Substance use disorder counselling list	**15 meetings in 19 weeks** **91 patients discussed** 16 referred for early DN/DMO follow-up – detailed follow-up in future Integration project **24 patients attended 1 or more sessions between Sept – Nov 2022** Sessions abandoned due to multiple staff absences
Increased education for primary care colleagues in mental health practice	Refresher session for DMOs and DNs – provided to 50% or more staff members	Mental Health Education afternoon report	**1 education session delivered** **Attended by 14/27 DMOs** **100% gave 4 or 5/5 for satisfaction with session** Nurses unable to attend at short notice
Improved communication about mental health to the community	Mental Health Awareness materials displayed in 100% district clinics	Posters delivered	Mental health awareness materials delivered during all engagement meetings since November 2022 however not feasible within this project to check with all clinics
Potential for improvement to medical staffing within	Contact established between HEE, MHRC and Royal College of Psychiatrists, UK, with a view	Updates from RC Psych, HEE, Ministry of Health SVG	Informal proposal submitted to PS and CMO, outcome awaited **Engagement ongoing from HEE, British High Commission SVG and RC Psych**

Psychiatry in St Vincent and the Grenadines	to setting up new managed clinical partnership involving temporary recruitment of psychiatry consultant		

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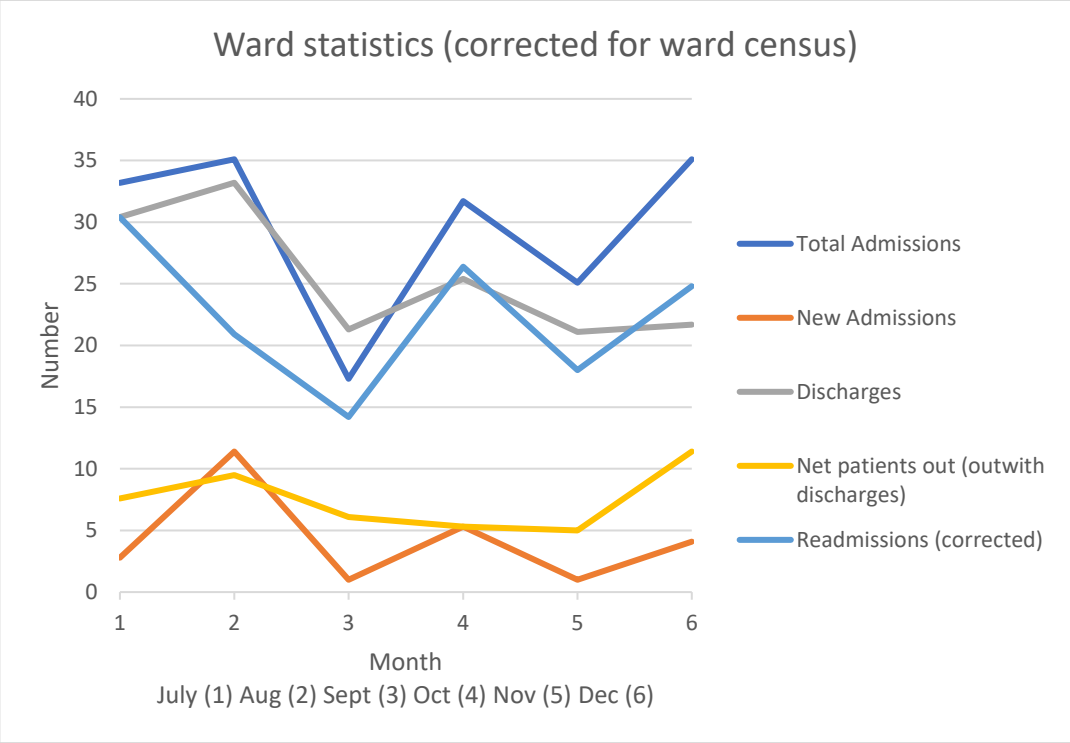

