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Case Studies

Throughout the workshop, case studies were presented of some of the successful mental health projects in Ghana, Kenya, and around the world. Although each case study was multifaceted and addressed many challenges, the workshop participants focused on distilling lessons learned from each project that could be applied to potential mental health demonstration projects.

AFRICA MENTAL HEALTH FOUNDATION[1]: COMMUNITY PARTNERSHIPS

Founded in 2004, AMHF has stated the vision of being "the center of excellence in Africa for research, training, knowledge translation, and advo-

cacy in mental health."[1] AMHF uses a multidisciplinary, multisectoral approach to improve mental health through programs at all levels, from physician specialist training to community-based stigma reduction, including school-based programs. According to David Ndetei, AMHF's greatest successes have been in creating community partnerships and joint ownership of programs. One partnership in particular that has been successful is the relationship AMHF has built with traditional and faith healers. AMHF works with them to build awareness of mental health disorders, to develop skills to screen for and refer cases of mental illness, and to deliver evidence-based, mhGAP-adapted psychosocial interventions. Other partnerships critical to the success of their programs, noted

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[1]See http://www.africamentalhealthfoundation.org (accessed July 14, 2015).

Ndetei, include those with county government where health services have been devolved and with the government of Kenya.

BASICNEEDS[2]

BasicNeeds was founded in 2000 with the goal of improving the lives of people around the world diagnosed with a mental illness or epilepsy, by ensuring that their basic needs are met and their rights are recognized and respected.

Ghana[3]: Building Capacity of NGOs

BasicNeeds' Mid-Ghana Project is focused on the Ashanti and Brong Ahafo regions. It is a community-based model that seeks to ensure that people with mental illness or epilepsy can access their human rights. Specifically, BasicNeeds' activities can be categorized into four main areas: identifying and supporting people who have treatment needs; training community health workers; creating awareness; and supporting service delivery through psychiatric outreach to communities. Since 2000, BasicNeeds Ghana has provided 7,800 women, men, and children with mental illness or epilepsy and caregivers access to mental health and development

services through community-based mental health, and it has developed 130 self-help user groups as a mechanism for patients and caregivers to express their needs and claim their rights to inclusion and development. Peter Yaro, executive director of BasicNeeds Ghana, said that a key component of their work is training local partners such as NGOs. BasicNeeds trains and supports key local partners on their Mental Health and Development model to enable the organizations to gain accreditation as a BasicNeeds franchise partner. The components of the model include capacity building, community mental health, sustainable livelihoods (e.g., promoting social reintegration), research, advocacy, policy, and collaboration. The NGOs they work with are not necessarily mental health organizations: for the Mid-Ghana project, for instance, the organizations were focused on child labor, reproductive health care, education, and women's issues. Yaro said that this type of collaboration among NGOs is a great way to align mental health activities with what

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[2]See http://www.basicneeds.org (accessed July 14, 2015).

[3]See http://www.basicneeds.org/where-we-work/ghana (accessed July 14, 2015).

the NGOs are already doing. He cautioned, however, that even though many NGOs are interested in working in mental health, they "sometimes do not know how." He said that if given the proper support and training, these NGOs can be valuable partners in improving community mental health. As a result, BasicNeeds Ghana established two regional mental health alliances that bring together more than 45 community-based organizations/NGOs and decentralized government ministries, departments, and agencies to foster these collaborations and implement work in mental health.

Kenya[4]: Patients as Ambassadors

BasicNeeds works at the community level to build the capacity of people with MNS disorders to participate in their own treatment and recovery, as well as to reduce stigma and prepare the rest of the community to help people with MNS disorders. Joyce Kingori reported that the critical part-

ners of BasicNeeds are the adults and children with MNS disorders "who have taken the courage to come and get treatment, to share their stories, to provide their insights." BasicNeeds uses mental health "ambassadors": young people who have been treated and now work to create awareness among their peers, and to reach out to provide support to those in need. Kingori noted that in addition to the critical partnership with patients, BasicNeeds also has important partnerships with organizations such as KAWE and AMHF, as well as the MoH and local government and health officials.

