

COMMUNITY MENTAL HEALTH PRACTICE

Seven Essential Features
for Scaling Up in
Low- and Middle-Income
Countries

Community Mental Health Practice is a multidimensional intervention process that effectively meets a community's need for appropriate mental health services



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Foreword

The innovative work of BasicNeeds is making a vital contribution globally to promoting the practice of community mental health. BasicNeeds works in places where people otherwise have very limited access to mental health services or support for recovery. It contributes through its practical work in communities, using existing strengths and resources, and through its focus on data gathering and research. The latter is important, as the necessary extension or scaling up of the practice of community mental health depends on a clear understanding of the relevant evidence and experience.

From the beginning BasicNeeds has emphasised the role of its research programme and here we see some of its fruits. The report presents case studies of the practice of community mental health in several countries, and distils the essential features of practice that allow scaling up. It examines the realities of WHO's recommendation to integrate mental health with primary health care and demonstrates the value of developing partnerships of many types. It helps remove the mystique that has hindered efforts to extend the practice of community mental health care.

The seven essential features of practice for scaling up are described with great clarity. They are practical and universal, and encourage local innovation. They include policy, funding and local management structure, as well as working with all possible partners and developing local context adaptations. The case studies give ideas and inspiration to develop new programmes and find ways around obstacles in existing programmes, especially through involving those with most at stake including users and their families and local community leaders.

The new comprehensive definition of community mental health practice as a multidimensional intervention process with its seven essential features, and the clear links with the development of primary health care, are great resources for those working to make evidence-based mental health care and rehabilitation available globally. The work demonstrates the value of an organised care structure within which community-based workers can be trained and supported in mental health work. Even though psychiatrists, mental health professionals and trained medical professionals are scarce, the case studies describe various ways in which it is possible to achieve the crucial link between these sources of mental health expertise and the community-based workers through training, supportive supervision and referral. Among the insights from reading the report are the multiple possible roles of all participants in the work. Users are described as receiving care as well as identifying and providing support and counselling for others in need, and participating in advocacy. Psychiatrists and other professionals give direct care, training, supervision, policy advice and advocacy and learn from users and their families.

The barriers to the practice of community mental health include stigma, unwarranted pessimism about the effectiveness of treatments and capacity to deliver these, and scarce resources dedicated to mental health. These barriers are evident almost everywhere but magnified in low-income countries. The solutions described here demonstrate the changes possible in all types of settings. I am delighted to see this report with its depth of understanding and experience. It has the potential to encourage significant expansion in the capacity to respond to the global burden of mental illness.

Helen Herrman

Director, World Health Organization (WHO)
Collaborating Centre for Mental Health, Melbourne

Acronyms And Glossary

CMH	Community Mental Health
LMIC	Low- and Middle-Income Countries
CMHP	Community Mental Health Practice
CMHS	Community Mental Health Services
BN	BasicNeeds
ORC	Outreach Clinic
OPC	Outpatient Clinic
GP	General Practitioner
CBW	Community-Based Worker (Note: This term is used to describe community-based personnel performing a clearly emerging set of functions relating to CMHS delivery).
CPN	Community Psychiatric Nurse
MHC	Mental Health Coordinator (government-appointed)
MHD	Mental Health and Development (BasicNeeds' intervention model).
DMHP	District Mental Health Programme
PHC	Primary Health Centre
MH	Mental Health
SHG	Self-Help Group
MHU	Mental Health Unit
FGD	Focus Group Discussion
CPU	Community Psychiatric Unit
GHS	Ghana Health Service
TOR	Terms of Reference

Programme participants– People with mental illness or epilepsy participating in CMHP facilitated by BasicNeeds (Note: The term 'users' is sometimes substituted for programme participants).

People with mental disorders – People affected by mental illness or epilepsy

Executive Summary

While Community Mental Health has long been considered a better alternative to institutional care in both high-income countries and LMICs, questions regarding the most effective ways to implement CMH remain. CMH care has been applied to numerous settings; yet the practice has to date been only very broadly defined in existing literature. As this approach to addressing mental health needs in low- and middle-income countries continues to grow, principles for effective practice become increasingly important. Community Mental Health Practice represents a vital component of the BasicNeeds Model for Mental Health and Development. This monograph offers a comprehensive definition of Community Mental Health Practice and a list of essential features that are required if CMHP is to be scaled up effectively. The CMHP definition and the essential features for scale-up, presented at the beginning of this monograph, are developed from an analysis of case studies of CMH practice in seven different LMICS. An analysis of these case studies provides evidence of effective practice, as well as challenges.

In the first six case studies, key informant interviews with government and NGO officials revealed detailed information on the process of implementing Community Mental Health, including strengths and limitations. Perspectives from users were also highlighted through focus group discussions in each region. The last case study from India is extracted from a WHO-commissioned case study of a district mental health programme offering CMHS in the Thiruvananthapuram District of the state of Kerala. This study was also carried out by BasicNeeds.

An analysis of these seven case studies revealed the following essential features for scaling up CMH practice:

1. Community-focused government policy
2. Dependable funding
3. Local management structure
4. Appropriately adequate human resources
5. Active user and caregiver participation
6. A network of stakeholders
7. Local context adaptations

It is the coming together of these essential features that can make CMHP dynamic and inclusive, thus providing a strong foundation for its spread. As CMHP continues to develop and multiply in LMICs, more people with mental illness or epilepsy will have the opportunity to receive much-needed treatment. Even more importantly, they will become a part of its scale-up.

Essential features for scaling up CMH practice:

- 1. Community-focused government policy*
- 2. Dependable funding*
- 3. Local management structure*
- 4. Appropriately adequate human resources*
- 5. Active user and caregiver participation*
- 6. A network of stakeholders*
- 7. Local context adaptations*

Introduction

The BasicNeeds Model for Mental Health and Development employs a developmental approach to community-based mental health intervention in LMICs with an emphasis on sustainability. The Model was conceived to address both mental health and socio-economic issues concurrently and is composed of five separate but interlinked modules: Capacity Building, Community Mental Health, Sustainable Livelihoods, Research and Management/Administration (Raja et al., 2008).

BasicNeeds was established in 2000 to initiate mental health and development programmes in less developed countries. BasicNeeds' programmes now operate in eight countries in Asia and Africa - India, Sri Lanka, Lao PDR, Nepal, Ghana, Tanzania, Kenya and Uganda. Country offices implement and manage these programmes.

This monograph focuses on the process of implementing Community Mental Health, an instrumental component, one module, of the Model for Mental Health and Development. It is important to note however that within BasicNeeds' field programmes this module is always implemented in conjunction with the other four modules. In practice there is significant overlap between the modules - this is the inherent nature of the integrated model. BasicNeeds works closely with government agencies, primary health care providers, NGOs, other local organizations and community groups for implementing the model.

The monograph provides a working definition and the essential features of Community Mental Health Practice. The definition is followed by a background literature review and discussion illuminating ground-level realities of Community Mental Health Practice. The definition and discussion of CMHP are based upon seven case studies (located in Chapter 4 of this monograph). They are from Lao PDR, Ghana, Uganda, Tanzania, Kenya, Sri Lanka and India. Six of these case studies were completed by BasicNeeds in May and June 2008. The India case study is taken from the following 2008 WHO report:

India: Integrated primary care for mental health in the Thiruvananthapuram District, Kerala State. In: Integrating mental health into primary care - A global perspective. World Health Organization and World Organization of Family Doctors (Wonca), Switzerland: WHO Press. 2008. p.109-123.

Definition and Seven Essential Features of Community Mental Health Practice

*Certain essential features
must come together for
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scaled up in LMICs.*

Community Mental Health Services are now offered in a variety of settings around the world. They may appear as outreach treatment services providing mental health treatment to people living far away from hospital services. CMHS may utilize volunteers or community health workers in resource-poor areas to compensate for a lack of specialized mental health staff. While research shows that many CMH programmes have been effective in increasing access to mental health treatment in certain areas, CMH initiatives are also commonly criticized for existing in isolation, allowing little opportunity for growth (Saraceno et al., 2007).

Community Mental Health Practice is a comprehensive approach to mental health care including but not limited to CMHS. This approach to mental health care requires involvement and commitment from the local community, national government and intermediary level stakeholders. CMHP, influenced by an overall network approach to care, provides a network base for CMHS. A working definition of CMHP may be expressed as follows:

Community Mental Health Practice is a multidimensional intervention process that effectively meets a community's need for appropriate mental health services through both engaging available local, tertiary and national resources and capabilities and stimulating multiple stakeholder awareness and commitment.

Essential Features of Community Mental Health Practice – For Scaling Up

The Lancet Global Mental Health Group has issued a call to scale up mental health service coverage, especially in LMICs (Chisholm et al., 2007). This call is in response to a rising demand for mental health treatment in resource-poor countries. A pressing challenge is to design CMH scale-up initiatives such that they are both effective and sustainable in LMICs.

Writing within the context of Community-Based Rehabilitation (CBR), Boyce et al. (1997) define scaling up as “a response to organizational growth and concerns the process that NGOs use in attempting to increase their impact.” Drawing from this definition, therefore, scaling up CMH initiatives involves the process of expanding the impact of these services. Crucial to the survival and sustainability of these services is ongoing cooperation between multiple sectors and a flexible infrastructure. This allows the scale-up process to take place in a natural, organic way. CMHP provides the structural framework to facilitate scale-up as the need grows. The following literature review and case study analysis yield essential features of CMHP which lay the necessary ground work for future scale-up. Thus, certain essential features must come together for effective and sustainable CMH operations to be scaled up in LMICs. These features are:

1. Community-Focused Government Policy

If CMHP is to be scaled up and sustained in LMICs, clear community-focused government policy backed by targeted legislation is a primary requirement. The crux of such policy should enable mental health services in or near communities by both ensuring provision of funds, human resources and other resources for CMHP and also holding governments accountable for its efficient and effective delivery.

2. Dependable Funding

A fundamental requirement for starting and continuing CMHP operations is dependable funds, made available mainly through district¹ annual plans and budgets. Priority in allocating these funds should be for the following objectives: 1) purchasing required psychotropic medicines at appropriate levels of primary care; 2) allocating appropriate salaries for personnel from the community level to the top; 3) ensuring training at various stages and locations; 4) supporting a local CMH management structure; and 5) forming user groups.

3. Local Management Structure

A dedicated local management body (preferably at the district level) that manages resources and processes at different levels to run and sustain CMHP is important. This management body must have the required authority to ensure integration of CMHP into general health services. The management process must be effected through annual operational plans and budget (as part of district plans and budgets) that cover user identification, diagnosis, prescription, follow-up, referrals, records maintenance, and routine service monitoring and evaluation. The management body must have planned engagement with multiple stakeholders so as to access funds and run mental health services (e.g. outreach clinics). Furthermore, the management body must ensure proper supply of psychotropic medicines according to demand as well as manage transportation needs. This local structure will be essential until such time that CMHS are well integrated into the general health facilities at primary and other relevant health care levels². Other functions of this body that link mental health services to the community may need to continue.

4. Appropriate and Adequate Human Resources

A systematised, policy-backed and steady supply of human resources that can ensure a proper link between CMHS and the communities served is essential. Thus, trained, salaried personnel who can execute appropriate functions at different levels and locations must be consistently available as follows:

Community-based workers – for identification of people with mental disorders from their communities, support to users and families to access CMHS, follow-up in the community and maintenance of basic records.

Psychiatric or trained medical personnel (e.g. medical or clinical officers, community psychiatric or general nurses) – for diagnosis, prescription, treatment at suitable health facilities within districts, maintenance of records, and training new or existing personnel in other districts.

Psychiatrists – for referral cases as required; supportive supervision of trained medical personnel, training and regular review of treatment quality provided through CMHP.

5. Active User and Caregiver Participation

Active participation of empowered user and caregiver groups that can sustain user demand for and government supply of CMHS is a crucial component of CMHP. Established user and caregiver groups should be given the opportunity to evaluate CMHS received through a planned mechanism built into the CMHS management structure. This can ensure that service providers are held accountable for delivery of CMHS. Thus a continuous and equitable engagement between the user groups and the local CMH management body is essential if CMHP is to raise the quality of services as well as attain efficiency and sustainability.

¹ District in this context refers to an administrative division managed by the local government. Size varies from country to country but the local government administration of districts is the key commonality.

² In the six case studies of BasicNeeds programmes, local BasicNeeds teams play a similar role, functioning as a local management body (e.g. bringing together multiple stakeholders, creating annual plans and budgets to get the CMHP process going, etc.).