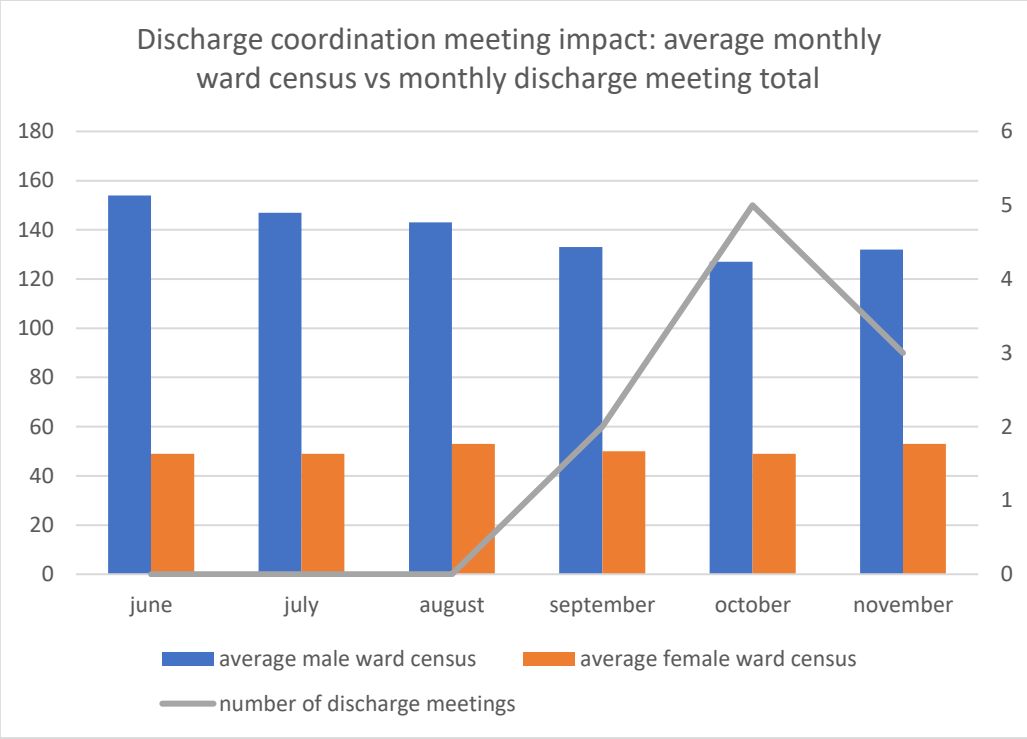

Key Meetings attended

Date	Meeting
30/11/22	Community nurse and police training session, MHRC. Integration Engagement summary for nurses present
7/12/22	DMO Integration Engagement meeting, Buccament Polyclinic
15/12/22	DMO/district staff Integration Engagement meeting, Chateaubelair

19/12/22	Project update meeting for key MHRC team members; presented progress at midpoint
22/12/22	Permanent secretary meeting: 1. Discussion about proposal for UK/SVG partnership to hire consultant psychiatrist from UK; 2. Discussion surrounding project progress and impressions surrounding integration at ministry level
5/1/23	DMO/district nurse Integration Engagement meeting, Georgetown clinic
12/1/23	Informal meeting on ward with discharge communication book champions for male/female wards
13/1/23	Senior Pharmacist Miss Guy, Mr Lowmans Community Mental Health Nurse, Dr Carstairs: problem-solving issue of patients not able to get medications in community
16/1/23	Team feedback and troubleshooting about discharge coordination meeting
25/1/23	Ministry of Health Project Update Meeting
Weekly	Discharge coordination meeting (except bank holidays)
Weekly	Clinical team meeting
Weekly	Meeting with Michelle Thompson HEE
Fortnightly	Meeting with Jane Appleton, mentor
Adhoc	Meeting with in-country supervisor, Dr Medford / Sr Gilgeours in lieu when Dr Medford on leave

