



Community Mental Health

Policy



Community Mental Health
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Executive Summary

Classification

Mental health is a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.

Neuro-psychiatric disorders is a collective name for mental illnesses and neurological conditions (e.g. epilepsy).

Mental illness, e.g. depression, schizophrenia affects an individual's cognition, emotion and/or behavioural control and interferes with his or her ability to learn and function in the family, at work and in society.

Intellectual disability, has its onset in childhood and is a life-long condition. It is characterised by an impairment of the skills related to intelligence such as language, memory, motor and social abilities.

Mental disorder is used to include both mental illness and intellectual disability.

Psychosocial disability takes into account the barriers that hinder an individual's full participation in society and is our preferred term in accordance with the CBM Disability and Development Policy.

Magnitude

WHO estimates that **one in four** people will have a mental or neurological disorder at some point during their lifetime.

WHO estimates, about **450 million people** worldwide currently experience a mental or neurological disorder: 150 million depression, 90 million alcohol or drug use disorder, 25 million schizophrenia and 38 million epilepsy. Every year, 10 to 20 million attempt and one million people commit suicide.

WHO's 2005 report attributed approximately **one third of all years lived with disability** to neuropsychiatric disorders.

Aim

To improve the quality of life of people with psychosocial disabilities through early identification of disorders, access to affordable treatment, improvement of social integration and livelihood security.

Strategy

CBM's strategy in community mental health (CMH) is human rights-based, seeks to empower service users and facilitate their active par-



ticipation in service provision, is culture, poverty and gender sensitive and based upon collaboration and networking with other organizations and the public sector.

The main delivery models are:

- Integration of CMH into existing **community-based rehabilitation (CBR)** programmes. The social model of disability underlying the concept of CBR adopted by CBM is also valid for CMH.
- Implementation of CMH services into **primary health care services** provided by the government with sharing of resources or the implementation of stand-alone CMH services.

I. Present Situation

I.1. Definitions

Mental health is a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community¹.

Community mental health (CMH)

- CMH is a strategy of community development that furthers the mental health of all community members through promotion of mental health and prevention of mental disorders.
- CMH services provide accessible, affordable, acceptable and quality mental health care in the community for people with psychosocial disabilities aiming at their social integration.
- CMH care is implemented with the active participation of service users, their families and communities together with health, education, social and employment services.

Terminology

The language used when referring to mental health problems and to people who experience them can be confusing because of the diversity of terms used. In accordance with the CBM Disability and Development Policy (2006) we choose the term '**psychosocial disability**' when referring to people with mental or neurological illnesses such as epilepsy, because '**psychosocial disability**' is the preferred term of users of mental health services and is based upon the social model of disability that focuses on barriers hindering the full participation of people with psychosocial disabilities in society.

¹ WHO (2004)



Only when referring to the underlying disorder (level of body functioning, ICF) or to epidemiological findings² we speak of **neuropsychiatric disorders** which is a collective name for mental and neurological illnesses. The term '**mental illness**' refers to disorders that affect an individual's cognition, emotion and/or behavioural control, and interferes with his or her ability to learn and function in the family, at work and in society, such as schizophrenia, depression, anxiety, dementia and others. The term '**neurological illness**' refers to conditions that affect the brain and nerves, the most common being epilepsy. Since most neurological disorders are surrounded by similar myths, misconceptions and prejudice as mental illness, they are considered together. The psychosocial disability resulting from neurological illness is often more disabling than the seizures themselves.

Intellectual impairment, on the other hand, has its onset in childhood; children can be born with an intellectual impairment or can acquire it in early childhood, for example through meningitis. It is a life-long condition and characterized by an impairment of the skills related to intelligence such as language, memory, motor and social abilities. **Intellectual disability** (formerly called mental retardation) is **not** considered in this policy since the needs of people with intellectual disability and respective services needed (see Concept Paper on Services for People with Intellectual Disabilities, CBR-AWG) are generally different from those of people with psychosocial disabilities. But just like anybody else, people with intellectual disability can develop an additional psychosocial disability.

I.2. Prevalence

Neuropsychiatric disorders are highly prevalent and disabling conditions half of which start before the age of 14 years³, and often have a chronic course.

WHO⁴ estimates that **one in four** people will have a mental or neurological disorder at some point during their lifetime.