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6. A Network of Stakeholders

CMH programmes cannot exist in vertical isolation. To function effectively and to also sustain, CMHP requires dynamic co-operation between diverse stakeholders, as well as their commitment and support. Depending upon unique local factors and specific country contexts, CMH stakeholders who come together could include district level government officials, psychiatric and health personnel, local private and voluntary organisations, traditional and faith healers, religious and community leaders, users and carers. An effective set of stakeholders can greatly enhance the identification of affected individuals in the community as well as mobilise communities to support such individuals and partner in advocacy efforts. The specific roles/contributions of the different stakeholders to CMHP have to be managed by the local CMH management body.

7. Local Context Adaptations

Within the broad framework of CMHP the manner in which the 'essential components' come together (or the process of CMHP) should remain flexible so as to adapt to the unique features of local implementation sites (i.e. resources, capacities, infrastructure and user needs). CMH programmes should be designed, planned and budgeted for by taking into account the strengths and weaknesses of local contexts. Close monitoring and evaluations by users and the management body are necessary to also recognise and adapt to changing conditions.

Background

Identifying effective approaches for assessing and meeting mental health needs in low- and middle-income countries has become a topic of much debate. Approximately 450 million people worldwide live with mental illness or epilepsy that could benefit from treatment. Mental disorders now account for an estimated 14% of the global burden of disease³ (Prince et al., 2007). Furthermore, this growing burden is expected to be most pronounced in LMICs, where existing mental health resources are severely limited. In Southeast Asia alone, 27% of years lived with disability (YLD) can be attributed to neuropsychiatric diseases (Lopez et al., 2006). While evidence-based knowledge on appropriate mental health treatment remains limited, community-based mental health care models have begun to emerge as new avenues for accessing treatment in LMICs.

This paper presents seven case studies of Community Mental Health Practice in seven BasicNeeds programme areas. They provide a practical context for illuminating the strengths and challenges in implementing effective community mental health programmes. A review of existing CMH literature in LMICs provides context for and adds to the case study analysis.

Treatment Gap

Although much of the global burden of mental disorders is located in LMICs, 90% of global mental health resources are located in high-income countries (WHO, 2005). Psychiatrists are scarce in LMICs. Only 1800 psychiatrists exist per 702 million people in Africa, whereas 89,000 psychiatrists practice in Europe per 879 million people. Similar inequities are evident in all other mental health professional groups such as psychiatric nurses. Furthermore, the World Mental Health Survey revealed that between 76.3 and 85.4% of people with mental illness or epilepsy in LMICs received no treatment in the 12 months prior to the interview (Demyttenaere et al., 2004).

Most mental health resources are concentrated in psychiatric hospitals in urban and affluent areas where poor people, especially those who live in rural areas, cannot access services. Though deinstitutionalization and integration of in-patient mental health care within general hospitals is an oft-stated policy objective, 74.4% of psychiatric beds in LMICs remain in psychiatric hospitals (WHO, 2005). Despite this apparent treatment gap, on average most African and Southeast Asian countries spend less than 1% of their national health budgets on mental health. While resources are scarce in LMICs, other factors can also determine receipt of care for mental disorders. For example, poor knowledge of and negative attitudes towards mental illness within the community often prevent people with mental illness or epilepsy and their families from seeking help (Gureje et al., 2005).

Moving towards CMH Care

A community-care approach to treating mental disorders means that power is shifted from the institutions to the community. Holistic care is provided locally and coordinated by health professionals and local organizations. Patients and carers are considered partners. Integration into the community is paramount. Mental health policy initiatives in LMICs, at least on paper, have moved away from institutionalized care towards a more community-

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³ The Global Burden of Disease (GBD) study uses a disability adjusted life years (DALY) indicator to provide an overview of the main causes of burden of disease in low- and middle-income countries as well as major trends since 1990 (WHO, 2004).

based approach to better address the treatment gap, particularly for poor people living in rural areas. Still, many researchers and policymakers argue for a necessary balance between community-based and hospital-based care (Thornicroft and Tansella, 2002).

The Principles of Care defined in the 2001 World Health Report state that community-based care should be able to identify resources and create healthy alliances that would otherwise remain hidden and inactivated. Some of the good care principles relevant to mental health are diagnosis, early intervention, rational use of treatment techniques, continuity of care, wide range of services, consumer involvement, partnership with families, involvement of the local community and integration into primary health care. Psychopharmacological progress, increased emphasis on human rights and a greater understanding of the combination of social and mental aspects of mental disorders contributed to this paradigm shift from institutional to community mental health care (WHO, 2001).

While the types of Community Mental Health Services vary between countries depending on the social, economic and political context, WHO recommends that countries develop a mix of services for mental health. Much of mental health care can be self-managed or managed by informal Community Mental Health Services (e.g., community groups, religious organizations and schools). Where additional expertise and support are needed, a more formalized network of services is required. These include primary care services, followed by specialist CMHS and psychiatric services based in general hospitals, and last, by specialist and long-stay mental health services (Funk et al., 2004). These current WHO guidelines in CMH development are quite general, leaving ways of implementation largely to the discretion of individual programmes. It is therefore not surprising that CMH programmes look very different depending upon the social, economic and cultural context of implementation, although key components remain.

Experiences in Community Care

High-Income Countries

For decades, CMHS have been implemented in high-income countries with variable success. Interventions frequently involve a reduction of beds in psychiatric hospitals, establishment of day hospitals, hostels for people with mental illness or epilepsy, community mental health centres, psychiatric wards in general hospitals and supervised accommodation (WHO European Ministerial Conference, 2005). A recent study in Finland found a link between multi-faceted Community Mental Health Services and lower suicide rates than in-patient treatment services (Pirkola et al., 2008). A meta-analysis of studies on mental health services in Europe found a common trend towards deinstitutionalization and improved community services across countries but that national mental health services still varied considerably. How this variation in services affects patient outcomes is unknown, requiring further exploration (Becker and Killian, 2002).

In Italy, changes in mental health policy towards a community-based approach occurred in 1978. Twenty years later, Barbato's study revealed that while in-patient admissions had dramatically reduced after the policy changes, residential facilities and community services were found to be inadequate and unevenly distributed (Barbato, 1998). A similar psychiatric reform programme in Greece saw vast improvements in the decentralization of mental health and rehabilitation services; however, these services were still not widely available in rural and semi-rural areas twenty years later (Madianos et al., 1999). Thus, available literature reveals gaps in our knowledge of CMHS effectiveness in high-income countries.

Low- and Middle-Income Countries

In the case of LMICs, more recent community-based efforts have also met with limited success. CMH interventions in poor countries lag behind and the treatment gap is widening. Most programmes have concentrated primarily on integrating mental health care into general health services. India began training primary health care staff in 1975 and formulated a

National Mental Health Programme in 1982. CMHS also exist, to some extent, in several other LMICs in Africa and Asia (WHO, 2001). Only a few of these programmes have been assessed, leaving many unanswered questions about the effective implementation of CMH in LMICs. A review of the literature on CMH care in LMICs revealed that many CMH programmes had a positive effect on most mental health outcomes and also proved to be cost effective (Wiley-Exley, 2007). Unfortunately, the follow-up duration of these programmes was less than two years so there is no indication of the long-term feasibility of these interventions.

A CMH awareness programme in Nigeria has shown sustained benefits over a four-year period of time, according to a recent study (Eaton and Agomoh, 2008). The programme trained village-based health workers to promote mental health referrals to a network of clinics across three states in Nigeria. The study showed a steady increase in the number of people receiving mental health treatment after four years.

Another study in rural Pakistan assessed five different types of CMH providers according to user perspectives (Mirza et al., 2006). They found treatment provided by general health practitioners to be the most effective. Additionally, this study highlights the need to standardize the treatment given by primary mental health care providers in Pakistan.

A randomized controlled trial in Santiago, Chile, studied a coordinated stepped care approach to treating depression (Araya et al., 2003). This multi-component intervention was led by a non-medical health worker and included group psychoeducation about depression, systematic monitoring of symptoms, and a structured drug programme for those with more severe or persistent depression. At the six-month follow-up, 70% of the stepped care group reported reduced clinical symptoms. This study marks one of the only randomized controlled trials used to assess a CMH intervention (Wells et al., 2004).

Jamaica has developed an innovative approach to treating people with severe mental illness or epilepsy outside of psychiatric hospitals. People with severe mental distress are instead treated in acute general hospital wards (Hickling et al., 2000). This way, trained clinicians in medical wards are able to treat acute psychosis in emergency situations. Those admitted to the ward rather than a psychiatric hospital had a shorter hospital stay and better compliance with treatment.

A few CMH programmes implemented in India have also been assessed. Murthy et al. studied outcomes for people with schizophrenia who had participated in a community outreach programme (Murthy et al., 2004). The study found that participants in the programme experienced positive clinical, functional and economic outcomes at a two-year follow-up assessment.

A three tiered community-based rehabilitation model has also been implemented and assessed in India. The model includes outpatient care (first tier) supplemented with support from community case workers (second tier) and community rehabilitation initiatives (third tier). Case workers are drawn from the populations they support and offer services to users, their families, and communities. Initiatives are planned in a forum called a village health group, which includes carers and key local stakeholders. Compared with outpatient treatment alone, the community-based rehabilitation model led to better outcomes for disability, compliance, and engagement with treatment (Chatterjee et al., 2003).

A follow-up study was conducted 16 years after the initiation of a Community Mental Health programme in Chennai, South India (Thara, 2004). The programme, run by the Schizophrenia Research Foundation (SCARF), was functional for 10 years and during this time training schemes for primary health centre staff, a referral system, a citizens' group and self-employment schemes were established. It was concluded that psychiatric services were not sustained due to the transfer of trained clinicians within 6 months, a lack of money for psychotropic and anti-convulsive drugs, and understaffed facilities. Clinicians were found to be unwilling to treat mental disorders. People with mental illness or epilepsy had disengaged from treatment

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due to the expense of the commute to clinics and, where medication had removed symptoms, the patients wrongly assumed they no longer required treatment. Most of these patients subsequently relapsed. The citizens' group ceased to exist as soon as the project coordinator and group leader left the area. The study concluded that the programme failed to continue due to a lack of family and community involvement. They highlight the need for a definite link with a medical service to provide mental health care and for key personnel within the community to assume responsibility for the activities. Policy and supportive measures for implementing CMH care have been initiated by many poor countries. However, they are rarely based on accurate information from practical field based evidence. Consequently these policy initiatives have yet to make a sustainable difference in mental health care delivery. The pathway between policy and implementation is unclear and existing gaps between policy and practice have been difficult to identify and bridge.

These seven case studies explore the practice of Community Mental Health. The first six case studies look at CMHP in relation to BasicNeeds' interventions. The India case study summary is based upon a 2008 WHO-commissioned case study done by BasicNeeds of the District Mental Health Programme in the Thiruvananthapuram District of Kerala, India. The analysis and ensuing discussion provide suggestions for refining existing approaches to CMH implementation to make it more clear, sustainable and scalable. It aims to understand the limitations of the present efforts and explore new ways of working with local communities and national governments on promoting CMH initiatives.

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CMHP: Process, Resources and Principles

The case studies in Chapter 4 reveal a detailed description of CMHP operating in various regions of seven different countries. Here the entire process and specific dynamics emerging through implementing CMHP is highlighted in Part 1. Part 2 illuminates the role of resources in CMHP. Part 3 focuses on patterns and principles of effective CMHP. The discussion provides us with a necessary context for our working definition and essential features of CMHP.

PART 1: CMH Process

Identification

CMHP across these case studies share common elements in the process a participant goes through from the point of first contact to follow-up. Participants are typically identified within their communities through a referral process. In some cases, hospitals and village health centres refer participants to CMHS but often-times identification occurs within the community through traditional healers, CBWs and village mobilizers. CMHS are publicized within the community at meetings and sensitization events. Identification typically happens at the community level, stressing the importance of promoting community awareness about mental disorders and addressing community stigma issues.

Registration and Diagnosis

Following identification, record keeping begins, as CBWs or nurses register new participants by opening individual files to collect relevant participant details and record their progress in the programme. In most cases, a clinical file with detailed diagnosis and treatment information is housed and maintained separately by doctors and nurses at PHCs. Registered participants then receive a diagnosis from trained psychiatrists, general doctors, nurses or medical officers. Often, hospital-sourced mental health clinicians are recruited to diagnose and prescribe treatment at the mental health clinics or camps, ORCs and OPCs. Most users reported that they are satisfied with the accessibility of the ORCs and OPCs. Diagnosis is determined from patients' history and their responses to questions. Participants return on a regular (usually monthly) basis for follow-up consultations with the clinician and to receive new prescriptions and medications. Occasionally, participants are referred to psychiatric hospitals for more specialized treatment. In some instances, MH-trained personnel are not available at the community or primary health care level to make a diagnosis and administer treatment. Then, BasicNeeds trains PHC staff to identify and prescribe medications.