Education sessions conducted

January 10th 2023, Ministry of Health: Mental Health Education for Community Healthcare Workers (DMO session)	
MHRC attendees	Sr Gilgeours, Julius Lowmans, Casheka Ollivierre, Dr Karen Providence, Melissa Stowe, Dr Claire Carstairs
DMO attendees	Dr Fernandez Casanova fernandezaria760@gmail.com Dr Dario Castro Basulto loicastin73@gmail.com Dr Michel Gonzales Sanchez michelgs255@gmail.com Dr Kevette Harry-Black kevetteblack@gmail.com Dr Kenzel Bullock keneilbullock@gmail.com / kenezilbullock@gmail.com Dr Nanyamka Snagg-John nsmandisa@gmail.com Dr Beneka Ferdinand benekab@gmail.com Dr Aurel Cato aurelioora@gmail.com Dr Jashika Williams drjashikawilliams@gmail.com Dr Kyrle Walker wlkrkyrle@gmail.com Dr Anabel Perera Vega apereravega@gmail.com
DMO attendees (via Zoom)	Dr Kishorn Richards Kishrich890@hotmail.com Dr Alisha Bonadie alishabonadie@yahoo.com Dr Snagg-John +1 (784) 593 3204
Sessions:	Dr Claire Carstairs – Welcome and update on mental health integration project

	Dr Providence – Basics of mental health diagnosis and management in the community Bipolar Affective Disorder for community staff Ward Manager Stowe – Mental health service referral pathway Mr Lowmans – Alcohol and substance use disorder for the community Staff Nurse Ollivierre – Breakaway and basic de-escalation training
Feedback	
How would you rate the usefulness of the content?	Score Number of respondents 1 0 2 0 3 0 4 4 5 7
How would you rate the presentations?	Score Number of respondents 1 0 2 0 3 0 4 4 5 7
Was the workshop above or below your current work level?	"It was perfect for community staff" "Adequate" "Above" "Yes" "Same" "It was appropriate for work level" "It was at my level" "Appropriate" "It was in line with things previously taught" "Appropriate" "It was above / appropriate"
What interested you the most?	"The techniques for de-escalation and how good the graphic show the levels of crisis because I was never trained in it" "De-escalating and … technique" "The presentation on bipolar disorder" "MDD/BPD presentations; de-escalation techniques" - "Flight or methods of de-escalation; information on bipolar" "Pharmacology on anti-psychotics and mood stabilizers" "BPD-I and MDD" "The presentation about Bipolar Disorder 1 and bipolar disorder 2 including the medications their effects and the best to use. The presentation about de-escalation and breakaway was useful as well" "The most interested for me was the presentation about BPD-1 and MDD "Bipolar disorder"

What interested you the least?	- “Nothing. Everything was relevant and interesting.” “De-escalation technique” “Everything was appropriate” - “Every aspect was valuable” “Unsure” “All is interesting” - “All is interested for me” -
What would you have liked to be added in today’s session	- “Dementia” - “Questionnaires” - “A brief run through of forms mentioned in presentation” “Anonymous cases by some individuals with mood disorders, psychosis etc and their experience in the system of mental health in SVG” “Emergency medication” “I would have liked that the presentation be available or some form of documents or pamphlet” “Emergency medications” “Alcohol use disorders and other illegal drugs”
Other comments	“We should repeat this meeting 2 times a year” “Would like on-call list for doctors to be available for contact about referrals and clinic follow-up” - “Great effort. Hope this can be done biannually or annually” - - “Well done overall” “…excellent” “Liked presentations looking forward to more of these in the future” “Repeat the event” -

New clinical services established

- Weekly discharge coordination meeting; possibility of referral for:
    - Early follow-up by DMOs/district nurses for patients at high risk of readmission
    - Substance/alcohol use disorder counselling (SUDC) group counselling sessions – weekly (paused in November 2022 due to inadequate staffing)

- Discharge communication monitoring system
    - Discharge communication monitoring book
    - Hand delivery system for all correspondence
    - Nurse to district nurse telephone handover procedure at discharge
- Shared follow-up referral system to integrate follow-up more into primary care setting (for stable patients)
    - Education programme for capacity building of district doctors/nurses commenced

