

# Comprehensive mental health and psychosocial support case management and indicative care pathways within humanitarian settings

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*This article describes the approach, implementation and evaluation of a pilot mental health and psychosocial support case management programme that was developed by the United Nations High Commissioner for Refugees in Syria. The aim was to provide a description of the programme approach, its implementation and outputs. The programme integrates different forms of case management approaches based on a multi-layered, stepped care model. Earlier results of mixed method monitoring and evaluation revealed improvement in wellbeing among programme participants. The step-wise approach indicates, in addition to the positive mental health outcome results, a functional case management system.*

**Keywords:** case management, Iraq, mental health outcome, refugee, Syria, wellbeing

## Introduction

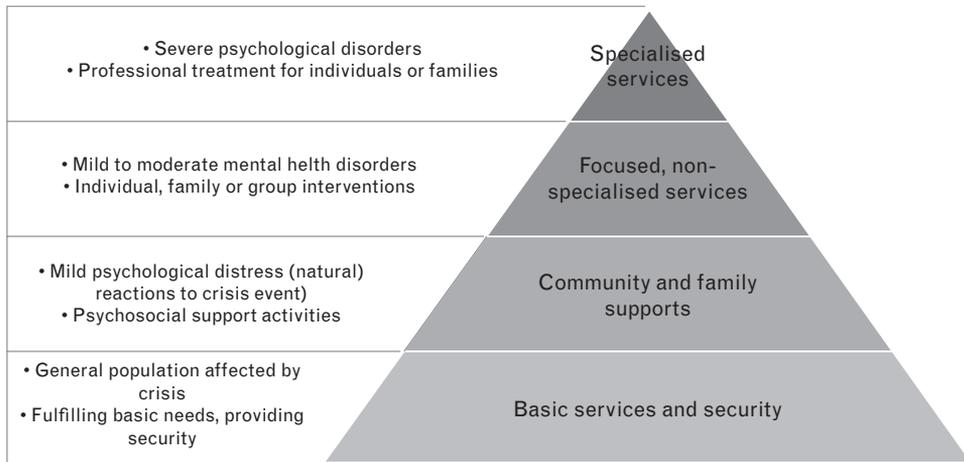
Mental health and psychosocial support (MHPSS) case management emerged in the 1960s and 1970s as a part of the development towards community care as a service delivery approach (Hangan, 2006). Case management is an individual approach to care that attempts, in general, to facilitate the identification of persons with severe mental disorders and psychosocial problems, linking them to mental health and psychosocial support services, and facilitating meeting basic needs by providing access to essential services. This is done through a process of identifying community resources

### Key implications for practice

- Case management can improve clients' and families' experience of mental health services
- Case managers facilitate the transitions between different layers of support and care systems
- The quality of case management is related to realistic caseloads and benchmarks

and support mechanisms, as well as supporting the client in contacting them. In some of the holistic approaches, it can also include shelter, financial assistance and income generating activities.

The case management literature tends to differentiate between two main models (i.e. Mas-Expósito, Amador-Campos, Gómez-Benito, & Lalucat-Jo, 2014). In standard case management, also known as the Broker approach, the case manager coordinates the care between different service providers and connects the person with the services needed. Contact with the person is usually made within a clinical setting, during standard working hours. On the other hand, intensive case management (ICM) and assertive community treatment (ACT) are more intensive and highly structured approaches that involve smaller case load size, a higher frequency of client and family contact and follow-up, and often incorporate



**Figure 1: Based on the intervention pyramid for mental health and psychosocial support in the IASC Guidelines (2007).**

outreach to the clients in the community (Hangan, 2006). ICM and ACT also often offer 24-hour coverage and support for the patient and are usually associated with the higher layers of the IASC MHPSS pyramid (IASC, 2007) (Figure 1).