Treatment

Treatment includes medication and counselling in all but one case study. Counselling is sometimes conducted at review consultations with the prescribing clinician. In other examples, counselling is offered informally through local partner organizations. Notably, counselling through traditional healers and local spiritual healers complements medical treatment in Uganda. Also, self-help groups are considered by users to be another valuable form of treatment where they can connect with one another and advocate for themselves. Many users stated that they are happy with the efficacy of their treatment, although sometimes relapses occur when adequate medication is not affordable or available.

CMHP across these case studies share common elements in the process a participant goes through from the point of first contact to follow-up.

Follow-Up

Home visits at the village level are crucial to the follow-up process in all case studies. Community-based workers or nurses visit the homes of participants regularly to assess and provide guidance on adherence to treatment. Where CBWs are not available, members of SHGs have taken responsibility for home visits in Uganda. Each visit is documented in the individual file. Users reported that the encouragement received from CBWs during home visits is very important to their success with treatment.

Meeting a Growing Demand

Finally, central to this entire process is the demand for mental health services existing in a community. In these countries, an often undiscovered need exists for CMHS. Need does not always translate into market demand due to inaccessibility of services and the stigma commonly associated with mental illness. Part of the role of effective CMHS is to uncover this latent need through awareness building and mobilization within communities. As the demand begins to grow, expanding the reach of CMHS becomes necessary. This can be achieved through ongoing training and improving the scope of existing processes and services, such as camps and ORCs.

PART 2: Resources

Infrastructure

A number of resources are required to run the CMHS mentioned in these case studies. An existing infrastructure at the district and community levels, including hospitals and PHCs, is necessary to effectively offer mental health services. Even so, these facilities require adequate room for growth to successfully integrate CMHS. At the village level, spaces such as offices, schools or religious buildings are required to hold local meetings. Transportation may be necessary for home visits, bringing programme participants to clinics and transporting clinicians to PHCs. Other essential items include furniture and writing material and computers for documentation.

Medicines

Access to psychiatric medicines is another crucial requirement. A growing demand for public access to psychiatric medicines accompanies the growth of a CMH programme. Government health systems must have the ability to supply and deliver appropriate medical treatment. The sustainability of CMHS depends upon this component. In each of the highlighted case studies, limited access to psychiatric medicines has proven to be a major stumbling block to CMH programmes.

People

Community-Based Workers

Of course, people comprise the most valuable resources necessary for the effective management and functioning of the CMHS process. Community-based workers are the backbone of these services, from the moment of identification to follow-up home visits. Trained CBWs assist in identifying new participants, registration, follow-up visits, and running self-help groups. As trusted members of the community, CBWs can have a positive influence on users as well as the surrounding community's response to mental illness. Community-based workers are given monetary compensation for their work, ensuring the sustainability of their role and the potential to expand it if necessary. Users expressed their satisfaction with and appreciation for the support from CBWs.

Programme Participants

Community-based workers have not worked quite as well in Uganda where there has been some difficulty in creating a system of incentives for them. Village mobilizers or SHG leaders have filled the CBW role in Uganda. As former programme participants, village mobilizers have a commitment to the programme, and offer valuable perspectives. Programme participants in other settings have the potential for offering strong support for maintaining CMHS.

Mental Health Personnel

In the Ghana and Uganda case studies, community psychiatric nurses play an important role in diagnosis and prescribing medicines. In countries where the number of psychiatrists is grossly inadequate to meet the demand for mental health services, well-trained community psychiatric nurses can fill this void. Government-trained and appointed mental health or clinical officers have also become important instruments of CMHS in Sri Lanka, Tanzania and Uganda. As a government position, this role is valuable to the integration of CMHS with other government health services. Psychiatrists can serve an important role supervising mental health personnel and providing ongoing training.

However, access to hospital-sourced or retired psychiatrists and psychiatric nurses is often limited. Some users reported delays in seeing psychiatrists due to non-availability. Also, the high turnover of psychiatrists in Ghana interferes with the continuity of treatment. In some cases, trained PHC staff also fill the diagnosis and prescription role. In Sri Lanka, medical officers trained by the government also diagnose and prescribe medicine for mental disorders. In the Tanzania case study, this continuity of care issue has been addressed, with the appointment of a Mental Health Coordinator who is responsible for training new primary health staff in mental health. Where trained mental health staff are not available, BasicNeeds employs mental health clinicians to train local PHC doctors and nurses in diagnosing mental disorders and prescribing medicines.

Support Positions

These CMHS also require local people from outside institutions. In Kenya, social workers from a local NGO provide counselling. In Uganda, traditional healers and religious leaders network their services with CMHS. Buddhist monks in Sri Lanka also offer support services to BN programme participants. Such resource people offer supplementary services to the treatment that is already provided through PHCs.

Training

Managing the human resource component of CMHS requires effective training at several levels. The India case study reveals an intensive training programme where a district mental health team trains PHC level staff. Doctors learn to diagnose mental disorders and prescribe psychiatric medicines. Nurses and health staff learn to provide counselling and other support services. Community-based workers learn to identify mental disorders and provide counselling. In Tanzania, staff turnover has been addressed with the government appointment of a stationary Mental Health Coordinator to train new PHC staff. Intensive and ongoing training is important at all levels of the human resource component.

Funding

The government, BasicNeeds and partner organizations provide the funding for CMH services. However, funding is currently inadequate for some of the above-mentioned resources. Therefore, psychiatric medicines are in short supply as several case studies show. BasicNeeds currently purchases medicines where the government is not able to supply affordable psychiatric drugs. In Lao PDR, Tanzania and Sri Lanka, BasicNeeds supplies most of the medicines available for treatment. This is not a sustainable solution and increased and dependable government funding for medicines is vital to effectively managing and sustaining CMHS.

Users reported that the encouragement received from CBWs during home visits is very important to their success with treatment.

A growing demand for public access to psychiatric medicines accompanies the growth of a CMH programme. Government health systems must have the ability to supply and deliver appropriate medical treatment.

Where trained mental health staff are not available, BasicNeeds employs mental health clinicians to train local PHC doctors and nurses in diagnosing mental disorders and prescribing medicines.

Psychiatrists and psychiatric nurses are of limited availability in most LMICs. This requires flexibility to tap into various sources to fulfil all of the roles.

Mental health training for health workers and CBWs is also currently funded by BasicNeeds. All CMH treatment services are dependant upon trained personnel and volunteers. Furthermore, vehicles for transportation are generally funded by BasicNeeds, as well as the miscellaneous office supplies needed for documentation. Sustainable funding sources are needed for these important resources for the programmes to continue.

PART 3: Effective Principles Of CMHP

The Community as a Resource

While funding issues are often cited as a key reason for failed mental health initiatives in LMICs, these case studies evidence how building existing infrastructures and personnel resources to deliver Community Mental Health Services can be accomplished in low-resource areas. Consequently, a combination of dynamics has led to the successful implementation of CMH services in these examples.

Engaging users, community leaders, local NGOs, PHC staff, traditional healers and national governments in the process is paramount to not only establishing a commitment to CMHS but also utilizing their unique perspectives and contributions. For example, Uganda's acceptance of alternative treatments offered by traditional healers and religious leaders allows a natural referral process to occur. Likewise, self-help groups comprised of users can offer psychosocial treatment as well as perform other responsibilities such as follow-up visits. These are low-cost, natural ways of building the CMH resource capacity.

Policy Supporting Community-Based Workers

Community-based workers currently fulfill a crucial role in delivering CMH services. Their role needs to be further defined, legislating where necessary, to ensure they are earning appropriate salaries and receiving requisite training for their work. Supporting community-based workers is vital to keeping CMHS cost effective, relevant to local communities and sustainable.

Enabling Health Professionals

Ongoing personnel and volunteer training at all levels ensures consistency in service delivery. Psychiatrists and psychiatric nurses are of limited availability in these case studies as well as most LMICs. This requires flexibility to tap into various sources to fulfil all of the roles highlighted previously. At the community level, partnerships with community-based workers, traditional healers and local leaders are crucial for identification and follow-up services. At the health facility level, PHC and ORC staff, including doctors and nurses, need ongoing training in diagnosing and prescribing where possible. This training can be imparted by district level mental health staff, also available at the referral level. District level mental health staff also oversee the distribution of medications at the PHC and ORC levels. While trainings continue, and are currently conducted by BasicNeeds in each of the case studies, the long-term sustainability of this essential service will be determined by the programmes' ability to infuse training into the existing health personnel infrastructure.

Policy Support for Health Professionals

In practice, psychiatrists are often unavailable to provide diagnoses and prescribe medications. Government policy must grant other health care personnel the authority to perform diagnoses (or identify persons with mental illness) and prescribe (or provide) medicines for mental disorders. Community psychiatric nurses and, in some cases, general practitioners can be supported through training to provide necessary diagnoses and treatment at accessible levels.

In practice, psychiatrists are often unavailable to provide diagnoses and prescribe medications. Government policy must grant other health care personnel the authority to perform diagnoses and prescribe medicines for mental disorders.

A 'Mental Health for All' System

As awareness and consequently demand for mental health services continues to increase in LMICs, CMHP must necessarily expand its scope. The effective provision of services to increasingly diverse populations becomes a challenge to rigid CMH programmes. CMHP must have space to grow organically. CMHP has been introduced in a number of countries to promote accessibility and adaptability to available resources. As evidenced by the case studies in Ghana, Tanzania and Sri Lanka, mental health camps and outreach clinics appear to be an appropriate starting point for addressing a need for mental health services. However, as this need morphs into a market demand for services, it has been possible to integrate mental health services into primary health care. If CMH programmes become rigid and isolated from their context within health systems and communities, little difference remains between such programmes and their institution-based counterparts. Effective CMH programmes continually shape and respond to evolving processes and resources.

While the integration of mental health into primary care is often considered a primary component of CMH, effective and sustained management of CMH requires dynamic cooperation between a number of different levels of service. The PHC may serve as a home base for these interactions, but a chain of activities occurs from the home to the village to the hospital. Diagnosis and prescription activities may happen at PHCs but follow-up visits and supporting services often occur within the village or the home of the user. Additionally, hospitals often source both mental health clinicians for diagnosis and psychiatric medicines. Referrals also flow between hospitals and PHCs. While the PHC is often considered the best place to coordinate these interactions, other levels of service delivery are necessary.

Policy Support from the Government

Finally, as evidenced by the case studies, governmental support for CMH now lags behind the complex processes, resources and dynamics previously discussed. Government mental health policy must accurately reflect and respond to ground-level realities of CMH service delivery. In order for CMHP to be effective, increased governmental support through legislation and funding is necessary in many areas.

For example, psychiatric medicines must be available to users at appropriate health care access points, especially if CMHS are to be integrated into primary health care. This requires governments to allocate more funding for psychiatric medicines, as well as formulate or reform legislation to support the delivery of treatment at multiple levels.

If CMH programmes become rigid and isolated from their context within health systems and communities, little difference remains between such programmes and their institution-based counterparts.

Glimpses of action from the ground



Ghana - Mental health outreach clinic



India - Mental health camp



Kenya - Mental health outreach clinic



Uganda - Home visits



Kenya - Mental health outreach clinic



Sri Lanka - Community meeting



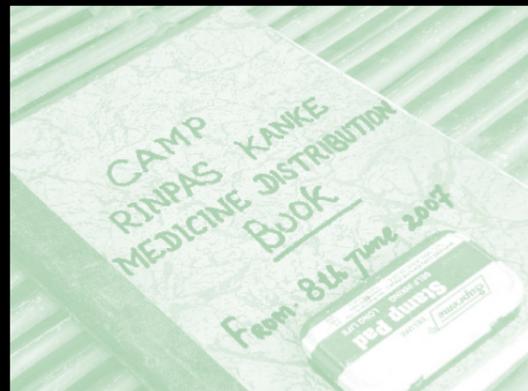
Lao PDR - Training community health volunteers



Tanzania - Members of the Sisi kwa sisi self-help group with their families



Lao PDR - Mental health outreach clinic



India - Mental health camp register



India - Training under District Mental Health Programme



Tanzania - Health worker training

CMHP: How Does It Work? Case Studies

The following case studies describe the practice of Community Mental Health within the six BN programmes and within the DMHP in India, with a focus on the organisation of services, the resources utilised and the challenges threatening its provision. Based on the content of these studies, critical issues in the implementation of CMH have been identified and discussed.

LAO PDR

Introduction to the Country

BasicNeeds Lao PDR (BNL) was established in May 2007 and is the first organisation to run a Mental Health and Development programme in the country. The programme is implemented in partnership with the Ministry of Health and Vientiane Capital Health Department. By the end of December 2008, 417 people had participated in the BNL programme and 155 of them were undergoing treatment.