According to WHO⁵ estimates, about 450 million people worldwide currently experience a mental or neurological disorder: 150 million depression, 90 million alcohol- or drug-use disorder, 25 million schizophrenia and 38 million epilepsy. Every year, 10 to 20 million attempt and one million people commit suicide.

² Part I of the Community Mental Health policy

³ Saxena S, Thornicroft G, Knapp M (2007)

⁴ WHO (2001)

⁵ WHO (2003)



Worldwide prevalence rates for **child and adolescent** mental disorders are around 20% with similar types of disorders being reported in different cultures⁶.

I.3. Burden of disease

WHO's 2005 report⁷ attributed approximately one third of all years lived with disability to neuropsychiatric disorders. Disability through neuropsychiatric disorders is present in every region of the world. Four of the six leading causes of years lived with disability are neuropsychiatric disorders: depression, alcohol-use disorders, schizophrenia and bipolar psychosis. The numbers of individuals with these disorders are likely to increase further in the coming years due to ageing of the population and worsening of social problems, ecological damage and armed conflicts.

I.4. Treatment options and treatment gap

Treatments with proven efficacy exist for depression, alcohol- and substance-use disorders, schizophrenia and epilepsy as well as other neuropsychiatric disorders. Treatment success can be expected in approximately two thirds of people treated⁸.

Despite this, in low and middle-income countries only a very small minority of people with these disorders ever receive treatment⁹. This is due to lack of services, lack of knowledge about neuropsychiatric disorders and reluctance to seek help. All of these factors are related to poverty, stigma and discrimination¹⁰.

Although children and adolescents comprise between a third and a half of the population in low- and middle-income countries and have a high prevalence of mental disorders, their access to mental health care is even more limited than for adults since most low- and middle-income countries do not provide any adequate care at all¹¹.

II. Present Activities within CBM-Supported Programmes

CBM-supported Community-Based Rehabilitation (CBR) programmes have been involved in providing services to people with epilepsy for

⁶ Saxena S, Thornicroft G, Knapp M (2007)

⁷ Prince M, Patel V, Saxena S, Maj M, Maselko J, Phillips M, Rahmann A. (2007)

⁸ WHO (2001)

⁹ WHO (2008)

¹⁰ Kohn R, Saxena S, Levav I, Saraceno B. (2004)

¹¹ Saxena S, Thornicroft G, Knapp M (2007)



many years since epilepsy often accompanies other disabilities such as cerebral palsy and intellectual disability, in this case epilepsy and other disabilities being concurrent sequelae of the underlying brain damage. Detailed statistical information about the involvement of CBM partners in mental health work is available since 2004. In fact, even by 2004, many CBR projects proved to be significantly involved in work with people with psychosocial disabilities. In that year, 13,125 people with epilepsy were seen in 48 countries and 5,273 people with mental disorders were seen in 36 countries.

Since 2004 the figures of people with psychosocial disabilities participating in CBR and CMH programmes have been rising continuously; people with mental disorders to 9,000 in 2005 and 14,000 in 2006, and people with epilepsy to 19,000 in 2006. Most of the increase was achieved in South East Asia and parts of Africa. In part this rise was due to the extension of CMH services to people affected by the Tsunami in Asia reaching out to people with pre-existing psychosocial disabilities in the realm of emergency relief and providing psychosocial trauma counselling.

III. Aims of Community Mental Health:

- To improve the quality of life of people with psychosocial disabilities through early identification of disorders, access to affordable treatment, improvement of social integration and livelihood security.
- To reduce the incidence of preventable mental and neurological disorders and their causes.
- To empower people with psychosocial disabilities, facilitate their participation in the development of their communities and emphasize the role of positive mental health for community development.

IV. Strategy

Values

➤ **CBM's core values**

CBM works worldwide with the poorest and most neglected people with psychosocial disabilities based upon CBM's core values¹².

¹² CBM (2006)



➤ **Human rights based approach to disability and development and active participation of service users**

- People with psychosocial disabilities have a right to be consulted and heard, take decisions on their own lives and fulfil meaningful social roles in the community.
- People with psychosocial disabilities and their carers are not considered as passive recipients of care in CMH but encouraged to participate actively in all phases of development and implementation of CMH services.
- CMH encourages the formation of groups run by service users and their carers such as self-help groups and associations for self-advocacy.
- CMH aims to abolish human rights violations against people with psychosocial disabilities, to achieve equal opportunities and facilitate their full social integration in the community.
- To combat exclusion, community-based activities seek to reduce stigma and discrimination. If funds are available these can be extended to regional and/or national levels.