### Evaluation of case management

Reviewing the evaluation research literature, within the context of the northern hemisphere, illustrates that there is a focus on either single intervention focused outcome research or targeted mental health case management approaches in the mental health services (i.e. Angell, Mahoney, & Martinez, 2006; Björkman & Hansson, 2000; Burns, Catty, Dash, Roberts, Lockwood, & Marshal, 2007; Dietrich, Irving, Park, & Marshall, 2010; Hemming & Yellowlees, 1997; McRae, Higgins, Sherman, & Lycan, 1990; Mueser, Bond, Drake, & Resnick, 1998; Okin et al., 2000; Simmonds, Coid, Joseph, Marriott, & Tyrer, 2001; Ziguras & Stuart, 2000). Meta-analytic studies show contradictory results, probably related to the heterogeneity of approaches to case management and the low strictness

of methodology followed in most studies (Mas-Expósito et al., 2014). Research has demonstrated that case management, in particular ICM, can improve clients' and families' experience of mental health services, but only when introduced and used for appropriately targeted client populations and when it is suitably resourced (Hagan, 2006, 157). It is difficult to evaluate case management through outcome or impact measures as it cannot be easily separated from services and support provided. In contrast, this article tries to evaluate case management through referral pathways as an indicator for the effective application of stepped, care based case management.

### United Nations High Commissioner for Refugees Syria's MHPSS case management approach

The MHPSS Programme was initiated by the United Nations High Commissioner for Refugees (UNHCR) after the massive influx of more than 200,000 Iraqi refugees into Syria in 2008 and has already been described elsewhere (Quosh, 2013). It is based

on a three-pronged approach, which includes: 1) comprehensive mental health and psychosocial support case management; 2) community outreach and psychosocial centres; and 3) inter-agency capacity building and coordination. The combination of overwhelming need, scarcity of resources, lack of qualified professionals and implementing partners in Syria, required UNHCR for the first time to integrate a comprehensive MHPSS programme into a refugee operation. This article is part of a series of articles that describe the UNHCR MHPSS programme in Syria. Previous articles have provided an overview of the programme (Quosh, 2013), a systematic review of literature with regards to mental health of refugees and displaced persons in Syria and surrounding countries (Quosh, Eloul, & Ajlani, 2013), and articles on two specific components of the programme, such as the multi-professional MHPSS capacity building (Quosh, 2011) and inter-agency coordination (Eloul et al., 2013). Personal reflections were shared by a case manager and volunteer engaged in the programme (Hassan, 2013; Ismael, 2013). This article is the last in that series and focuses on the third component of the programme: integrated mental health and psychosocial support case management.

### **General features of the programme**

Two risk groups (a survival risk group and displaced persons with severe negative mental health outcomes as a consequence of experiencing violent conflict, persecution and forced displacement) were identified as priorities in participatory needs assessments at the outset of the programme development (Quosh, 2013).

Given the overwhelming need, different access barriers, the limited resources and the particularities of an urban setting, the initiation of the MHPSS case management system focused on providing adequate and coordinated care and support to these

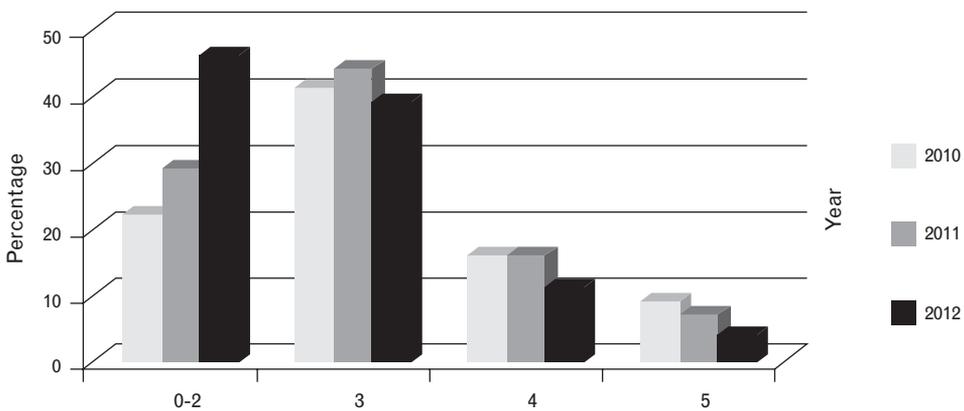
groups navigating an urban environment. The MHPSS case management teams were located mainly in primary health care settings. Initially, case management was provided centrally by the UNHCR office. Based on the analysis of user records and databases, neighbourhoods with higher numbers of clients were tracked, merged into catchment areas, and the primary health care clinics of those districts contacted.