Locality

BN programmes exist in 2 districts within the capital, Vientiane. This study describes the progress of programmes in 2 village groups, Nong Niew and Thangone, located in the Sikhottabong and Xaythani Districts, respectively. Nong Niew is composed of 8 villages; Thangone is composed of 11.

	Sikhottabong	Xaythani
Total number of villages	60	104
Total number of habitants	99,908	150,793
Male	49,936	77,460
Female	49,972	73,333
Population in Rural Areas	15,310	25,598
Population in Urban Areas	84,598	125,195

The treatment, service and the actual implementation of the MHD programme takes place at outreach clinics, held on a monthly basis. Originally held in a temple, the Thangone ORC has recently relocated to the district hospital. ORCs operate from 2 locations to service the widely dispersed Nong Niew village group. They are both held in village health centres. Programme participants are allocated to the clinics based on the proximity of their homes.

Process

Identification

Intervention begins with the identification of people with mental illness. Those present at the field consultation meeting⁴ are encouraged to communicate the details of a forthcoming ORC to affected individuals known to them. District hospitals and village health centres send a number of participants to the programme; government-backed village organisations (Lao Front and women and youth unions) and individuals (village chief, community volunteers) may also identify community members with a mental illness.

Registration

Upon arrival at the ORC a participant is issued a queue number and seen on a first-come-first-served basis. A community-based worker⁵ will register the participant before they are physically examined by a nurse. Details such as weight and blood pressure are recorded. Consultation with the psychiatrist or BNL-trained doctor follows the examination.

Diagnosis

Diagnosis is carried out by the psychiatrist, GP or general medical doctor. Diagnosis is arrived at by compiling patient history, physical examination results and responses to questions within the consultation. The participant is initially seen individually before carers are invited into the consultation room. In this way a comprehensive understanding of the participant and his or her social circumstance is generated aiding diagnosis, appropriate treatment and support.

Prescriptions

The doctor or psychiatrist is responsible for prescribing medication. Drugs are issued by the nurse. Currently available medications include Valium, Phenobarbital, Lexomil, Artane, Tranxene, Largactil, Haldol and Tryptanol.

Documents and Records

Thorough documentation and record keeping are emphasised. CMH services utilise 4 principal documents: New Patient Code Book (CBWs or nurses record the name, age, sex, employment, address, date of registration and diagnosis of the participant, the name of the care provider and the patient identification code), Summary of Patient Record Book (nurses or medical students record the number of ORC participants), Medication Record Book (documenting medications issued per patient per ORC) and Clinical File (recording patient history, carer's consent to patient's involvement with services, treatment and progress updates). Clinical files are colour-coded according to diagnosis. Only ORC staff are aware of the code to avoid discrimination and ensure confidentiality. All documents are currently housed at the BNL office.

Treatment

Hospitals and health centres in the country manage revolving drug funds financed by the Ministry of Health. These funds enable the health care facility to independently manage the

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Hospitals and health centres in the country manage revolving drug funds financed by the Ministry of Health. These funds enable the health care facility to independently manage the amount, source, and time the procurement of essential medicines.

⁴ Field consultation meeting – All BasicNeeds programmes hold field consultations. They are community meetings usually held before the start of active programme implementation. These consultations are generally coordinated by a local community-based organisation, potential partner or ally, and initially animated by BasicNeeds' staff. At the consultations programme participants, their carers/other family members, CBO field staff discuss participants' needs, suggest solutions and the way forward.

⁵ Depending upon the specific circumstances of a programme some community members will be volunteers, others may receive expenses or paid wages. In different countries they are referred to differently – as community health workers, volunteers, members of the village health team, for example. To avoid confusion we have referred to them as community-based workers throughout.

amount, source, and time the procurement of essential medicines. Valium is the only drug for mental disorders provided by these funds. BN therefore funds medications issued at the ORC to treat a variety of disorders. Counselling of programme participants and carers is incorporated into the ORC consultation with the doctor or psychiatrist. A self-help group is being piloted by a BNL officer and a CBW. The group meets during the ORC to provide group counselling for affected individuals and their carers. Traditional healing methods are widely used within the community and integrating mental health services with traditional healers in the future could yield positive results.

Follow-up

The frequency of follow-up visits is determined by the severity of mental illness: severe illness may require home visits whilst programme participants with milder symptoms are invited to attend the clinic every month. Community volunteers are responsible for reminding registered programme participants of subsequent ORCs. Home visits are carried out by staff at the ORC accompanied by a district hospital or village health centre staff member and are intended to promote the correct use of medicines, monitor drug side-effects and identify social or physical obstacles hindering a participant's return to health. Emergency home visits may be requested from the district hospital (via telephone) by the patient or carer where there are difficulties in managing the illness. In theory, acute illness is referred to the MHU of the Mahosot Hospital. In practice, referral is reserved for exceptional cases due to the limited number of beds (15) and staff in this ward.

Training

One major area of focus for the BN Lao PDR CMH programme has been training general health workers to perform mental health services. This ongoing training has been conducted by one of only two psychiatrists in Lao PDR, who is also the BNL Programme Manager. Community-based workers have also been trained to conduct home visits and assist with follow-up services. BNL has completed a study to evaluate its training programme.

Resources

Government-sourced	BNL-sourced
<ul style="list-style-type: none"> • Consultation rooms • Table/chairs • Clinicians/nurses 	<ul style="list-style-type: none"> • Records/books • Medication • Transportation for staff • Payment for clinicians, nurses and community-based workers • Equipment for physical examination, for e.g. weight, blood pressure • Additional tables/chairs/provision of shade

User Perspectives

Feedback from the FGD was generally positive. Group members were emphatic about the provision of free medication.

"I am so glad there is now a project for the poor like us that we can rely on to give us new hope, and we do not have to spend money on treatment."

They emphasised that the opportunity to discuss their problems and receive support and advice was important to them. Group members also praised the location of the ORCs within their communities and the consequent reduction in transport costs and travel time.

"I am so glad there is now a project for the poor like us that we can rely on to give us new hope, and we do not have to spend money on treatment."

"I like the idea of an outreach clinic based in my community. It is not far. I can ride a bicycle or simply walk to the clinic."

They commended the role of the CBW and the concept of the home visit. They appreciated being reminded of ORC dates and group meetings and noted that the volunteers were concerned about their welfare.

Group members were concerned about the sustainability of the services. They also wanted access to more information on the referral system and specialised MH services. The discussion included requests for an emergency MH hotline and scanning equipment for ORCs indicating the ambitious attitudes of the service users.

Group members reported that drug side-effects like fatigue, skin rashes, vomiting, cramps and dizziness caused them to independently alter their doses or stop their medication entirely.

Examples of Effective Practice

1. Establishing local walk-in ORCs

Prior to the BN programme, mental health patients in Lao PDR were institutionalised at the MHU, Mahosot Hospital, and the Military Hospital, both located in the centre of Vientiane. Facilities were coordinated by two psychiatrists and there was a deficit of health care providers trained in MH. Psychotropic drugs were not available outside of these facilities and follow-up care was non-existent. The BN CMH programme addressed these issues by organising local walk-in ORCs where psychotropic drugs and medical expertise are available at no cost to the patient.

2. Training local medical staff and community-based workers

BNL is headed by one of Lao PDR's psychiatrists who is actively involved in training general medical doctors from partner hospitals. CBWs, a previously unrecognised MH staff resource in Lao PDR, have been recruited from the communities. Follow-up is proactive and programme participants are visited by the CBWs and ORC staff.

3. Engaging local stakeholders in CMHS

Central to CMH in Lao PDR is a network of stakeholders. BNL has established partnerships with government health services and governance structures within the Ministry of Health, specifically, MHU, Mahosot Hospital, and Vientiane Capital Health Department. Though the programme receives no funding from these partners it does utilise their resources, including room facilities, doctors and nurses. At the grassroots level BNL works with district authorities and health offices, village authorities and health centres. CBWs are critical to the provision of outreach clinics, follow-up and CMH awareness. CMHS provision relies absolutely on the commitment and coordination of all these stakeholders. For example, the ORC could not take place without the provision of premises by the Ministry of Health, the diagnostic and treatment skills of the psychiatrist and doctors, the organisation of registration by the CBWs and finally, the commitment of programme participants and carers to the BN programme and to their recovery.

Issues for Consideration

Lack of financial investment by the government

Lao PDR's Mental Health Policy drafted and prepared by the MHU of Mahosot Hospital in coordination with WHO, was endorsed by the Ministry of Health in 2007. This is a milestone for mental health provision in the country and it is hoped this will lead to financial commitments to implement CMHS. However, despite this dramatic improvement, service provision continues to lack government financial investment and is almost entirely dependent on the BN budget.

Central to CMH in Lao PDR is a network of stakeholders. CMHS provision relies absolutely on the commitment and coordination of all these stakeholders.

GHANA

Town criers may be recruited to spread the message and community-based workers are instructed to remind programme participants of the clinic details. CPNs organise talks in local hospitals, schools and communities.

BasicNeeds Ghana (BNG) was established in 2002. BNG, in partnership with the Department for Community Development and the Ghana Health Service, has implemented Mental Health and Development programmes in Greater Accra, Northern, Upper East, Upper and West Regions of the country. By the end of December 2008, there were 16,363 programme participants and 16,036 of them were under treatment.

Locality

The selected case study areas were the largely rural areas of Bolgatanga Municipal Area in the Upper East Region (population 228, 778), Kassena-Nankana District (population 149,491) and Okaikoi Sub-Metropolitan Area in the Greater Accra Region. The sources of medical treatment in these localities are termed community psychiatric units. In the Kassena-Nankana District, the CPU is located in the district hospital in Navrongo. ORCs are held at the CPU and at sub district health centres in order to provide a local service for remote communities.

Process

Identification

Community psychiatric nurses identify in-patients in psychiatric wards who may benefit from treatment within their community. General nurses, community-based workers, field staff of BNG's implementation partners, members of the Upper East Regional Alliance and community health workers have also been trained to recognise the symptoms of mental illness. Affected individuals may self-refer or be referred to the programme by a carer. ORCs are publicised at meetings of religious community groups (Christian and Islamic). Town criers may be recruited to spread the message and community-based workers are instructed to remind programme participants of the clinic details. CPNs organise talks in local hospitals, schools and communities to publicise the programme.

Registration

Upon arrival at the ORC, new programme participants are registered by the CPN. BN staff and auxiliary nurses may register patients during busy periods.

Diagnosis

In Bolgatanga and Okaikoi Districts, CPNs are responsible for diagnosis until the programme participant can be seen by a psychiatrist visiting the district. A programme participant is usually required to wait 2 months after identification to see a psychiatrist. Some districts do not currently have CPNs. In these areas BNG has trained general nurses and staff involved in health service delivery in basic psychiatry to enable them to assume the role of the CPN. Diagnosis involves gathering a history of the mental disorder and assessing responses to questions asked during the consultation.

Prescriptions

The CPN prescribes and issues the medication. However, many medications are not available at the CPN level of distribution due to Ghana Essential Medicines List policy restrictions dictating that certain medications are only available at higher levels of delivery. Additionally, medicines that are supposed to be available are often not available due to short supply from the government.

Documents and Records

Programme participant details, including name, age, sex, address and diagnosis are documented along with the names and the age of carers (where present) and a psychiatric report. Documentation is the responsibility of the staff member present (e.g. CPN, psychiatrist, CBW). Hard copies are held by the regional and district Health Directorate. Hard and soft copies are also stored by BNG. Detailed clinical files remain with the community psychiatric unit.

Treatment

Psychotropic and anti-convulsive drugs are distributed to the CPUs which, in turn, source the ORCs.

Anti-Depressants	Tranquilisers	Anti-Psychotic drugs	Anti-Convulsants	Anti-Reaction drugs
Imipramine Amitryptiline	Diazepam Lorazepam	Chlorpromazine Trifluoperazine Haloperidol	Carbamazepine Phenobarb Phenytoin	Cogentin Artane

In theory, the drugs listed above are available. However, shortages are a common occurrence. Carbamazepine, a first generation anti-convulsant and mood-stabilising drug included in the WHO list of essential medicines, has been out of stock in Accra and Northern Ghana for the last 2 years. Prescribed medicines are issued at no cost. New programme participants are issued 2 weeks of medicines and requested to attend the clinic after that time. Counselling is an integral part of the consultation delivered by the psychiatrist or CPN. Cases judged to be beyond the scope of CMH treatment facilities are referred to the national psychiatric hospital in Accra.