DIRECT RELIEF[5] AND BREAST CARE INTERNATIONAL[6]: COLLABORATION

Founded in 1948, Direct Relief provides medical resources to areas affected by poverty or emergency situations. It focuses primarily on maternal and child health, disease prevention and treatment, emergency preparedness and response, and strengthening health systems.[5] In partnership with Breast Care International (BCI), a Ghanaian-based organization dedicated to breast cancer awareness, the two organizations conducted a mental

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[4]See http://www.basicneeds.org/where-we-work/kenya (accessed July 14, 2015).

[5]See http://www.directrelief.org/about (accessed July 14, 2015).

[6]See http://www.breastcareghana.com/about (accessed July 14, 2015).

health research project in the Ashanti region of Ghana. They are currently collecting data on the burden of mental health and examining what types of mental health services are available, with the purpose of using the data to recommend measures to address the challenges in the region. Andrew Schroeder, director of research and analytics for Direct Relief, and Samuel Kwasi Agyei, of BCI, stressed the importance of collaboration in their work. Schroeder noted that the collaboration with BCI was critical to the success of the project because they are a community-based organization that is trusted in the area in which they work. In addition, because of BCI's interest in broad-based health care, the project is working to embed mental

health care services in the general health care system, rather than operating as a stand-alone mental health program, thus making improvements that are systematic and sustainable.

EMERGING MENTAL HEALTH SYSTEMS IN LOW- AND MIDDLE-INCOME COUNTRIES (EMERALD)[7]: STRENGTHENING HEALTH SYSTEMS

EMERALD, or Emerging Mental Health Systems in Low- and Middle-Income Countries, is a 5-year program (2012–2017) that works in six countries (Ethiopia, India, Nepal, Nigeria, South Africa, and Uganda) to improve mental health outcomes by improving health system performance, said Jibril Abdulmalik, Co-Investigator of EMERALD at the University of Ibadan in Nigeria. The program consists of six work packages: (1) project management and coordination; (2) capacity building in mental health systems research; (3) adequate, fair, and sustainable resourcing for mental health (health systems inputs); (4) integrated provision of mental health services (mental health system processes); (5) improved coverage and goal attainment in mental health (health system outputs); and (6) dissemination. EMERALD seeks to strengthen the system itself through activities such as holding trainings for policy makers, researchers, and service users; providing scholarships for students seeking advanced degrees in mental health; developing curricula for master's training in public mental health; helping countries with cost projections; facilitating the integration of mental health into primary care; and improving health information systems. Abdulmalik added that having cultivated

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[7]See http://www.emerald-project.eu (accessed July 14, 2015).

relationships with policy makers and key stakeholders was useful to understanding health care systems hierarchy, as well as leveraging existing platforms. He acknowledged that some of these individual efforts are "droplets" in a bucket, but he hoped that the EMERALD project, as a whole, would result in a comprehensive template for strengthening mental health

systems in low- and middle-income countries.

FIGHT AGAINST EPILEPSY[8]: STAKEHOLDER ENGAGEMENT

WHO and the Ghana MoH, with support from Sanofi Espoir Foundation, have teamed up for a 4-year project (2012–2015) to reduce the epilepsy treatment gap, using a variety of strategies: promoting training of all health care providers, improving community awareness to reduce stigma and increase demand for care, and integrating epilepsy care within the primary health care system. Since the initiation of the project:

- A national/district coordinating committee was established;
- A situation analysis report was developed at the national, regional, and district levels;
- 330 volunteers and 404 primary health care providers were trained in epilepsy management;
- Gradual scale up occurred, with coverage now in 10 districts in 5 regions;
- A monitoring and evaluation strategy was developed; and
- A draft model of epilepsy care was developed.