The programme combined different forms of case management and outreach. Most persons entered the case management service, because they were identified by a frontline worker as having psychosocial problems or mental disorders and were unable to locate and access appropriate supports and services. Some users were referred from either inpatient care or specialised outpatient care, and still others accessed the service through self-referral. Community frontline workers were trained in identifying potential users at community and primary health care centres in high-density areas, as well as at the UNHCR office, and in providing initial first line support including psychological first aid. The different priority categories were determined by MHPSS case managers through combined quantitative and qualitative assessment of mental health, comorbidities, resilience, coping strategies, socio-economic and other context factors. User's needs and mental health can change over time, and it is not unusual for a person who moves from specialised care to psychosocial support relapses and warrants a change in intensity of case management and care, or treatment package.

The MHPSS case managers also provide participatory, comprehensive, goal based and individualised support and counselling, as well as care planning through the joint development of a care plan that matches needs, resources, and goals to available assistance, support systems and mental health services, aimed at ensuring basic needs are met and to enter at the lowest possible mental health service and

psychosocial support level. Regularly updated service mappings and referral pathways provide up-to-date information and coordination between services providers through the MHPSS working group. The mental health case management services are divided into two tracks. High priority clients and those with severe mental health problems requiring intensive follow-up and facilitating access to (community) mental health services (priorities 0–2, see Figure 2) and users with mild to moderate mental health problems in need of lower level psychosocial support, which includes basic counselling on different services and support options available (priorities 3–5, see Figure 2) including the refugee run Psychosocial Support Center, nongovernmental organisation community centres, and refugee outreach volunteers. The first group follows an intensive care approach, while the second follows a case management broker approach. While persons with mild to moderate mental disorders can usually be managed by qualified primary health care doctors, persons with more severe mental disorders often require specialised mental health care. If necessary, mobile psychiatrist

and psychiatric nursing services are made available. Case managers who follow-up intensive case management clients regularly document, monitor, follow-up and review clients' progress, according to agreed goals and care plans, and maintain contact through in-office counselling, home visits, and phone counselling, as required. They facilitate the transfer between different layers of mental health services, with the aim of moving down the service pyramid, and ideally empowering beneficiaries to eventually manage their own utilisation of services. The lead case manager is determined jointly between the client, the initial case manager and the main services provider, taking a likely pathway into account. The lead case manager is, therefore, also responsible for smooth transitions between different support and care systems, as well as ensuring quality along the pathway. Case managers are supported by peer case managers and community outreach volunteers who support home follow-up and accompaniment to services (active referral), if applicable. The protocol requires lead reference case managers to have a background in either



**Figure 2: Priority category.**

**Table 1. A summary of key dimensions of the MHPSS case management programme**

<b>Approach</b>	Integration of bio-psycho-social components in assessment and support/intervention combined with ecological and public health approaches, guided by the ADAPT model <sup>a</sup> Case management approach: combination between broker/standard and intensive case management, as well as integration of community outreach and support
<b>Defining core elements</b>	<ul style="list-style-type: none"> <li>- Identification</li> <li>- Comprehensive MHPSS Assessment (quantitative and qualitative) including identification of goals as the foundation for the joint care plan</li> <li>- Referral (active or passive)</li> <li>- Matching MHPSS needs and resources to available assistance, support systems and services</li> <li>- Linking clients to formal and informal MHPSS service and support systems, helping to navigate the system if necessary</li> <li>- If possible, following up, closure and re-assessment when required</li> </ul>
<b>Purpose</b>	<ul style="list-style-type: none"> <li>- Coordinating access to, and delivery of, various MHPSS care services</li> <li>- Facilitating transfer between layers, continuity of care, stepped care approach</li> <li>- Integration of support and service systems</li> <li>- Monitoring access and availability of support and services, evaluating outcome of services and quality</li> </ul>
<b>Principles</b>	<ul style="list-style-type: none"> <li>- Client centred, comprehensive, culturally sensitive, participatory, rights and community based</li> </ul>
<b>Staffing, roles and structure</b>	<p>Team approach with core reference/lead case manager</p> <ul style="list-style-type: none"> <li>- MHPSS case managers engage in case management with broker function, basic counselling and intensive case management, based on specific requirements</li> <li>- Case managers work in collaboration with peer case managers and outreach volunteers as well as</li> <li>- Mobile psychiatrists and psychiatric nurses</li> </ul>
<b>Location</b>	<ul style="list-style-type: none"> <li>- Case managers are primarily based in polyclinics and primary health care centres in high density areas and areas identified with high needs. This is complemented by centrally located case managers, mobility of case managers and peer case managers, as well as mental health professionals</li> </ul>
<b>Background and training</b>	<ul style="list-style-type: none"> <li>- Case managers are required to have a mental health or social work background</li> </ul>