Follow-up

Review consultations are conducted by the CPN during an ORC to discuss progress. The CPN adjusts the drug dosage (alternative drugs may also be prescribed by the CPN) as necessary and may issue a further 30-day course of drugs (further review after a month). Programme participants are seen earlier than their review date where adverse reactions to the prescribed medicines occur. Counselling is incorporated into the review consultation by the CPN.

Patients referred to the Accra Psychiatric Hospital are also reviewed by the CPN to ensure their admittance and effective treatment. The CPN will visit the participant's home upon failure to report to the hospital.

Home visits are carried out to review adherence to medication and how participants and carers are coping with the treatment programme. Currently home visits by CPNs are rare due to inadequate transportation and a limited number of staff (see below); they are reserved for the most severe cases and non-attenders at the ORC. Consequently CBWs carry out the majority of home visits. They may or may not be accompanied by a CPN.

CPNs have been trained in diagnosis, prescribing and distributing but the current CPN workforce is small and many are of an age where they may soon retire from this work. The training and recruitment of younger mental health workers is a necessary next step to ensure the sustainability of these services.

Resources

Government-sourced	BNG-sourced
<ul style="list-style-type: none"> • CPNs • Psychiatrists • Office space for ORC • Vehicles • Medicine • Accommodation and food for psychiatrist on rural visit 	<ul style="list-style-type: none"> • Community-based workers • Wages and transport allowance for ORC staff • Telephones (to enable participants to contact staff) • Public education material: leaflets, health cards, television and video/DVD player, digital cameras

Home visits are carried out to review adherence to medication and how participants and carers are coping with the treatment programme.

User Perspectives

FGDs revealed that programme participants are happy with the treatment they receive at the ORCs and described how their conditions had improved.

“The medicine has changed my condition. I used to experience frequent seizures, but now it has reduced to about once in two months.”

They noted the efficacy of the medication over the treatment they had previously received from traditional healers and spiritual camps.

Group members expressed concerns about their medication, describing a lack of consensus between the visiting psychiatrists regarding treatment and the consequent amendments to medication. Members attributed relapses to such amendments and they noted that the frequent changes in visiting psychiatrists caused delays in the consultation process as the new specialists are required to familiarise themselves with the participant’s history. This is thought to contribute to the lengthy waiting time at the clinics; that caused anxieties to some participants.

“We are not usually comfortable with the long queues, coupled with the selection of who sees the psychiatrist first. Some of us were here since 2 am but it’s only now, 1:45 pm, that we have been able to see him.”

Group members travelling from their homes in Dedeiman in Accra and Nayagnia in Navrongo described how they currently have to travel more than 50 km and 15 km respectively to reach the polyclinic at Kaneshie and the psychiatric unit of the Navrongo Hospital in Navrongo. Participants and carers are forced to walk these distances: push-bikes are a relative luxury and public transport is too expensive. Carers, particularly of epileptic participants, reported that participants had difficulty travelling to clinics on their own and seizures are not uncommon during the journey.

Lack of drugs at the ORCs was a major theme. Group members explained that they are forced to resort to private pharmacies and pay above their means and it is frequently financially impossible to acquire the prescribed quantity of drugs.

Examples of Effective Practice

1. Stimulating partner organizations to action

Prior to BNG programmes, public MH services were provided in three severely under-resourced psychiatric hospitals located in the Accra region in the South of the country. BNG programmes have worked towards decentralising the system and facilitating CMHS in remote areas. This has been achieved by stimulating and encouraging partner organisations. Consequently clinics have been integrated into district hospitals, polyclinics and health centres, new roles have been forged for existing CPU staff and follow-up has been provided outside the clinic.

2. Facilitating communication between CMHS and general health services

BNG has engaged with the Department for Community Development and the Ghana Health Service. These partner organisations have brought staff and legal expertise to the project along with the capacity to effect, mobilise and coordinate mental health services in Ghana. The partnership with the GHS created a new role: the focal person. A volunteer or GHS staff member assumes responsibility for mental health work in their areas of operation, supervising the activities of CBWs working with people with mental illness. This role merges the home-visiting and mobilising duties of the CBW with new responsibilities such as reporting to BN and the GHS on the treatment of people with mental illness or epilepsy in their district. Reports are based on health records and case files recorded by the focal person.

3. Expanding CPN tasks

In the BNG programme the role of the CPN has also been extended. There are no psychiatrists in Northern Ghana and programme participants in these regions are visited quarterly by a psychiatrist from the South. Consequently CPNs assume tasks traditionally undertaken by the psychiatrist such as diagnosing and prescribing medication. Training a sufficient number of psychiatrists to service the entire country is not realistic at present. If it were, encouraging psychiatrists to practice in the remote rural northern regions would be difficult. Training CPNs is a realistic solution to the lack of psychiatrists. The lack of CPNs in the region has been remedied by training health workers to carry out their work. By developing the skills of existing staff, BNG has realised a way to overcome the apparent deficit of resources.

Issues for Consideration

1. Lack of drug availability at ORCs

The troubling gap between supply and demand for psychiatric medicines at ORCs interferes with effective CMHS delivery in Ghana. As ORC medicines are currently sourced by CPUs, the scarce availability of many of these medicines at the CPU level and above trickles down to the ORCs, where many participants must either turn to private pharmacies or go without needed medicines. If participants receive diagnoses and prescriptions at ORCs but are not able to access their prescribed medicines at this same level of service delivery, it poses a significant challenge to CMHS.

2. Distance to ORC

For some participants, even to travel the distance to the ORC is a major impediment. Public transportation is expensive for many. This leaves walking long distances as the only alternative for programme participants.

UGANDA

BN began implementing MHD in Uganda in 2004. CMHS have been facilitated in the districts of Sembabule, Masaka, Holma and Luliisa in partnership with primary health care staff. BN works alongside Kamwokya Christian Caring Community (KCCC) to provide CMH care in Kamwokya Parish in the Kampala District. At the end of December 2008, there were 1177 programme participants and 820 of them were under treatment.

Locality

The Ugandan case study focuses on the implementation of CMHS in the urban slum community of Kamwokya Parish, Kampala District, and in a rural community in the district of Sembabule.

In Kamwokya Parish, BN works closely with Kamwokya Christian Caring Community, a faith-based NGO, with a robust health programme. The CMH programme exists within the structure of the KCCC health programme. The weekly mental health clinic provides treatment at a primary level for the local urban community. Acute illness is referred to the National Mental Health Hospital in Butabika.

In Sembabule, medical treatment is provided at 4 different levels: 6 village health centres staffed by CBWs comprise level I. Level II includes 18 health centres at the parish level staffed by Health Assistants. Level III includes 6 health centres at the sub-district level which employ a Health Officer. Two level IV health centres at the district level employ a medical doctor. Above this level referrals are made to Masaka Regional Hospital. This study focuses on the CMH services at the Ntete Village Health Centre (level I). The facility holds a monthly mental health clinic.

Members noted that the frequent changes in visiting psychiatrists caused delays in the consultation process as the new specialists are required to familiarise themselves with the participant’s history.

BNG programmes have worked towards decentralising the system and facilitating CMHS in remote areas. Clinics have been integrated into district hospitals, polyclinics and health centres, new roles have been forged for existing CPU staff and follow-up has been provided outside the clinic.

For some participants, even to travel the distance to the ORC is a major impediment. Public transportation is expensive for many. This leaves walking long distances as the only alternative for programme participants.

BasicNeeds Uganda has forged partnerships with 37 healers and religious leaders.

Process

Identification

In Kamwokya Parish, participants with mental illness or epilepsy attending other KCCC clinics are referred to the mental health clinic by KCCC staff. The police in the area also refer affected individuals known to them.

In Sembabule, people are identified and referred to the mental health clinic by CBWs and village mobilisers (described below). Particularly in the rural communities, affected individuals may initially seek the help of traditional healers, faith healers and religious leaders. BasicNeeds Uganda (BNU) has forged partnerships with 37 healers and religious leaders. They have attended training in the identification of mental disorders and are encouraged to refer participants to the mental health clinic.

BNU relies on community members to raise awareness of the programme, including sub-county, parish and village leaders.

Registration

At the KCCC mental health clinic CBWs are responsible for registration. At the Ntete Health Centre mental health clinic the responsibility lies with the nurse due to a lack of reading and writing skills amongst the volunteers. During busy periods the nurse is also assisted by midwives working at the health centre. New participant registration is not restricted to clinic days.

Diagnosis

Clinical officers trained in psychiatry at level II and III health centres are responsible for diagnosing mental disorders.

Prescription

Nurses at level II and III health centres prescribe the appropriate medication. Medication may be prescribed for periods of 3 months in Kamwokya for children attending boarding school.

Documents and Records

Progressive documentation of a participant's history and progress with treatment is carried out by BNU and its partner organisations. At KCCC clinics a summary form is completed detailing a participant's name, age, address, their carer's details and basic information on their treatment and diagnosis. This information is compiled and entered into a register and is supplemented by a patient history form, usually completed by the carer upon registration of the participant. An individual patient file is maintained, documenting consultation details and treatment progression. This is completed by the programme participant with the support of their carer and a CBW. As described above, CBWs record details of follow-up visits.

Treatment

Psychotropic and anti-convulsive drugs are issued at a monthly cost of UGX 1500 (\$0.94) and 2000 (\$1.25) per participant in Kamwokya and at the Ntete Health Centre respectively. Free treatment and credit can be negotiated with health centre staff where necessary. Programme participants continue to seek alternative treatments to complement those provided within the BN programme. Traditional healers offer a counselling service; faith healers and religious leaders provide spiritual therapy.

Follow-up

Monthly reviews are organised at the clinic. Programme participants may visit the health centres outside of mental health clinic timings when there are difficulties associated with their treatment.

CBWs visit programme participants in their homes and may arrange meetings at self-help groups, churches, workplaces and schools where this is deemed appropriate. Kamwokya Parish is split into zones. CBWs are responsible for visiting participants living in their zones. A CBW is expected to visit 5 participants in a month. A health worker is responsible for overseeing participant follow-up in each zone and CBWs are expected to submit a report on each participant to the health worker on a monthly basis. The report is based on information compiled on a "face sheet." This document is updated at each visit and records a participant's health status, current treatment, livelihood activities, social participation and economic status.

It became apparent that follow-up visits were not taking place in the Sembabule District as the CBWs were not provided with an incentive. The responsibility was subsequently taken on by members of the user self-help group, Bulamu Kwejjanjaba Mental Health Association - BUKA. A village mobiliser was appointed from this group for each village to monitor and follow up participant absences from the ORC, counsel new participants and support carers.

"We feel this work is better done by us because it is we who are sick and should therefore support each other," Mary Nabyonga, Chairperson of BUKA.

"My work has been simplified a lot by the village mobilisers because in the past village health teams did not know about all the participants in their village since many of them were not users or carers. But village mobilisers from the user group know every participant in their village and will quickly report any case of relapse, fits and extreme side-effects to the health unit for action." Mr. Kakande Gerald, Health Assistant, Ntete Health Centre.

Village mobilisers are thus more familiar with participants in their community, have a vested interest in the BNU project, have experience of treatment and are aware of the benefits of the project to participants' lives. Village mobilisers are an example of the direct engagement of service users in the provision of CMH. BNU offers training for health centre staff as well as partner organizations on a periodic basis.

Resources

Government-sourced	BNU-sourced
<ul style="list-style-type: none"> Psychotropic and anti-convulsive drugs Ntete Health Centre staff Contribution of funds to livelihood activities 	<ul style="list-style-type: none"> Training health centre staff Training partner organisations

BNU's partner, KCCC, also sources psychotropic and anti-convulsive drugs, mobilises health centre staff, volunteers and ambulance services and engages in micro-credit initiatives.

User Perspectives

Users reported that increasing the awareness of mental disorders in their communities has reduced the stigma they experience.

There is an overwhelming sense of responsibility amongst users for the delivery of CMH services as observed by a Health Management Committee responsible for the management of Ntete Health Centre and follow-up duties.

Users described the difficulties of affording treatment within the programme. They are able to contribute to their medicines during the harvest season but they cannot sustain this through the drought season when they have very little to fall back on. Users reported that in some cases participants have left the programme and sought treatment from traditional healers.

Follow-up visits were not taking place in the Sembabule District as the CBWs were not provided with an incentive. The responsibility was subsequently taken on by members of the user self-help group.

Users are able to contribute to their medicines during the harvest season but they cannot sustain this through the drought season when they have very little to fall back on.

BNU relies on community members to raise awareness of the programme, including sub-county, parish and village leaders.

Psychotropic and anti-convulsive drugs are issued at a monthly cost of UGX 1500 (\$0.94) and 2000 (\$1.25) per participant in Kamwokya and at the Ntete Health Centre respectively. Free treatment and credit can be negotiated with health centre staff where necessary.