Cynthia Sottie, national coordinator of the Fight Against Epilepsy project at the Ghana Health Service, said that engaging with stakeholders at all levels, at all stages of the project, has been critical to the project's success. She noted that they have involved the Minister of Health, representatives from the teaching hospitals, national and international NGOs, the Mental Health Society of Ghana, regional health directors, faith healers, and community members. By involving so many stakeholders from the beginning of the project, "everybody was involved [and] everybody knows what is going on at each time." Sottie said that everyone's in-

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[8]See http://fondation-sanofi-espoir.com/download/2012-10-22_CP_Ghana_EN.pdf (accessed July 14, 2015).

volvement was vital to getting the support and participation necessary to

carry out the project.

KENYA ASSOCIATION FOR THE WELFARE OF PEOPLE WITH EPILEPSY[9]: PUBLIC EDUCATION

KAWE was founded in 1982 and seeks to improve the lives of those with epilepsy through a variety of efforts, including the training of primary health workers, awareness creation and stigma reduction through community projects, medical provision and support (e.g., epilepsy clinics, patient groups), and policy advocacy at the MoH in Kenya. Between 2000 and 2014, KAWE trained 1,814 clinical officers and nurses and 3,095 CHWs, and the organization's awareness programs reached an estimated 254,000 people directly and more than 3 million through mass media, said Osman Miyanji. In addition, more than 25,000 patients have been registered throughout clinics in Nairobi, Kenya, as a result of KAWE's community programs, and from a training perspective, the organization helped launch national epilepsy guidelines and developed a more comprehensive curriculum for medical training institutions. Miyanji reported that KAWE has demonstrated that they can close the treatment gap, and he noted that in 30 years of experience, public education to address social stigma and reduce ignorance has been a key element of their success.

THE KINTAMPO PROJECT[10]: FOCUS ON COMMUNITY-BASED CARE

The Kintampo Project, a collaboration between Ghana and the United Kingdom, is "training a new generation of mental health workers," said Joseph B. Asare. The project trains clinical psychiatry officers (CPOs) and community mental health officers (CMHOs). CPOs can diagnose mental illness and prescribe medication, while CMHOs focus on detection of mental illness in the community, education of local people, and reducing stigma and discrimination. CMHOs work in part by developing relationships with local families, schools, prayer camps, and tradi-

[9]See http://www.kawe-kenya.org (accessed July 14, 2015).

[10]See http://www.thekintampoproject.org (accessed July 14, 2015).

tional healers. The organization's objective is to have one CPO and two to three CMHOs in each of Ghana's 216 districts by 2017. Through the Kintampo Project, workers have been trained and deployed all over Ghana, helping thousands of the most needy people. The project is on track to boost the mental health workforce by 60 percent and the number of patients treated per year by 500 percent. By focusing on community-based care, Kintampo is shifting the focus of mental health care away from large hospitals and into the community where it is most needed, Asare said.

PROGRAM FOR IMPROVING MENTAL HEALTH CARE (PRIME)[11]: BUY-IN, BUY-IN, BUY-IN

Tedla Wolde-Giorgis provided an overview of PRIME's efforts to integrate mental health into the existing health delivery system in five countries (Ethiopia, India, Nepal, South Africa, and Uganda). The purpose of the 6-year study, launched in 2011, is to research the magnitude, impact, and tractability of mental disorders in low- and middle-income countries. Using Ethiopia as an example, Wolde-Giorgis reported that integration was an incredibly complex process (beyond the instructions in the mhGAP intervention guide [IG]) that required buy-in from decision makers at all levels—national, regional, and community—as well as support from health care facilities and NGOs. Wolde-Giorgis said that, regardless of the level of support at the top, a top-down approach will not work; ultimately, the day-to-day work is done in the community and facilities, so it must be led at this level. He also noted that stigma reduction is a critical part of getting buy-in at the community level. For an effort to be sustainable, the buy-in must be continuous—it is not a one-time effort. Leadership must be continuously reminded of the importance of mental health and how it aligns with national priorities because there are so many other competing health concerns and health initiatives (e.g., MDGs).