Contributions to local protocols

Pending – protocol for discharge meeting, discharge communication, shared follow up model £

Other resources developed

August – November 2022

- Discharge Coordination Meeting pro-forma
- Discharge Coordination whiteboard
- Discharge Coordination complex patient list
- Discharge communication book (one each for Male/Female ward)
- Delivery folders for each health district and in-tray to store them to await delivery
- OPD notification pro-forma *(to communicate to DMOs/DNs requests for shared follow-up)*
- OPD shared follow-up monitoring form *(for clinicians to record name of patient, date seen in clinic, community in which patient is resident and whether they agreed to shared follow-up*
- Information leaflet/poster for patients regarding integration
- Information leaflet/poster for community staff regarding integration
- Presentation for Integration Engagement meeting
- Patient Questionnaire
- MHRC Staff Questionnaire
- Community Staff Questionnaire

November ’22 – January 2023

- Sourced from PAHO and distributed:
    - Mental health awareness posters

    - MH Gap booklets
    - MH Gap app link
- Presentation for MHRC staff to update on project progress
- Programme and collated presentations for Mental Health Education for Community Staff afternoon teaching session
- Educational session feedback form (acquired from MHRC existing forms)
- Adapted discharge co-ordination meeting pro-forma
- Draft proposal for Ministry of Health/HEE/RCPsych partnership to promote employment of psychiatry consultant/s in SVG
- Dropbox folder for MHRC staff and future fellows

Overall project review

What went well	**Reason**
Discharge coordination meeting	
Successful introduction of a meeting based on evidence-based principles of discharge planning in a psychiatric setting, surpassed aim for number of patients to be discussed (40), with good sustainability. Staff attitudes to the efficiency of the discharge process improved on the MHRC staff questionnaire.	Idea was based on listening to opinions of key stakeholders within MHRC team. It was adapted by a collaborative, iterative process, in terms of which patients to list for discussion, items included on the pro-forma and how to run meeting. Handed over at midpoint to MHRC team to run, with team members assigned to facilitate and document, and keep the whiteboard up to date, which allowed an opportunity to troubleshoot the meeting in the form in which it will continue.
Successful pilot of a substance/alcohol use disorder	
Reduction in number of readmissions per month	
Reduced overall ward census	
21 patients were discharged and re-admitted since 12/9/22 (first discharge discussion date). Of these, 16 were not discussed in the discharge meeting during their last admission; 4 were discussed.	
Mean time to readmission comparable between those discussed/not discussed (again, small numbers). This could be considered an achievement given that the more complex patients are selected for discussion over more straightforward patients, so one might expect those discussed to re-present SOONER than the other group if no discussion happens	
Much improved MHRC staff attitudes to efficiency of discharge process	
Improve communication with community primary healthcare teams at point of discharge	
100% discharged patients documented in discharge coordination book	

Improved proportion of discharged patients having discharge letters produced and placed in delivery folder between midpoint and end point – 64% of discharge discussion list patients → 75%	
36% patients having telephone handover to community at discharge, compared to 0 at midpoint of project	
Improved outcomes on community staff questionnaire on receiving discharge letters - 0%-20% strongly agreed that they most often receive a discharge notification	
Shared primary / mental healthcare follow-up for stable patients	
Excellent engagement from district doctors and nurses approached regarding shared follow-up of psychiatric patients. All doctors and all but one nurse agreed from those met to date. Majority of doctors and nurses have attended an engagement session	
Better-than-expected acceptability of shared follow-up for patients – only two cases documented of patients declining this service	
Highly successful first Mental Health Education afternoon – well-attended by DMOs and all attendees gave 4-5/5 for satisfaction with session	
Improved questionnaire responses for district clinic staff in terms of willingness to perform early follow-up post-discharge	
Number of patients referred to district for shared follow-up increased after midpoint of project, and a number were confirmed to be successfully attending district clinic for main follow-up	
Questionnaire response – increased confidence in diagnosing/managing mental health problems in the community; adequate resources to manage mental health issues; fewer felt that mental health issues should be treated separately from other health issues	Majority of respondents likely to have attended education afternoon; dissemination of MH Gap materials, promoting MH Gap app
Establishing partnership between Ministry of Health, HEE, RC Psych to facilitate employment of consultant psychiatrist	
Ongoing engagement between Ministry of Health, HEE, RC Psych and British High Commission, SVG	