➤ **Gender perspective**

- Although the overall prevalence of all types of mental disorders is not different between men and women, gender differences are very relevant when considering specific types of mental disorders. Rates of major depression and anxiety are significantly higher in women than in men across the life span.
- Factors that increase vulnerability of women are poverty, violence and abuse, low social status, caring responsibilities and exposure to adverse life events. Women are less likely to receive adequate mental health care and tend to experience more discrimination if they have a psychosocial disability.
- CMH takes into account gender specific prevalence rates and risk factors offering accessible services and prevention specifically for women.



Models and approaches

➤ Models of CMH implementation

- The choice of the adequate model depends on the availability of local resources and existing health services taking into account sustainability.
- The primary model in CBM is integration of CMH into existing community-based rehabilitation (CBR) programmes. The social model of disability underlying the concept of CBR adopted by CBM is also valid for CMH.
- Alternative models for the implementation of CMH services are integration into primary health care services provided by the government with sharing of resources or the implementation of stand-alone CMH services.

➤ Context-based approach

- CMH uses a culturally sensitive approach appropriate for the local context that takes into account the community perception of psychosocial disabilities and local healing traditions if not harmful.
- Simplified diagnoses that consider the ability/disability of the person to participate in community life may be more adequate than a formal medicalised diagnosis.
- CBM partners are informed about CMH and are encouraged to include CMH activities in accordance with local needs and experience.

➤ Focus on community development and poverty reduction

- There is a close relationship between poverty and mental health. Positive mental health is important for all community members and a prerequisite for social cohesion, community development and poverty reduction.
- In CMH the mental health necessities of all community members are taken into account involving community leaders and members in this process. CMH builds on existing community resources and encourages the commitment of community volunteers.
- People with psychosocial disabilities can and are entitled to contribute to the development of their communities.



➤ **Multidisciplinary and inter-sectoral collaboration**

- Needs of people with psychosocial disabilities are multiple and cut across service sectors, so CMH services need to develop good inter-sectoral and multidisciplinary collaboration.
- Links are needed with PHC services, psychiatric services provided through general hospitals, psychiatric hospitals if existent and other referral centres. Mental health promotion and identification of children and adolescents with psychosocial disabilities can take place in schools and colleges.

Areas for action

➤ **Community-based identification, diagnosis, treatment and rehabilitation for people with psychosocial disabilities**

- CMH provides accessible, affordable, acceptable and high quality services in the community for people with psychosocial disabilities that include early recognition, psychosocial interventions and support for a reliable supply of essential drugs.
- Intensive efforts and advocacy to secure a reliable supply of essential psychotropic drugs (see CBM list of essential drugs in implementation guidelines) through the public health sector are necessary to achieve sustainability. Only in cases where this aim cannot be achieved due to insurmountable barriers should alternatives be sought.
- In accordance with WHO mental health Global Action Programme (mhGAP)¹³ one or several of the priority conditions to be identified and treated are depression, schizophrenia and other psychotic disorders, suicide, epilepsy, dementia, alcohol and substance use disorders and mental disorders in children, because they are highly prevalent and disabling. Many of them are associated with human rights violations.
- Rehabilitation services take into account the need of people with psychosocial disabilities to lead a productive life. Livelihood activities are promoted as a basis for independence and empowerment of people with psychosocial disabilities.

¹³ WHO (2008)



➤ **Mental health promotion and prevention of mental disorders.**

- To reduce the burden of psychosocial disabilities it is not sufficient to only provide services for treatment and rehabilitation, but it is also necessary to promote positive mental health and prevent mental disorders by fighting against poverty, violence, abuse and neglect.
- CMH increases public awareness about the importance of mental well-being, the causes of mental disorders and how to prevent them through targeted information and media campaigns.
- Preventative measures are especially effective in childhood and adolescence, for example a simple training of nurses to support mothers with new-born babies improves the mental health of young people, and improvement of nutrition including micronutrients can prevent developmental disabilities and mental health problems in children. CBR programmes should combine prevention of psychosocial disabilities with prevention of other types of disability.
- Prevention and promotion should be undertaken together with other organisations and agencies in networks to increase the impact.