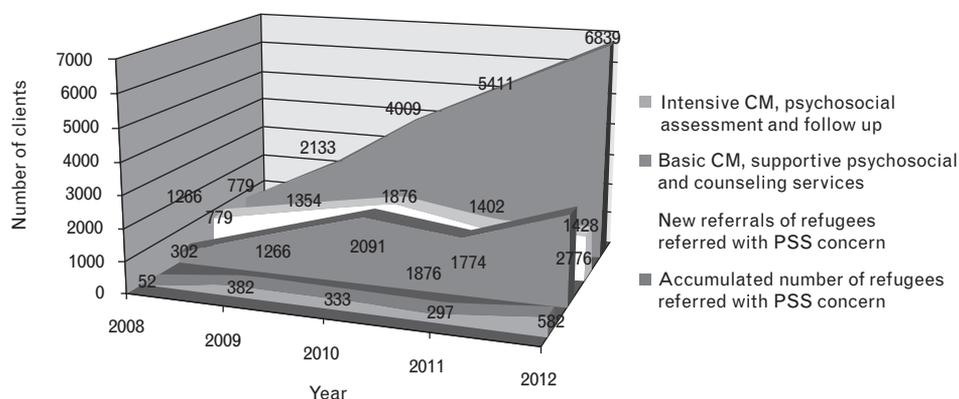
<b>Supervision</b>	- A specific mandatory MHPSS training programme was developed comprising of three months theoretical training and shadowing, and three months on-the-job training that every case manager has to pass, based on integrated assignments and tests
<b>Clients/users</b>	- Integrated supervision and continuous training - Regular clinical individual and group supervision Refugees and displaced persons (all ages) as well as host population, free
<b>Services provided</b>	- Counselling (in clinic, outreach, phone hotlines) - Intake, scheduling, reception - Comprehensive MHPSS assessments, home visits - Joint service plan with clients based on goals - Referrals to applicable support and services (including active referral through accompaniment if applicable) - Coordination and follow-up with services - Mapping of support and services - Follow-up with client and outcome evaluation - Training (identification, referral, psychological first aid to referral partners), awareness raising, advocacy
<b>Benchmarks</b>	Performance, case load and service, catchment area access, index
<b>Monitoring and evaluation</b>	Mixed method (quantitative, qualitative)  - Culturally sensitive measure and standardised mental health measures through interviews with clients, feedback from service providers and focus groups - Key indicators: improved wellbeing, symptom reduction, goal attainment, case management satisfaction, compliance
<b>Mobility / Outreach</b>	Home visits and follow-up, link to mobile community outreach volunteers, peer case managers and mobile mental health services initiated by and supported through the overall programme
<b>Link to other services</b>	Basic needs, health, protection, support and services for persons with specific needs

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<sup>a</sup>The Adaptation and Development after Persecution and Trauma model (Silove, 2013).

psychology or social work, although background requirements could be questioned and broadened to other applicable disciplines. UNHCR Syria developed a three month, full time MHPSS case management training programme, followed by an on-the-job training period (Table 1). UNHCR staff directly implemented the case management from 2008 to 2011. Since the

beginning of 2012, the case management component was transferred to the national health partner organisation, the Sexual Assault/Spouse Abuse Resource Centres (SARCs), primary health care clinics, and UNHCR has maintained a partial default case management function. Initial centralisation of case management services at UNHCR was important in order to



**Figure 3: New referrals per year and accumulated number of clients from 2008 to 2012.**

understand community profiles and resources, to design urban catchment areas, referral networks and in order to build a decentralised community mental health system and case management capacities.