What worked less well	How did you address challenges faced
Discharge coordination meeting	
Original plan was to involve patients and DMOs (eg by telephone) in discharge meeting. Not done because - A slick meeting protocol needed to be established first, in order to make the best use of time - Patients are not routinely brought to the office section of the MHRC. A separate clinical space could possibly be made use of	

- As it is not an established part of MHRC culture, without prior preparation, it may be intimidating for patients to face a room full of healthcare professionals - High work volume to arrange presence of next of kin and district clinic staff, and notice needed	
Following up on whether patients received early DN/DMO follow-up – did not anticipate problems such as lack of contact details for patient/NOK, difficulties getting through to district nurse by telephone, DMOs working across clinics and so not knowing when to call to get through to them, new medical officers kjnowing to request	Focused instead on overall impact on discharge coordination meeting
Not easy to collect previous admission/discharge dates for patients due to multiple sets of notes, disorganised filing system	
21 patients discharged and readmitted 12/9/22 – 16/1/23; 8 had documented discharge date from last admission and admission date from most recent admission in report book - Discussed in meeting on last admission (N=5) – mean 31 days to readmission, median 18 days Not discussed in meeting (N=8) – mean 31.4 days to readmission, median 31 days	
Substance/alcohol use disorder counselling sessions could not continue due to staff absences	
Incidents on ward increased from 5 – 7 July to November (however not a clear upward trend)	
Improve communication with community primary healthcare teams at point of discharge	
Originally aimed for letters/referrals to be delivered by email	
Delivery of letters is patchy/very delayed and letters for Kingstown are sit for a long time as there is no field clinic there	
MHRC staff questionnaires – worse impressions of communication with DMOs and district nurses	
Shared primary / mental healthcare follow-up for stable patients	
Small number of patients referred for shared follow-up. Aim was for 10% of MHRC clinic patients (~30 patients per clinic). Total number: 17.	In part this was due to a change in approach. As engagement was gained from most communities, it made sense to broaden the potential for shared follow-up referral to all clinics, if the patient came from a relevant community. However, importance of community staff engagement and upskilling became clear, and possibly more patients declined shared follow-up than were recorded by staff members. Future fellows should continue to gain community staff engagement and education, but also do more work on patient engagement.
District staff questionnaires – less positive response towards following up stable patients	Not reflective of response in engagement sessions, though this may suggest that staff members felt more empowered to disagree anonymously. Some respondents may not

	have attended engagement meeting. Continue capacity building through education events in ongoing fellowship
Telephoning patients to follow up after referral for shared follow-up	List of referred patients shared with Mr Lowmans, who suggested he could check with local clinics regularly whether the patients are attending their DN/DMO follow-up, when carrying out field clinics or district community mental health clinics
Some anecdotal reports of patients attending district clinics but usual medications were unavailable	Regular (fortnightly) meeting established with Ms Guy, senior pharmacist, to update on latest referrals and medication lists
No nurses yet able to attend education session	
Other	
Minimal interventions to directly address stigma within this phase of the project	
Mental health awareness materials distributed opportunistically however not able to appraise how widely these were displayed within remit of project	

What can be learnt for the future? How do you envisage the project moving forward?