Examples of Effective Practice

1. Establishing user-led action groups

BNU programmes have achieved this success by encouraging a dynamic user-led initiative and engaging a variety of partners at all levels of CMH intervention. In this way people with mental illness or epilepsy are actively taking responsibility for their treatment by reminding carers about clinic days, reporting side-effects, completing monitoring sheets and complying with treatment. Carers are providing support, food, shelter, assistance and, at Ntete, they replace CBWs in the follow-up of participants and the management of the health centres.

The BNU programme highlights the resourcefulness of service users and their commitment here negates the requirement for CBWs as volunteers. They are ideally suited to take over participant follow-up and clinic organisation due to their familiarity with mental disorders and the programme participants as well as their sense of purpose in sustaining CMHS.

2. Mobilizing community groups to support CMHS

Community groups such as the police, traditional healers and religious leaders support the programme by raising its profile and identifying new participants. Boda-Boda cyclists, a scooter taxi organisation, transport participants to and from clinics. Stigma prevents people with mental illness or epilepsy from using public transport, thus the cyclists are key stakeholders. Health workers provide a large part of the medical care and in turn liaise with district offices in order to procure drugs and effect service development. The vast number of groups involved share the responsibility for CMHS delivery, which is essential for programme sustainability.

3. Expanding the role of general health workers

Interestingly, there are no psychiatrists in the Sembabule District which has, instead, developed by enhancing the skills of existing general health workers. This suggests that general health workers may be well positioned to help compensate for a lack of trained psychiatrists in Uganda.

Issues for Consideration

Shortage of psychiatric medicines

Despite the commitment described above, governmental support is not fully dependable. In theory they have agreed to support CMHS by supplying psychotropic and anti-convulsive medicines. In reality these medicines are out of stock and supplies are infrequent. As a result, participants must contribute to their treatment and this is often beyond their means. The numerous groups described above must be supported in lobbying for government commitment to CMH intervention in order to secure service sustainability.

TANZANIA

BasicNeeds Tanzania (BNT) operates in the southern region of Mtwara as well as parts of Dar-es-Salaam. The programme began in 2003. At the end of December 2008 there were 4290 programme participants and of these 4047 were under treatment.

Locality

This case study describes CMH practice in the Mtwara region. The CMH unit is comprised of 2 types of clinics: outpatient and outreach. Outpatient clinics take place in hospitals, health centres and dispensaries on a monthly basis. OPCs are not exclusively for mental disorders. From these clinics people with mental illness or epilepsy may be referred to the Ligula Psychiatric Unit. Monthly outreach clinics operate in remote areas where travel to outpatient clinics is not logistically or financially feasible for participants. They

are held in locations affording confidential consultations and distribution of medicines, for e.g. schools and ward offices. Staff are transported from the site of OPCs to the ORCs where they are supported by CBWs. BN Tanzania works closely with the following partner organizations: Ministry of Health, Mtwara Small Scale Development Association, Mtwara Women Entrepreneurs, Masasi Women's Development Association, Tandahimba Farmers' Associations and the Newala Farmers' Associations.

Process

Identification

Traditional healers have an important role in the identification of programme participants. As a result of cultural beliefs and inadequate local mental health provisions, healers are the first point of contact for many participants. BNT has trained healers to recognise and refer mental illness to the programme. CBWs have also been trained in the identification of new participants.

Registration

New participants attending an OPC are registered by a nurse or clinical officer trained in mental illness. At the ORC CBWs conduct registration.

Diagnosis

Clinical officers are responsible for diagnosis at the OPCs. At hospital-based OPCs participants are then referred to the psychiatrist at the psychiatric unit for further diagnosis. In health centres and dispensaries diagnosis is conducted by trained generalist clinical officers and nurses. Clinical officers are responsible for diagnosis at the ORCs.

Prescription

Prescriptions are issued by the clinical officer/nurse/psychiatrist who diagnosed the participant at the OPC/ORC. Medicines are prescribed for a month.

Documents and Records

Each participant has a Clinical File which is updated after every consultation and stored at health centres. CBWs update Individual Patient Files with feedback from home visits. These documents are stored at the home of the volunteer. Clinical and individual files are compiled quarterly by a Mental Health Coordinator and the report submitted to BNT.

Treatment

Medication is issued at the clinic. Shortages of psychotropic and anti-convulsive drugs are a common occurrence at both OPCs and ORCs and prescribed medicines are commonly substituted with an equivalent (e.g. thioridazine for haloperidol, chlorpromazine for fluphenazine injection). Clinical officers are not adequately trained to prescribe these equivalents and hence treatment is often compromised. Counselling services do not form part of the CMHS in the Mtwara region.

Follow-up

All programme participants are encouraged to attend monthly review consultations at the OPC/ORC where they first received treatment. Follow-up consultations at the ORC are conducted and documented by CBWs and by nurses or clinical officers at the OPC. Alterations to medication are made by clinical officers at both clinics. A retired psychiatrist also conducts reviews of participants and staff performance every 3 months.

Home visits are undertaken by CBWs living in the participant's ward. These visits enable CBWs to ensure that medication is being administered correctly and provide support and advice for

Each participant has a Clinical File which is updated after every consultation and stored at health centres. CBWs update Individual Patient Files with feedback from home visits.

Boda-Boda cyclists, a scooter taxi organisation, transport participants to and from clinics.

Outpatient clinics take place in hospitals, health centres and dispensaries on a monthly basis. Monthly outreach clinics operate in remote areas where travel to outpatient clinics is not logistically or financially feasible for participants.

the participant and their family. Push-bikes are used to reach participants and their availability determines the number of participants seen, though attempts are made to visit a participant 3 times a month.

Training

Mental Health Coordinators receive mental health training and are then able to train general health staff and CBWs. Unfortunately, doctors and nurses are rotated around frequently and there is high staff turnover in these areas. The Mental Health Coordinator remains a constant presence and is able to train new staff to administer mental health services.

Resources

Government-sourced	BNT-sourced
<ul style="list-style-type: none"> • General health workers • Mental Health Coordinators • Office space for ORCs 	<ul style="list-style-type: none"> • Travel costs for health workers • Transport for health workers • Transport for home visits • Psychotropic/anti-convulsive drugs. • Transport for staff • Wages for BN staff • Furniture • Stationery

User Perspectives

Focus group discussions revealed users' concerns about the availability of drugs at the clinics.

"The outpatient clinic is a very good approach because it is a way of integrating mental health services into primary health services. However, the shortage of drugs is a snag to the whole process. Therefore, in order to succeed, drugs should be given the first priority. The integration should incorporate the issue of drugs distribution at the primary health care level."

Users reported that shortages of drugs resulted in the substitution of their usual medicine with an alternative.

"Alternative drugs are not effective... He gives me other types of drugs which are not effective. Last month I felt dizzy and fell down. I explained my problem at the outpatient clinic but the doctor said that the drugs that he gave me previously are not available in the dispensary."

FGDs also revealed the discomfort experienced by people with mental illness or epilepsy attending an OPC. This was stated by a psychiatric nurse working at the clinic:

"The outpatient clinic is a challenge for people with mental illness since they have to join a queue with other participants. Some of them refuse to do so and go away without the drugs."

Examples of Effective Practice

1. Forging local partnerships with traditional healers and birth attendants

Since its inception in 2003, more than ten thousand people with mental illness or epilepsy have been involved with the BN programme in Tanzania. This has been achieved through the provision of CMHS in remote areas, the formation of local and governmental partnerships and staff training. BNT has recognised traditional healers and birth attendants as vital partners in

the provision of CMHS and the additional culturally sensitive dimension they bring to the programme. They are key community members: they are trusted, respected and familiar to the communities in which they work. Working with them to tailor their practices to support CMH has brought new participants into the programme. These partners may also provide a counselling service in the future.

2. Training consistent MH staff

Government-staffed Mental Health Coordinators received training in mental health and are now able to train general health staff, volunteers and other BN partners. Doctors, nurses and clinical health staff are rotated around the country on a variety of placements. This posed a problem to the programme as trained health staff were transferred from the area and were replaced with untrained colleagues. This was overcome by training Mental Health Coordinators, who have a permanent post in the area, to train the new health staff.

3. Providing consultation and medicines through ORCs

The programme has actively brought people into the programme by holding ORCs. BNT recognises that the sustainability of this type of clinic is limited since it is not integrated into existing government structures and it is expensive to run. However, it does provide remote communities with a very convenient source of drugs. The improvements seen in the people that access these drugs at ORCs provide them with the motivation to travel further to reach the OPC. ORCs are thus a successful temporary CMH intervention.

Issues for Consideration

1. Limitations of the primary care setting for CMHS

This case study identifies the need to refine the objective of total integration of CMHS into primary care. FGDs revealed the discomfort people with mental illness or epilepsy experience during OPC clinics which treat all medical illnesses. Existing WHO and governmental policy also prohibits administration of some psychotropic and anti-convulsive drugs in a primary care setting. Generalist health workers have been trained to administer these drugs but according to current policy they are unable to do so. The sustainability of the OPC vis-a-vis the ORC is recognised and attributed to the integration of the OPC into primary care. Clearly there are benefits and limitations of integrating services that must be accounted for in the design of CMHS.

2. Inadequate treatment resources

The programme in Tanzania suffers from severe shortages of drugs at the OPCs and ORCs. Equivalent drugs are available at the clinics but they are not being used effectively. Training health staff to accurately prescribe these drugs and thus utilise an existing resource would improve the situation. The programme recognises that the provision of counselling would complement the medical treatment participants receive and aims to establish this service in the future.

KENYA

In 2004, BasicNeeds Kenya (BNKE) piloted a MHD programme in the Kangemi District in Nairobi West District. The Kenya Association for the Welfare of People with Epilepsy (KAWWE) and the Schizophrenia Foundation of Kenya (SFK) were BNKE's primary partner organizations. At the end of December there were 3458 (which includes the newer rural programme) programme participants and of these 2806 were under treatment.

BNT has recognised traditional healers and birth attendants as vital partners in the provision of CMHS and the additional culturally sensitive dimension they bring to the programme.

Existing WHO and governmental policy also prohibits administration of some psychotropic and anti-convulsive drugs in a primary care setting.

Locality

This case study describes the existing CMH unit in the Kangemi District. Composed of 12 villages, the population of the district is estimated at 75,000 (GOK, Ministry of Planning, Population and Housing Census, 1999). Fifteen percent of the participants involved in the programme travel from neighbouring districts (Kawangware, Waithaka, Kikuyu, Kiambu and Limuru, Naivasha and Nyahururu). The mental health clinic provides the medical aspect of CMH care in the Kangemi region. Clinics take place at 4 locations: the Kangemi Health Centre, the Lower Kabete Dispensary, Lusigetti and Jamhuri Park. This case study will focus on the clinics held at the Kangemi Health Centre and the Lower Kabete Dispensary. Opened in May 2006, the clinic at the Kangemi Health Centre is situated in a 40-foot shipping container within the centre grounds. Clinics are held every Wednesday from 8.30 am to 4 pm. In June 2007, monthly clinics began at the Lower Kabete Dispensary. Clinics run from 9 am to 5 pm. Both clinic locations are managed by the Nairobi City Council (NCC). Self-help groups are established in the villages and social workers from SFK see programme participants from all the villages.

Process

Identification

Effective community sensitisation events have raised awareness of mental disorders and the BN programme. People with mental illness or epilepsy are thus advised to attend the clinics by family and friends. BNKE facilitated the training of CBWs to enable them to identify the symptoms of mental disorders and refer individuals to the programme.

Registration

Registration is conducted by 2 CBWs at the Kangemi Health Centre and 3 CBWs at the Lower Kabete Dispensary.

Diagnosis

The psychiatric nurse sourced from Mathari Hospital is responsible for diagnosis at both clinics. At the dispensary the nurse is assisted by a retired psychiatric nurse.

Prescription

The psychiatric nurses are also responsible for prescribing medications.

Documents and Records

A Clinical Form was designed to record clinical detail from mental health clinic consultations and is completed by the nurse and/or volunteer. Forms are compiled to create a participant's clinical file (described in previous case studies). A registration book is maintained by CBWs at the mental health clinic and stored at the site. Information regarding the participant's socio-economic information is entered on a database.

Treatment

Medication is issued at the mental health clinic. Programme participants also receive psychosocial support from qualified social workers through SFK-organised services.

Follow-up

People with mental illness or epilepsy may receive treatment at general clinics other than the mental health clinic at the Kangemi Health Centre. Individuals attending the general clinics at the dispensary are referred to the health centre. Home visits are conducted by SFK social workers and community volunteers.