### UNHCR Syria’s MHPSS Case Management Programme Outputs and indicative pathways

On average, around 1,400 clients per year (more than 6000 in the 2008–2012 period) were managed by the MHPSS case management teams (see Figure 3: new referrals per

year and accumulated number of clients from 2008 to 2012). UNHCR and SARC received an average of 120 to 150 clients for case management every month. Demographics of those given consent to share their data are summarised in Table 2.

Table 2 contains the demographic profiles of these clients. Groups at high risk, who had been exposed to potentially traumatic experiences and violence, i.e. survivors of torture, extreme violence, and/or sexual and gender based violence. A significant proportion of the case management clients

**Table 2. Statistics of documented MHPSS case management clients 2012 (N: 3,570)**

<u>Gender:</u>	<u>Nationality:</u>	<u>Exposure to different forms of violence:</u>	<u>Additional factors:</u>
Female: 44%	Iraqi: 96 %	Survivor of torture and extreme violence: 23%	Female headed households: 15%
Male: 56%	Non-Iraqi: 4%	Survivor of sexual and gender based violence: 11 %	Serious medical condition: 23%
<u>Age:</u>	<u>Family Size:</u>	Domestic violence: 6 %	Persons with disability: 6%
Below 18: 14%	Single: 20%	Other traumatic experiences: 17%	Older persons without a carer: 2%
18–29: 18%	Above 8: 2 %		
30–59: 62%			
Above 60: 6%			

also suffered from serious medical conditions and disabilities. Fifteen percent of the case management users were female headed households. More than 30% of the MHPSS case management clients reported additional specific needs and vulnerabilities, which can significantly impact longer-term mental health outcomes (see Table 2).

The most common diagnoses among the documented case management clients with moderate mental disorders were firstly mood disorders, in particular depression, and secondly anxiety disorders, especially posttraumatic stress disorder (PTSD). Lower prevalence rates of people who had severe mental disorders, such as psychosis and severe depression co-morbid with PTSD, were reported. Most of the latter were unable or unwilling to participate in the study, which has to be considered when interpreting results.

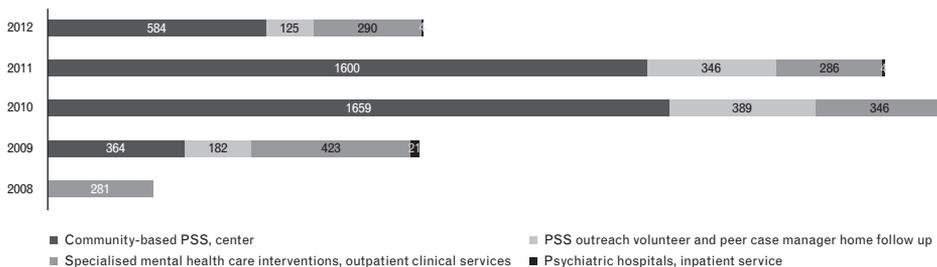
Children suffered attachment and cognitive development problems (including learning difficulties) and high rates of enuresis (uncontrollable urination, especially at night) confirming results of a previous participatory assessment undertaken on a yearly basis by the organisation.

The proportion of high priority clients and corresponding vulnerability and complexity increased significantly over time from 22% in 2010, to 29% in 2011, and 46% in 2012.

Despite the overall number of refugees decreasing in 2012, the number of clients approaching MHPSS case management services had remained consistently high. This could suggest that, in a protracted forced displacement setting with recurring conflict and violence, people are at higher risk of negative mental health outcomes over time, and the potential for recovery is lower compared to non-protracted settings. This highlights the need for sustainable services and support, particularly in dispersed settings such as urban environments.