[11]See http://www.prime.uct.ac.za (accessed July 14, 2015).

PROJECT FIVES ALIVE![12]: SCALING UP

The goal of Project Fives Alive! is to reduce mortality rates among children below age 5. Sodzi Sodzi-Tettey said the project uses a quality improvement approach, which requires forming quality improvement teams, having the teams develop initiatives on how to change mortality rates, implementing these initiatives, and then using data to assess if there was a positive effect. The project started in 9 hospitals but has since been scaled up to 200 hospitals. Sodzi-Tettey said that the initial 9 hospitals were chosen because they were high-burden hospitals with high rates of mortality for children below age 5. By the end of the first 18 months of operation, 6 of the 9 hospitals showed significant improvement in mortality reduction. By learning what worked in these high-burden hospitals, the project created a "change package," which consisted of data-driven initiatives that had led to improvement related to improving delay in seeking and providing care and to reliable use of protocols. Sodzi-Tettey said that of the 134 hospitals in which the project currently operates, nearly 70 percent have adopted ideas from the change package, while also developing their own initiatives (e.g., targeted health education on early care-seeking using interactive platforms, triage systems for screening and emergency treatment of critically ill children, and training staff on protocols, followed by regular coaching and mentoring) (Twum-Danso et al., 2012). In these 134 hospitals, there has been a 31 percent reduction in facility-based mortality in children younger than age 5. Sodzi-Tettey reported on three lessons learned from the project. First, initiatives should be tested promptly and on a small scale; this creates data that management can use to decide whether or not to implement a change. Second, teams should be empowered to know and use their own data. Sodzi-Tettey said that many workers were used to reporting data to the top but had not been aware of their own performance. Once they had the ability to track their own progress, they became even more invested in improvement. Finally, Sodzi-Tettey said that sustainability is only possible if a project understands and works within the existing health system, rather than with its own schedule and priorities.

[12]See http://www.ihi.org/engage/initiatives/ghana/pages/default.aspx (accessed July 14, 2015).

PARTNERS IN HEALTH IN RWANDA[13]: INTEGRATION OF MENTAL HEALTH INTO THE GENERAL CARE SYSTEM THROUGH PUBLIC-SECTOR COLLABORATION AND LEVERAGE OF EXISTING HEALTH PLATFORMS

Partners In Health strives "to bring the benefits of modern medical science to those most in need of them and to serve as an antidote to despair."[13] The Partners In Health program in Rwanda focused on close collaboration within the public sector to integrate mental health care into the general community-based care system within the district. At each level (hospital, health centers, and community), health workers were trained in mental health care. Partners In Health's primary mental health endeavor in Rwanda was the integration of mental health care into health centers using existing structure of intensive supported supervision and quality improvement following training. One challenge that the program faced was resistance from the staff to admitting and treating psychiatric patients in the general ward. Smith offered several reasons for the resistance, including stigma and discrimination. She said the most successful strategy for reducing stigma among the health care workers was effective treatment of patients. When staff saw people come in with very acute psychiatric conditions, receive treatment, and get better, the workers' perspective on mental health was significantly changed. Smith recalled the story of a district hospital manager who unknowingly hired a former patient to work on the grounds of the hospital. When he learned that she had been admitted to his hospital as a psychiatric patient only 2 months earlier, and was now capable of holding a job, he "became a big advocate for the work." Smith said, "It was the witnessing of people getting better that was the most destig-

matizing." In addition to reducing stigma, Smith said that another key element of successful integration was leveraging the existing system structures and human resources. Rather than restructuring or bringing in new people, they worked within the existing system by mapping skill sets and matching them to the skills needed for mental health care. Smith said that by using what was already available, a much more rapid and efficient integration into primary care was possible.