- Feb 2023 – to continue:
    - **Improve communication with community primary healthcare teams at point of discharge**
    - **Shared primary care and mental healthcare follow-up**
- Other IGH project recommendations within the themes of Integration/Stigma:
    - Community capacity-building for alcohol and substance use disorder counselling
        - Note Dr Providence has expressed willingness to provide training and there is already a list of interested community staff compiled, so at a good starting point
    - Reducing stigma surrounding mental health, in the community, within healthcare and beyond
    - Reducing unnecessary admissions by working with MCMH and district staff and police
- Future IGH projects:
    - **Introduction of discharge co-ordination meeting**
        - Re-audit and assess ongoing impact in 6-12 month

- Urgent projects outwith integration/stigma
    - Patient safety – culture change surrounding reducing unavoidable harm to patients with a focus on system failures
    - Staff wellbeing and retention of staff in the health service

Feb 2023 fellow

Discharge communications

Continue to monitor and improve discharge letter and telephone handover

Shared follow-up

Engagement with: Dr Cardenas (Kingstown – on vacation); Dr Adams (Sion Hill, Belair – on vacation); Dr Guanes Garbon (Stubbs); Dr Quashie-Brown (Stubbs – maternity leave); Dr Danilo (Fancy, Overland, Owia, Sandy Bay); Dr Martin (Georgetown)

At least one nurse/NA from 12 communities

Patient engagement sessions

Continue education sessions for community staff

Future IGH project: audit ongoing impact of discharge coordination meeting when more data is available eg 6-12 months

Future IGH project: restart alcohol/substance use disorder counselling programme, commence monitoring of impact of SUDC sessions as part of broader substance/alcohol use disorder community management project

Activities – updated

Timescale	Task	Outcome
Weeks 1-4:	Observation of clinical practices	**Complete**
	Project planning	**Complete**
	Interviewing staff/discussions with stakeholders	**Complete**
	Gather clinic and inpatient data	**Complete**
	Radio public health announcement about project	**Complete**
	Observing clinical duties: ward rounds, outpatient clinics, weekly departmental meetings	**Complete**

	Reviewing the inpatient and outpatient statistics	**Complete**
Weeks 5-11:	Create visible shared list of patients likely for imminent discharge, who might benefit from discussion in complex discharge planning meeting	**Complete**
	Launch complex discharge planning meeting, Mondays 1pm, with pro-forma as guide; after initial meetings to work out structure and timing, invite listed patients and next-of-kin to attend	**Complete**
	- Of patients discussed, carry out continuous monitoring: o Duration of admission o Previous number of admissions o Average time between admissions o Number followed up within 1 month of discharge o Plan after discharge coordination meeting	 Future Project Future Project **Adapted for up to 3 most recent admissions - complete** Future project **Complete**
	Assist community psychiatric nurse in re-establishing regular substance misuse disorder counselling session, initially weekly, for selected inpatients, to continue following discharge	Completed but lapsed due to short staffing – future project
	Following complex discharge planning meeting, contact district clinics of patients likely to benefit from increased primary care input to provide communication and arrange district follow-up (eg to check drug compliance and for early detection of worsening symptoms)	**Complete – via discharge letters/telephone handover**
	Establish route of sending written communications to district clinics and introduce new discharge notification (sent by email or delivered by community clinic team opportunistically).	Complete – requires ongoing monitoring
	Gather data: Monthly inpatient totals: admissions (new/re-admissions), total inpatients, discharges, incidents on ward	**Complete – requires ongoing monitoring**
	Gather data: Monthly outpatient data: number of visits made by community team, number of client visits to psychiatric outpatient clinics (in community), number of patients seen in MHRC OPD	**Complete**
	Audit of 100 MHRC OPD patients to identify number for whom shared care with district team may be appropriate	**Complete**
	Carry out surveys of staff, patients and next-of-kin on attitudes to mental health and factors involved in integration	**Complete**
	Arrange DMO and district nurse engagement meetings for discussion about integration of mental health into community and seek buy-in	**Feb 2023 fellow to complete (6 DMOs and nurses from 12 district clinics outstanding)**
	Use suggestions and outcomes from DMO discussions to commence planning DMO/district nurse education event	**Complete**
	Complete education event/s for DMOs and district nurses	**Complete X 1 – for next fellow to continue**
	Review OPD patient list seen at MHRC with community psychiatric nurses/doctors and assess which could have follow-up frequency reduced, with interim follow-up from district team. Clinicians to provide psychoeducation to patients commencing longer-interval follow-up, written counselling (to be prepared as part of project) and communications to district team via new OPD notification.	Started – for ongoing monitoring by Feb 2023 fellow
	Create and distribute mental health awareness materials for district clinics	Started – for continuation by future fellow
	Planning for new Psychiatry partnership between UK and SVG	Ongoing monitoring by Dr Carstairs