### Referral services

Out of the more than 6,000 case management clients, more than 60% were referred to other services (see Figure 4). Case management initially focused on providing access to care for the most vulnerable while, in parallel, building capacity and structure of service providers within the refugee and host community. Over time, referrals to specialised inpatient care decreased, referrals to outpatient mental health care stayed consistent, and the capacity of community based support increased manifold. Due to increased community mental health capacity, including psychiatric nursing outreach and home follow up, the number of longer-term hospitalisations was relatively low.



**Figure 4: Overview referral services 2008–2012.**

Due to an increase in security issues in 2012, the psychosocial centre was temporarily closed in August 2012, which explains the drop in participants, as well as home follow-ups by psychosocial volunteers. This was compensated by increased phone follow-ups, and the operating of several crisis hotlines.

Out of 1,626 case management clients referred to outpatient community mental health care, 439 were closely followed-up with regards to treatment compliance. The average number of treatment sessions per client increased from 2.5 in 2009, to 5.6 in 2010 and 7.3 in 2011. This could be related to the implementation of the case management strategy. It can be hypothesised that, as time passed, trust in services increased and stigma decreased, so more clients with complex psychosocial and mental health problems were able to approach the programme.

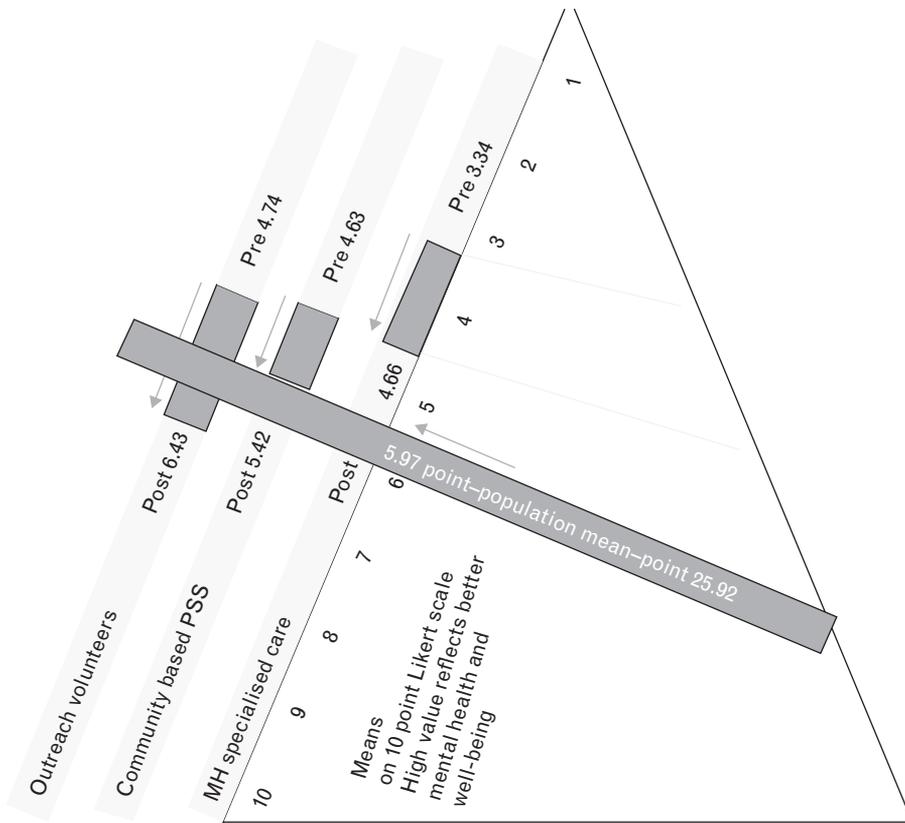
### Wellbeing and distress

In an earlier publication, the positive mental health outcomes of the different

interventions provided by the MHPSS Programme was presented (Quosh, 2013). Presented here are the results of the *Mental Health and Psychosocial Well-being and Distress Measurement*, an 18-item culturally based assessment instrument that was applied to three different samples and a control group of general population: (a) a retrospective design (sample 1), (b) pre intervention and 3 months after initiating an intervention (samples 2 and 3). The control group (sample 4) was randomly drawn from UNHCR registration data with baseline and 3 months after baseline measures (see Table 3). The items measure levels of stability, life satisfaction, security, financial stability, physical health, trust, social support, fatigue, anxiety and fear, isolation, coping with life tasks, hopelessness, anger, ambition, and religious beliefs and practices. Preliminary data suggest that the measure has good reliability (internal consistency), with Cronbach's alphas between 0.814 and 0.910 (see Table 3). The pre-measurement total score had not been used