The clinic at the Kangemi Health Centre is situated in a 40-foot shipping container within the centre grounds. Clinics are held every Wednesday from 8.30 am to 4 pm.

Support groups are organised in the villages by KAWE. These groups focus on sustainable livelihood activities, advocacy and user-led lobbying on issues such as drug procurement.

Resources

Government-sourced	BNKE-sourced
<ul style="list-style-type: none">• Psychotropic and anti-convulsive drugs• 2 psychiatric nurses (Mathari Hospital)• General nurse (Kangemi Clinic)• Office space	<ul style="list-style-type: none">• Emergency supplies of psychotropic and anti-convulsive drugs• Stationery: files, folders, books, writing paper, pens and pencils.• Internet connection• Training workshops in MH for CBWs and primary health care staff• Data entry course for one CBW

NCC, a BNKE partner organization, provides clinic room facilities. Another partner, SFK, provides 3 social workers.

Examples of Effective Practice

1. Engaging partners at different levels to cooperate with CMHS

The Ministry of Health, Division of Mental Health, in liaison with the Nairobi City Council (NCC), Kangemi Health Centre and Mathari Hospital (Kenya's only mental health hospital) provide the premises, nursing staff and drugs. BNKE sourced staff from BasicNeeds' Uganda programme to train general nursing staff and community volunteers. The network of BN partners designed their roles and agreed on their parameters of functioning, signing Memorandums of Understanding to demonstrate their commitment to the project. The African Mental Health Foundation (AMHF) partners BNKE in research, documentation and policy lobbying. The Kenya Association for the Welfare of People with Epilepsy organises local, village-based support groups. The Schizophrenia Foundation of Kenya provides psychosocial support for participants and carers. Therefore community-based district and governmental organisations cooperate to deliver CMHS in this programme.

2. Supporting diverse perspectives on MH treatment

BNKE recognises the benefits of working with traditional healers to incorporate a culturally relevant dimension into the programme; however, some partner organisations fail to recognise the value of traditional practice and favour a strictly western CMH model. Similarly, opinions differed on approaches to research: AMHF favours a quantitative approach; BN research incorporates a combination of qualitative participatory approaches.

Issues for Consideration

Inadequate drug supply

CMHS in this case study are severely threatened by a lack of drugs. The clinics may run but they serve no purpose if they cannot supply affected individuals with the required medicines. The inadequate supplies are a result of the push system, meaning the drug supplies issued by the government are not sensitive to demand. Presently the BNKE budget funds the additional drugs required to run the programme. This is not a sustainable measure and the government must commit to the provision of a reliable drug distribution system that is informed by need. USP-K, a user-led advocacy group, has been developed by the programme. This group is committed to lobbying for such changes.

Support groups are organised in the villages. These groups focus on sustainable livelihood activities, advocacy and user-led lobbying on issues such as drug procurement.

The Ministry of Health, Division of Mental Health, in liaison with the Nairobi City Council (NCC), Kangemi Health Centre and Mathari Hospital (Kenya's only mental health hospital) provide the premises, nursing staff and drugs.

In a move away from integration into primary health care, BNKE recommends that mental health clinics be managed and run as satellite hospital facilities. In this way they would benefit from mental health clinicians and a more adequate supply of drugs.

SRI LANKA

The first BasicNeeds programme in Sri Lanka began in 2003 in the Southern Province. At the end of December 2008, there were 1239 programme participants and 1039 of them were under treatment.

Locality

This case study focuses on CMHP in the Southern Province. The province is divided into 3 districts, Hambantota, Matara and Galle, and subdivided into 46 secretarial divisions. The BN programmes operate in 22 of these divisions and work with 5112 affected individuals of the estimated 12751 people with mental illness or epilepsy in the province. Medical treatment is sourced from mental health camps which are held in schools, temples and hospitals. Self-help groups exist in the villages, served by the mental health camp. Where a programme participant is unable to attend the camp a psychiatrist or medical officer of mental health arranges a home visit.

Process

Identification

Trained CBWs identify people with mental illness or epilepsy known to them in their community and encourage them to engage with the programme.

Registration

CBWs are responsible for the registration and organisation of participants at the mental health camp.

Diagnosis

Diagnosis is undertaken by a psychiatrist or a Medical Officer for Mental Health (MOMH). This post was designed in response to the lack of psychiatrists in the country. The government trains the Medical Officers for Mental Health. They are qualified to diagnose and prescribe medicines for mental illness. Prescriptions are issued by the psychiatrist or MOMH.

Documents and Records

A clinical individual file documents registration details, patient history and review consultations and is completed by CBWs. Clinicians complete the diagnosis and treatment sections of the file. Collated information from these files is used to review the success of mental health camps. Follow-up forms, completed by the community volunteers during the follow-up visit, record participants' experiences relating to medication and their illness as well as their mood and participation in everyday activities. These forms are used at SHG meetings to formulate coping strategies and solutions that may arise during the deliberations.

Treatment

Psychotropic and anti-convulsive drugs are available at the mental health camp, 80% of which are funded by BN. Local Buddhist priests provide a spiritual aspect to treatment through tailored meditation sessions and individual and group sessions.

Self-help groups provide a counselling aspect to treatment and are led by CBWs. Groups consist of participants, carers and CBWs, between 6 to 10 people per meeting. Group members take turns hosting the SHG in their homes. Activities vary from group to group:

the meetings provide an opportunity to share experiences and the problems encountered. This is not all. Gardening and group farming may also be incorporated by some SHGs as therapeutic activities.

Follow-up

Follow-up visits to a participant's home are conducted by CBWs and take place, ideally, on a monthly basis. However, the actual frequency of the visits is influenced by the number of CBWs available and the location of the participant's home. CBWs record details of the follow-up consultations in individual files.

Resources

Government-sourced	BasicNeeds Sri Lanka (BNSL)-sourced
<ul style="list-style-type: none"> • Psychiatrist • Premises for hospital-based mental health camp • 20% psychotropic and anti-convulsive drugs 	<ul style="list-style-type: none"> • Trained community-based workers • Experts to lead staff training • 80 % psychotropic and anti-convulsive drugs • Vehicles for transport of CMH staff • Drinks and refreshments for CMH clinics and events (occasionally funded by local banks and social welfare services) • Stationery: flip charts, marker pens and other writing material • A computer network for information storage

User Perspectives

Users voiced their appreciation of the CBWs and described the support and encouragement they received during follow-up visits. CBWs have helped them manage the side-effects of their medication. They have also encouraged affected individuals, previously dependent on traditional healers, to access pharmacological treatment. The process of accessing treatment is thus facilitated by the trust and respect the villagers have for the CBWs.

The opportunity to discuss their condition and the hardships they face is of great significance to users. They described the participatory and encouraging attitudes of the psychiatrists and MOMHs. Users also reported that they feel more confident as they are able to contact and share experiences with other users through the BN programme.

Examples of Effective Practice

1. Shifting attitudes about CMHS through proper training

Prior to the BN programme mental health services in Sri Lanka were centralised and provided by a handful of institutions. Services in the Galle District were limited to the Karapitiya Teaching Hospital and the Unawatuana Hospital. In the rural district of Hambantota, mental health clinics were conducted at the Tangalle Hospital. However, they did not run on a regular basis due to a lack of qualified staff. In Matara, also a rural district, mental health clinics were infrequently held at the Matara General Hospital. The BN programme has successfully facilitated CMHS in the province to treat mental disorders and support affected individuals and their families. These services are delivered by dynamic staff members whose skills have been developed through BN-funded training.

The training of psychiatrists and MOMHs has focused on shifting their attitudes, to get them to understand the need to travel into the communities to treat participants and to provide holistic care for the individual and the family. In turn, psychiatrists and MOMHs have trained other staff members. Health administrators have a key role in drug procurement and health care developments. BN has organised field visits and policy workshops to foster their

Psychotropic and anti-convulsive drugs are available at the mental health camp, 80% of which are funded by BN. Local Buddhist priests provide a spiritual aspect to treatment through tailored meditation sessions and individual and group sessions. Self-help groups provide a counselling aspect to treatment.

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The training of psychiatrists and MOMHs has focused on shifting their attitudes, to get them to understand the need to travel into the communities to treat participants.

understanding of the developmental aspects of CMH and the current burden of mental illness in the province. Health administrators have consequently prioritised mental health services and allocated more staff, vehicles and drugs to the programme. Primary health care staff have been involved with the programme, they have been trained to identify and refer people with mental illness or epilepsy and support CBWs in organising mental health camps and SHGs.

2. Utilizing CBWs

The vital role of the CBW is also highlighted by this case study. Their roles are many: identifying, registering, mobilising, documenting, generating community awareness and conducting follow-up visits. Their larger role is attributed to the support participants receive from the follow-up visits they make. Their visits encourage participants to continue their medication and manage their side-effects.

3. Encouraging the active participation of users

The programme encourages participants to take responsibility for their treatment. BN family education programmes, SHGs and mental health camp staff have enabled them to manage their medications. It motivates them to take part in livelihood activities and in raising the community's awareness of mental health. Participants and carers have a major role in the design of CMHS. They attend frequent meetings with BN staff and partners to review the success of the various services implemented. The sustainability of CMHS will require the involvement and commitment demonstrated by programme participants.

Issues for Consideration

Sustainability of services

BNSL has worked closely with two partner organisations: Navajeevana and GIDES. GIDES is a micro-credit enterprise based in Hambantota. Navajeevana is a community-based rehabilitation organisation for people with disabilities. They joined the BN programme, providing staff and resources, and referring participants with mental illness, already known to them, to the mental health camps. They were involved at all levels of CMHS organisation and gradually assumed the major share of responsibility for CMHS in the Southern Province. Creative Action, an organisation founded by a group of ex-BN staff, has taken over the organisation of CMH in the Galle District.

Currently BN funds 80% of the drugs required; securing alternative funds poses a major challenge to the continuation of these services. Village-based mental health camps are not envisaged as a sustainable service but as a means to initially enable people to access treatment. Programme participants attending the camps are advised to continue their treatment at hospital-based mental health clinics. Partner organisations must thus develop an alternative CMH programme that does not rely on remote camps but continues to provide accessible treatment for people in these communities.

INDIA

This case study describes CMH practice in Thiruvananthapuram, Kerala. The District Mental Health Programme, as part of the India National Mental Health Programme, integrates mental health into primary care in each district in India. CMHS are found in primary care centres, community health centres, and taluk hospitals. This district currently has mental health clinics in 22 different locations: 11 primary care centres, 8 community health centres, and 3 taluk hospitals⁶. Two taluk hospitals are staffed by psychiatrists. The District Mental Health Team, comprised of a psychiatrist, clinical psychologist, psychiatric social worker, and staff nurse, makes monthly visits to all other clinics.

⁶ Referral centre with both in-patient and outpatient care.

Process

Identification

Patients are identified by various members of the community trained to recognize mental illness. This includes school teachers, police personnel and community-based workers. Patients are also referred by primary care centre staff, mental hospital staff, and District Mental Health Team members.

Diagnosis

A medical officer sees new referrals at primary or community health centres. Medical officers trained by the District Mental Health Programme can make a diagnosis and subsequently prescribe treatment. Medical officers who have not been trained tell the participant to return on a mental health clinic day when the District Mental Health Team is present. On mental health clinic days, a psychiatrist sees the programme participant and caregivers. The psychiatrist records a diagnosis in the patient book.

Prescriptions

Only trained medical officers prescribe psychotropic medicines. Untrained medical officers will only select medications already prescribed by the team psychiatrist.

On mental health clinic days, the District Mental Health Team brings medications to the facility. They are kept there for the use of participants, until the next mental health clinic. The psychiatrist records the prescription in the patient book. The team nurse then dispenses the medications as indicated.

Documents and records

Participants keep patient books and bring these books on subsequent visits. The patient books contain medical information as well as other relevant records. The psychiatrist also keeps additional records of each patient. The team nurse keeps a register of clinic attendance and dispensed medications. This record is housed at the primary or community health centre. The nurse also maintains an inventory of medicines at each facility.

Treatment

The mental health clinics offer diagnosis, medication and treatment planning to new programme participants. On the first visit, participants also receive psychoeducation on the nature of their mental disorder, how it can be prevented, treated, monitored and managed. Some participants are referred for counselling in the form of group therapy sessions with a social worker. The social worker refers participants to other government services as necessary. The clinical psychologist and psychiatrist also conduct some individual counselling. Self-help groups were also organized.

Follow-Up

Trained medical officers follow up with participants in between mental health clinics as necessary. In some cases, the social worker also makes follow-up home visits to promote continuing adherence to treatment.