	Establish regular substance use disorder counselling session (Monday 9:30am) run by Mr Lowmans, Community Psychiatric Nurse	Completed but lapsed – for future fellow to restart
Week 12	Repeat data collection: - Monthly inpatient totals: admissions (new/re-admissions), total inpatients, discharges, incidents on ward - Monthly outpatient data: number of visits made by community team, number of client visits to psychiatric outpatient clinics (in community), number of patients seen in MHRC OPD - Audit OPD clinics to identify number for whom shared care with district team may be appropriate	**Complete** Not done due to low number of patients referred for shared follow up " "
	Repeat surveys of staff, patients and next-of-kin on attitudes to mental health and factors involved in integration	**Complete (end of project)**
	Update data for cohort of patients discussed in discharge coordination meeting: o Duration of admission o Previous number of admissions o Average time between admissions o Number followed up within 1 month of discharge	Incomplete data available Incomplete data available **Complete for up to 3 admissions** **Complete**
	Complete Project Progress Report	**Complete**
	Planning for new Psychiatry partnership between UK and SVG	Ongoing (Dr Carstairs)
	Explore capacity building resources from HEE eg Running Effective Meetings training	Unavailable
Weeks 13-24:	Assess impact of initial changes and adjust depending on success at this stage	**Complete**
	Possibilities to expand project: - Assess admission criteria, formulate admission protocol and reduce admissions via hospital, meet with hospital stakeholders, education sessions for hospital stakeholders	For future fellows
	Possibilities to expand project: - Proposal for Substance misuse centre/residential home/"halfway house"	**Proposal for Substance Use Disorder centre sent to ministry as requested by Dr Medford – no response**
	Assess how many district clinics are still displaying mental health awareness materials	For future fellow
	Review the optimal timing for the Discharge Coordination meeting and hand over the responsibilities to the MHRC team	**Complete**
	Establish a discharge communication book to monitor and prompt: o Discharge letter completion and sending o Telephone handover to district nurses and request for early follow-up	**Complete**
	Create delivery reminders with team going out on field clinics to ensure OPD notifications and discharge letters reach the required destination	Feb 2023 fellow to continue
	Follow up with discharged patients to assess whether early follow-up has taken place if requested	For future fellows
	Repeat MHRC staff, community staff and patient questionnaires and compare to initial results	**Complete**
	Review monthly statistics on admissions, readmissions, new admissions, inpatient numbers, ward incidents and discharges August-January	**Complete** Patient questionnaires to be completed after further patient engagement
	Review notes of any patients discussed in discharge coordination meeting who are discharged and re-admitted during 6-month project, and establish time between admissions and any areas for improvement in community care that can be established from these cases	**Complete**

	Arrange further mental health integration meetings with DMOs, focusing on communities from which patients routinely travel to MHRC Friday clinics, and nurses from clinics in which the DMO has already agreed to the shared follow-up model	Continued but for Feb 2023 fellow to complete
	Review number of patients referred for shared district clinic follow-up, and those that decline (and reasons why)	**Complete**
	Arrange educational event for district clinicians to refresh psychiatric knowledge and deliver mental health awareness and educational materials	Commenced but for Feb 2023 fellow to continue
	Create a dropbox folder for MHRC team and future fellows with contacts and useful documents	**Complete**
	Continue to work with MoH, HEE and RCPsych to plan clinical partnership to attract consultant psychiatrists to SVG	Ongoing – Dr Claire Carstairs

Local Team

Key Contacts

Photos