**Table 3**

	Intervention samples						Population sample	
	S1 Outreach volunteers		S2 Community- based PSS		S3 Specialised MH care		S4	
Sample	pre	post	pre	post	pre	post	point 1	point 2
N total	98	98	429	123	157	102	199	174
Male/female in%	7/93	7/93	25/75	24/76	51/49	53/47	58/42	62/38
Mean	4.74	6.43	4.63	5.42	3.34	4.66	5.97	5.92
SD	1.46	1.16	1.52	1.45	1.33	1.34	1.45	1.54
t (df), P	-10.45 (97), 0.000	-5.71 (122), 0.000	-5.27 (101), 0.000	1.67 (173), 0.1				
Cronbach's alpha	0.892	0.883	0.910	0.897	0.866	0.891	0.814	0.845



**Figure 5: Indicative pathway.**

in making a referral decision at the time of determining the level and referral to support and care.

The scores of sample 4 (general population) are much higher than those of the intervention samples and do not significantly change over time (at 0.01 and 0.05 level). For the three intervention samples, our data show that the wellbeing score is lower for the higher the intensity of care level entered. The results show significant improvement in wellbeing scores for the three intervention groups. In addition, the post scores of one intervention are in close range to the scores of the next intensity level of intervention, suggesting adequate pathways of care (see Table 3 and Figure 5).

## Discussion

### Difficulties in implementation

In the beginning, case managers focused on initial assessments and referral, but neglected appropriate follow-up. In addition, although the process and criteria for the closure of a client case were predefined by the *Standard Operating Procedures* (SOPs), the guidance protocols and part of the case management training, it was difficult for case managers to implement case closures properly. Due to limited human resources, the direct quality monitoring of referral services was restricted as well.

### Limitations

The data set did not allow capturing of the moving up and down of individual clients

between different support and service levels, and therefore, no statement can be made on the appropriate transitioning between the layers of interventions and support. Furthermore, the heterogeneous samples, the low sample size of samples 1 and 3 and the high drop-out rate of sample 2 all limit the interpretation of results. Follow-up time frame was also limited to 3 months, due to the context of emergency and displacement. Our comparison group was the general population. A research design including a real non-intervention, or control group of people with MH problems, was not feasible. Hence, change over time cannot be attributed directly to interventions, taking natural remission over time and change in environmental stress into account.

### Lessons learned

Four elements deserve particular attention as important lessons:

- 1) **Identification and phased approach** The quality of identification and timely referral matters ensure an effective identification and 'intake' process. The programme invested in training front-line workers on identification and referrals. It was also important to respond immediately to high priority cases at the beginning of the programme, while building identification and system capacities in parallel, which allowed for a broadening of the scope over time.
- 2) **Caseload size and index** In humanitarian contexts there is often an overstretch of human resources that affects the health and wellbeing of case managers (Priebe, Fakhoury, Hoffman, & Powell, 2005), and which impacts the outcome of case management, quality of service provision and often prevents adequate follow-up and the conclusion of case management cycles. It would therefore be important to develop inter-agency guidelines with guidance on realistic benchmarks for caseloads to be

integrated into monitoring and evaluation (M&E) frameworks.

- 3) **Case management process and case closure** Case management training, including on the job training, as well as supervision, should emphasise the importance and build the necessary skills for closure. This is closely related to unrealistic benchmarks and limited human resources.
- 4) **Monitoring and evaluation** While assessing pathways is one approach that has been proven successful in this case study to analyse stepped care, this should be embedded in comprehensive approaches to evaluation to also assess effectiveness, efficiency, access, appropriateness, quality and accountability (Gevers & Eslick, 2000).

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