➤ **Mental health needs of people with disabilities and carers**

- People with physical, intellectual and sensorial disabilities have an increased risk of developing additional psychosocial disabilities mainly due to the exclusion and discrimination they have to face. The risk of developing neurological disorders like epilepsy is also increased due to biological factors such as brain damage.
- CMH takes into account the vulnerability of people with disabilities and their special needs for mental health care. It aims to improve their self-esteem and their capacity for self-help and self-advocacy.
- Carers of people with psychosocial disabilities and/or other disabilities are vulnerable to mental health problems such as depression and burn-out. This applies especially to women and children who often take over the responsibility for the care of the person with a disability.
- CMH takes preventive measures to ease the burden of the caring role facilitating community support, sharing of care by other family members, self-help groups etc.



➤ **Mental health of children and adolescents**

- Studies show that half of all lifetime cases of mental illness begin before the age of 14. There is evidence that prognosis of mental disorders is improved with early diagnosis and treatment.
- To be more effective CMH must take into account children and adolescents in prevention, promotion and community-based mental health care. For example, protecting children from physical and sexual abuse in the community is a highly effective preventive action. Children with physical, intellectual and sensorial disabilities, especially those with hearing disability, have a higher risk of developing behavioural disorders and need early mental health interventions.
- Interventions for children and adolescents are often best placed in schools using existing community resources.

➤ **Emergencies and disasters**

- In the rehabilitation and development phase after emergencies CMH engages in psychosocial rehabilitation, especially where CBM supported projects and programmes already exist before the disaster.
- Special attention is given to people with disabilities, especially people with pre-existing psychosocial disabilities, because of their marked vulnerability to the traumatizing effects of emergencies, and their need for access to supply of medication. People with psychosocial disabilities related to trauma may also need specific support.

➤ **Advocacy, networking and alliance building.**

- Advocacy, involvement of stakeholders, alliance building and networking are necessary in CMH to cover the wide field of mental health including fight against stigma, improvement of community-based services, prevention and promotion, influencing mental health policy and legislation.
- CMH activates resources at all levels beginning with community resources.
- The protagonist role of service users and families in self-advocacy is encouraged in the fight against human rights abuses, inaccessible services, restraint and coercive treatment.



➤ **Training, quality control and research**

- In CMH training is needed on several levels: for community volunteers and CBR staff, for health workers in primary health care services (nurses and general physicians), for psychiatric nurses and for mental health professionals in hospitals.
- Locally available resource persons for training are identified and motivated to take part as trainers.
- Training focuses on those who have the potential to pass on their knowledge to others (multiplicators).
- In CMH strategies with proven effectiveness are preferred. Service delivery has to comply with established quality standards.
- Needs assessment, project planning, monitoring and evaluation (PCM) are done together with community members, people with psychosocial disabilities and their carers.
- CMH services participate in research on epidemiological issues (prevalence, incidence) and investigations on course, outcomes, service effectiveness and impact of intervention and prevention strategies on communities.

➤ **Mental health as a cross-cutting issue**

- As there is no health without mental health, mental health is a cross-cutting topic in all CBM programmes and should be considered in all services provided to people with disabilities, their families and communities.
- Sensitisation for mental health needs and basic training should be provided to all partners of CBM, even if they are not directly involved in mental health work, offering for example training of basic listening and counselling skills. Special mental health interventions may be needed in specialised services, for example services for people with hearing impairment should take into account the need for prevention of depression and suicide.
- The importance of mental health and the need for activities in the field of mental health should be promoted within CBM taking also into account the mental health needs of staff.



Literature/References

CBM (2006)

Disability and Development Policy

Kohn R., Saxena S., Levav I., Saraceno B. (2004)

The treatment gap in mental health care, Bull WHO 82, pp 858-866

Prince M., Patel V, Saxena S., Maj M., Maselko J., Phillips M., Rahmann A. (2007)

No health without mental health, The Lancet, Global Mental Health

Saxena S., Thornicroft G., Knapp M., Whiteford H. (2007)

Resources for mental health: scarcity, inequity, and inefficiency. The Lancet, Global Mental Health

WHO (2001)

The World Health Report. Mental Health: New Understanding, New Hope

WHO (2003)

Investing in Mental Health

WHO (2004)

Promoting Mental Health. Concepts, Emerging Evidence, Practice

WHO (2008)

Mental Health Global Action Programme (mhGAP) – Scaling up care for mental, neurological, and substance use disorders; http://www.who.int/mental_health/mhgap_final_english.pdf (accessed 07/2009)



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