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[13]See http://www.pih.org (accessed July 14, 2015).

MENTAL HEALTH CARE IN TURKEY: POLICY DEVELOPMENT

Oğuz Karamustafalioğlu, professor of psychiatry at Üsküdar University, provided an overview of mental health care in Turkey. He noted the high treatment gap for schizophrenia, depression, and substance use problems, and the lack of human and material (i.e., psychiatric beds) resources needed to adequately meet the demands of patients. In 2006, the MoH in Turkey released a National Mental Health Policy (NMHP)[14] aimed at mobilizing resources to ensure that mental health care services are accessible and balanced. Karamustafalioğlu stated that the NMHP encouraged preventative methods to decrease the burden of mental disorders, to increase attainable mental health care and services at both primary and secondary care levels, to encourage the respect of human rights for those with a mental illness, and to support the necessary legislation to protect their rights. Although there have been some successes since the NMHP was released—including an increase in the outpatient mental health care units at the general hospitals, the number of adult and child psychiatrists, and public education and awareness programs about mental health to reduce stigma—he emphasized that there is still more to be done to provide care and treatment to all patients.

WORLD ASSOCIATION FOR SOCIAL PSYCHIATRY AND

SANOFI: COUNTRY-SPECIFIC APPROACHES

Sanofi's Access to Medicines department works in some of the world's poorest countries, disseminating information about MNS disorders, improving diagnosis, and making treatment affordable and accessible to patients, said Francois Bompart. Programs are specifically tailored to each country in which they work, an approach that is critical to success. For example, Sanofi works in Comoros, a small group of islands off the coast of Mozambique. Bompart said that several issues complicate mental health care in Comoros: transportation is difficult and expensive, and there is only one psychiatrist in the country. In order to work within these confines, Sanofi is working to train primary health care providers to use telemedicine to connect to the one psychiatrist—a tailored approach that works for the specific context of Comoros but might be wholly inappropriate elsewhere. Similarly, in Guatemala, Sanofi tailored its approach by choosing to partner with a local NGO instead of the MoH because of instability in the government. With regards to cultural and societal sensitivities, Bompart noted that in some areas in countries such as Morocco, traditional and faith healers were not involved in the awareness programs given the local contexts.

[14]See https://www.mindbank.info/item/69 (accessed August 13, 2015).

686 PROJECT IN CHINA: FOCUS ON GENERAL PRACTITIONERS

The 686 project was a 2004 initiative that launched mental health reform in China after the severe acute respiratory syndrome (SARS) epidemic. Prior to the reform, mental health institutions (565 hospitals) were worn and outdated, there were no community-based mental health care services, and medical insurance was provided only to employed people. Ma Hong, deputy director of mental health programs at the China MoH, stated that initially, the government granted 6.86 million Yuan (860,000 USD) to train providers in mental health, and as the program continued, it covered free hospital treatment for patients and out-of-pocket medical costs for

impoverished patients. Hong noted that it was critical to learn how to express the need for funding and the overall burden of mental health in the language of the government. The project consisted of 60 demonstration projects reaching a population of 42.9 million people, in which providers were trained; hospital services were expanded to communities; and, when universal medical insurance was implemented in China, the project covered out-of-pocket costs for impoverished patients. One significant challenge was that while there was adequate funding for services, the human resources necessary to actually provide care lagged behind. Hong said, "Money does not equal service—human resources development is much slower than simply building a new hospital." She proposed that too much reliance on specialists in rural areas is misguided, and that when building a mental health program, the focus should be on expanding general practitioners' knowledge of mental health and building their capacity to diagnose and treat MNS disorders. Hong noted that a hospital–community continuous care system has since been established and 4.29 million patients have been registered in the health information system, including 3.41 million patients who have received community health care, 61.7 percent of whom are farmers.

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