Training

In this district, several training programmes have been instituted. A team of mental health centre doctors trained medical officers, nurses, health workers and community-based workers. Medical officers were given 12 days of intensive training in identification, diagnosis and treatment of mental disorders. Nurses and health workers underwent 6 days of training in a variety of mental health-related topics, which included rehabilitation, counselling and

Trained medical officers follow up with participants in between mental health clinics as necessary. In some cases, the social worker also makes follow-up home visits to promote continuing adherence to treatment.

psychiatric nursing. Ongoing training for new health workers has been difficult due to funding difficulties. Community-based workers were trained for 5 days in the identification of mental disorders and counselling.

Examples of Effective Practice

Intensive Primary Health Care Training

Many primary and community health centre staff have received intensive training in mental health, allowing a more complete integration of mental health and primary care. Because of this, medical officers can actually diagnose and prescribe medications on days when mental health clinics are not available. This training also gives PHC staff the resources needed to periodically follow up with participants, when the District Mental Health Team has been unable to do so. This training programme has been very successful in improving access to mental health care through primary and community health centres.

Consistent Record Keeping

Medical files are kept both with the programme participants and at the primary health centre. This process facilitates informed follow-up visits for each participant. Furthermore, the detailed documentation of medications allows PHC staff to put in requests from the District Mental Health Team. Consistent record keeping of referrals, diagnoses and prescribed treatment promotes the cohesive functioning of CMHS.

District Mental Health Team

The District Mental Health Team has been another crucial component in the success of the District Mental Health Programme. Cycling through primary and community health centres on a monthly basis, the team provided necessary training and referral and support services. In situations where the training of medical officers was either limited or inadequate, the District Mental Health Team successfully filled in the treatment gap.

Issues for Consideration

Lack of Ongoing Primary Health Worker Training

One issue that arises from this mental health initiative has been inadequate funding for ongoing primary health worker training. Because state health workers are reassigned to different districts on a periodic basis, there is a need for ongoing mental health training. This requires additional funding. Recently, government funding was temporarily secured for this purpose. Continued government support for mental health training is necessary to maintain the success of this and other similar programmes

Methodology

This collection of case studies presents a holistic view of the practice of Community Mental Health. Case studies from Lao PDR, Tanzania, Sri Lanka, Uganda, Ghana, and Kenya look at CMH as implemented within the context of the BasicNeeds Model for Mental Health and Development. The case study summary from India looks at a government District Mental Health Programme operating independent of BasicNeeds' programmes.

A case study methodology was selected as the method to study Community Mental Health programmes. Case studies have been highlighted in recent literature as a rigorous method of in-depth exploration of mental health programmes (Neale et al., 2006; Badger et al., 2003; Yin, 2003; Cohen et al., 2002; Stake, 1995). These case studies present detailed information collected through multiple methods (including interviews, group discussions, document reviews and observations) to capture key dynamics in Community Mental Health Practice. The study is exploratory in nature and focuses on delivery rather than the impact of CMH care.

The site for the first six studies defines the geographical area in which BN and its partner organisations are working to implement the Model for Mental Health and Development. The process of CMH, forming part of this model, is delivered through services located in these regions. The sites represent urban, sub-urban, and rural areas.

The Kerala, India, study of a District Mental Health Programme also employed a case study methodology. BasicNeeds staff carried out this 2008 case study using key informant interviews with programme pioneers and existing health centre officials, secondary document reviews and site observations to collect data. Therefore, the Kerala study methodology is very similar to the approach employed by the other six case studies found in this monograph. However, the data collection and analysis description below apply to the case studies commissioned specifically for this monograph (Tanzania, Ghana, Uganda, Kenya, Sri Lanka and Lao PDR).

Data Collection

Primary Data

The six original case studies were developed in line with a common terms of reference designed by the Principal Investigator to capture key information (e.g. locations, services offered, people involved). (See Appendix 1). Primary data was sourced from focus group discussions, observational sessions and interviews with key informants conducted during the months of May and June 2008.

Data was collected by the Research Officer for each case study site with the assistance of one or two research volunteers trained by the Research Officer. These people are directly involved in the delivery of CMH in the areas on which they report. They have regular contact with programme participants and service providers and, in their various roles, have personal experience with how CMH works at the grassroots level.

Focus Group Discussions

Altogether, 19 focus group discussions were held. Programmes in Sri Lanka, Kenya, Lao PDR and Uganda each held 2 discussions; 4 and 3 discussions took place in Tanzania and Ghana respectively. Focus groups comprised between 11 and 28 BN participants. Discussions were led by Research Officers and conducted in the respective local language. A question guide was used in the discussions to customize structures within a country. Each country developed

The District Mental Health Team has been another crucial component in the success of the District Mental Health Programme. Cycling through primary and community health centres on a monthly basis, the team provided necessary training and referral and support services.

individualized question guides with similar themes (See Appendix 2 for an example guide). A convenience sample of CMH programme participants was recruited to participate in focus group discussions. In most cases, discussions took place after an outreach clinic in order to avoid additional travel for participants. No one declined participation in the study.

Interviews

Each research team conducted interviews with key informants. Interviewees were selected based upon individuals who held key positions in the coordination and implementation of CMHS at the case study site. A total of 22 interviews were conducted across the 6 countries. Interviews were conducted in person by the Research Officer and were structured according to a question guide. As with the focus group discussions, the interview question guides were not standardised across projects but were tailored to the local situation.

Focused Observational Sessions

Though the role of BN Research Officers frequently requires them to assist at mental health clinics, officers visited the clinics specifically to gather data for this study. This enabled them to observe the process of CMH in detail and enhanced their understanding of the attitudes and opinions of programme participants expressed during interviews and focus group discussions. Each Research Officer attended, on average, 2 outreach clinics for this purpose.

Secondary Data

Each country conducted its own document review. Common documents included BN project review meetings, outreach clinic reviews and patient consultations. Life stories of BN participants gathered prior to this study were used, as well as the bi-annual project reports and statistical tracking sheets⁷.

Analysis

Data from each programme was submitted in the form of a report identifying the key findings of each research team. Qualitative data was first translated and then coded, based on categories established in the TOR, using a priori coding techniques. Initial coding was conducted by Research Officers from each case study site according to common themes directed by the TOR.

Each programme submitted a descriptive case study to the central BN research office. The case studies represent examples of how CMH is being implemented in a selection of LMICs. A Research Assistant consolidated the case studies for analysis. The Principal Investigator and a Research Coordinator further analysed the six case studies as well as the India case study to generate a cross-case analysis on the practice of CMH in these seven areas.

Ethical Considerations

Participants were informed about the purpose of the meeting and provided informed consent before inclusion in the discussions.

Limitations

The context of these case studies is both financially and geographically challenging. This imposed some unique constraints on the methodology. Six research teams worked independently of each other. The terms of reference were interpreted and applied in a manner appropriate to each individual case study site. As a result, the consistency of data collection and cross-study analysis may be reduced. Additionally, the India case study, commissioned by WHO for another report, was also included in the overall analysis for this monograph.

⁷ Statistical Tracking Sheets are BN records with statistical information on each country programme regarding diagnosis, treatment and the health status of all entrants.

The case studies may be prone to some researcher bias as one BN Research Officer from each country collected and analyzed the data. While their active involvement in CMH programme activities in each region provided the researchers with a unique in-depth perspective on the topic, this perspective may have also influenced the independence of their analysis.

The study sites are not homogenous; the programmes described are at different stages of implementation. For example, the programme in Ghana is six years old and the programme in Lao PDR began two months before data for this study was collected. The stage of implementation affects the extent to which partner organisations are involved in the programme. The challenges facing each programme are similarly dependent on the stage of the programme; however, defining aspects of the CMH development process may be generalized across case study sites.

FGDs and interviews incurred limitations. Due to the nature of the population we were sampling, it was impossible to achieve a random sample for the FGDs; the majority of participants were selected based on their attendance at the clinic on the day of the FGD. Additionally FGDs are prone to group consensus and individual opinions are difficult to identify. Furthermore, the size of the focus group varied between countries. Qualitative responses in six different languages were translated as accurately as possible; however, back-translation was absent from this study, representing a further limitation.

Conclusion

As CMHP continues to develop and multiply in LMICs, more people with mental illness or epilepsy will have the opportunity to receive much-needed treatment. Even more importantly, they will become a part of its scale-up.

While CMH has long been considered a better alternative to institutional care in both high-income countries and LMICs, questions regarding the most effective ways to implement CMH remain. These seven case studies provide detailed examples of CMH practice, including many aspects which have worked well and other issues that pose challenges. While the contexts for these case studies varied significantly from one to another, the successes and challenges in each region shared some common elements highlighting essential components that have to come together for successful CMH programmes. It is the coming together of these essential components that can make CMHP dynamic and inclusive; thus providing a strong foundation for its spread. As CMHP continues to develop and multiply in LMICs, more people with mental illness or epilepsy will have the opportunity to receive much-needed treatment. Even more importantly, they will become a part of its scale-up.

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Appendix 1

TOR for Case Studies

Scope of the Study

1. **Brief introduction** to your programme: including location, coverage, funding and placing the Community Mental Health module within the overall programme delivery.
2. **Case Study**, Community Mental Health in your programme – Thus describing what CMH is and how it works in your programme. Through a descriptive case study of the work in one or two specific service locations following through into the community and homes.

Example:

What are the locations where different aspects of CMH take place? For example, health centre/ district hospital, community/homes etc.

What is the process exactly? For example, how are people with mental illness or epilepsy identified? What happens next?

Who are the people involved? For example, who gives a diagnosis, who prescribes medication? Description of what exactly happens at a mental health clinic or camp.

Who does a follow-up? How is it done? What exactly happens during follow-up?

What other/alternative treatments are available? Where exactly and by whom?

What are the records maintained? What is the documentation done? Who does this? Where are they kept? How are they used?

What resources are required for providing Community Mental Health Services? Money, medicines, psychiatric staff, general health staff, community workers/volunteers etc.

User perspectives on reliability, quality of CMH services they receive and some issues they bring up.

3. Discussion -

- Identifying the “key ingredients” of good quality CMH services
- Challenges in ensuring sustainable CMH with all these “key ingredients”

4. Recommendations - To ensure reliable, high quality and affordable CMHS

Method

This will be in the form of a case study. The **case study** will be developed following the questions in the scope (above). The presentation of the information will be descriptive and under suitable headings. The information or data for the case study will be gathered from:

- a) Documented evidence already available with the programme
- b) Observation of PHC activities, mental health clinic or camp, follow-up activity in the community etc.
- c) Focus groups (with users)
- d) Key informant interviews

Almost all of the data collection will take place only within the selected case study site and will be done directly by the Research Officer.

The length of the final document to be no more than 20 pages.

To be completed by 29th June 2008.

Appendix 2

Question Guide for FGDs

Example: Kenya

1. How were your mental disorders identified? What happened next?
2. What are your experiences with the quality of services at Kangemi? For example, the quality and reliability of services, drugs, attitude of the health practitioner, who gives a diagnosis, who prescribes medication? Description of what exactly happens at a mental health clinic or camp.
3. Were any of you followed up at your homes? Who did it? What are your views about the process, the people in the follow-up?
4. Are there any alternative treatments that are available to you? From where do you get them?
5. What are your feelings about your records being documented? Do you know why it is necessary and what they are used for?

Appendix 3

People with mental illness or epilepsy in BasicNeeds' programmes at the end of December 2008

Diagnosis	Ghana		Kenya		Lao PDR		Tanzania		Uganda		Sri Lanka		Total		
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	Total
	Anxiety	83	118	121	96	35	135	83	94	4	15	7	3	333	461
Depression	131	364	152	172	7	21	87	146	20	33	44	143	441	879	1320
Schizophrenia	830	814	98	76	25	28	438	352	18	17	57	52	1466	1339	2805
Unspecified Psychosis	1519	1232	76	83	11	9	108	120	11	16	25	20	1750	1480	3230
Bipolar Disorder	3	5	66	35	1	4	81	112	36	54	15	16	202	226	428
Depression with Psychotic Symptoms	36	47	147	128	0	2	165	110	2	4	2	4	352	295	647
Epilepsy	4902	4106	496	474	35	33	1337	1323	431	404	41	33	7242	6373	13615
Other Disorders	1066	1059	270	203	42	29	111	105	60	40	94	148	1643	1584	3227
Diagnosis not known	57	50	417	444	0	0	13	11	10	2	203	332	700	839	1539
Total	8627	7795	1843	1711	156	261	2423	2373	592	585	488	751	14129	13476	27605
Country Total		16422		3554		417		4796		1177		1239			27605
Drop-outs		59		96		0		506		0		0			661
TOTAL		16363		3458		417		4290		1177		1239			26944



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