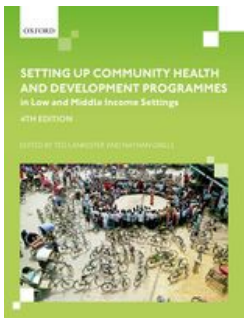

Setting up Community Health and Development Programmes in Low and Middle Income Settings (4 edn)

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CHAPTER

24 Setting up community mental health (CMH) programmes

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Abstract

This chapter explains why mental health is important for well-being and community development and briefly gives the history of mental health services in low- and middle-income countries. It suggests the best ways of engaging with the needs of those with no access to services and how to improve the current situation. The chapter lists the essential elements of a community mental health programme, discusses medical, psychological, and social aspects of mental ill health, and how to raise community awareness and empowerment to use services. It describes how to establish a mental health programme, including analysing the situation, planning the stages, implementing the programme, and monitoring and evaluation (M&E).

Keywords: CMH, mental health services, low- and middle-income countries, health systems, human rights, global mental health.

Subject: Public Health

What we need to know

Why mental health is important for well-being and community development

The expression ‘there is no health without mental health’ refers to the close connections between physical and mental health. Until recently, health services have generally just included physical health. Finally, however, more people now realize the huge importance of mental health.

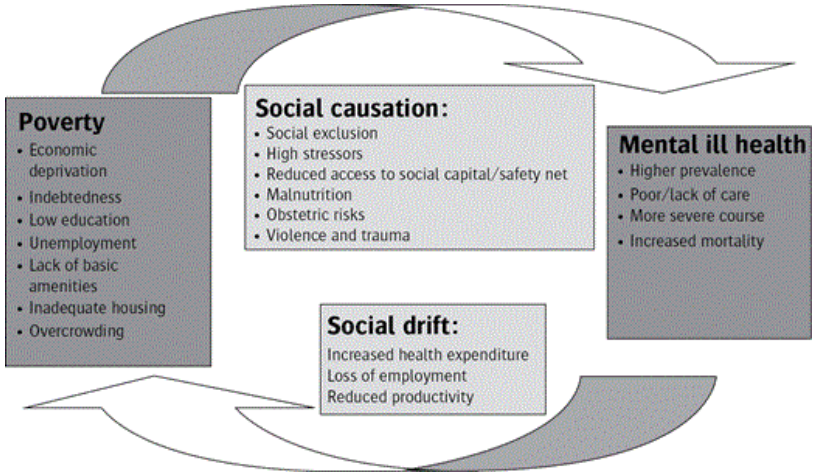
The Sustainable Development Goals (SDGs) state that:

> By 2030, [we should] promote mental health and well-being and strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol.

The field of ‘global mental health’ can be described as the science and practice of improving care based on evidence and equity around the globe. It often focuses on parts of the world where mental health is most neglected.

It is increasingly clear that mental illnesses are very common. They not only cause individual disability, but have a negative impact on community development. Mental illness traps people in poverty. Poverty also increases people’s risk of mental illness, forming a vicious cycle that makes community development more challenging. Many mental illnesses affect people from a young age, can last throughout their lives, and can affect those years where they would normally be working and earning a living for themselves and their family (Figure 24.1).

Figure 24.1



Mental ill health and poverty form a vicious cycle, each reinforcing the other negatively.

Happily, growing evidence shows that many conditions respond well to treatment, which reduces disability, increases quality of life, and can be achieved in a cost-effective way. This means that it is increasingly possible to improve mental health as an essential part of overall health and well-being, which in turn helps to promote community development.

Despite this, in many low-income countries, only around 15 per cent of people receive the mental health care they need. This unacceptable treatment gap slows global development, prevents some people from participating in community life, and may even cause exclusion. There is increasing research demonstrating
p. 419 the neglect of mental health globally. Growing advocacy and action by people affected by mental distress ↳ has led to a movement for coordinated action for mental health and scale-up of mental health services, especially in low and middle-income countries (LMICs, Box 24.1).[1]

Box 24.1 What do we mean by mental health and mental illness? Some notes on terminology

Good mental health is when somebody feels good about themselves, can cope with the stresses of life, and can meet their normal day-to-day responsibilities. When someone is mentally healthy, they can maintain good relationships with those around them and effectively contribute to society.

Policies, programmes, and research that address mental health in poor settings usually include common problems like insomnia, mild depression, and anxiety, as well as severe and disabling conditions like severe depression, schizophrenia, and bipolar affective disorder. Although the way that people understand and experience mental illness, and seek care, varies according to culture, the illnesses seen across the world share many similarities, and treatment, if given appropriately, can benefit people from any country.

Due to the similarities in pathways to care, stigmatizing attitudes of society, and treatment needs, epilepsy (a neurological condition) and dementia have generally been addressed under the same programmes as mental illnesses. Similarly, problems associated with alcohol and substance use have also been included in the same programmes and packages of care. This grouping is often called *Mental, Neurological and Substance Use Disorders (MNS)*, and is the term used by the WHO and others.

While childhood mental illness is an important part of this field, generally, *intellectual disability* (usually due to permanent brain injury before or around the time of birth) does not share many of the characteristics of mental illness, and services are focused on education rather than medical treatment (though some individuals may have both problems, and programmes may address both issues).

The term that people living with disability by social and psychological consequences of mental illness have come to use at an international level is *psychosocial disability* (reinforced by the use of this term in the UN Convention on the Rights of Persons with Disability). This recognizes the enormous impact on quality of life that the experience of discrimination and rejection has for many. This discrimination can be institutionalized, with arbitrary imprisonment, chaining, and social exclusion often being enacted in a way it is not for other people.

Mental health is something we all have, to some degree, whereas people might or might not have a *mental illness*. In fact, while all of us might experience mental distress sometimes (e.g. when we lose a loved one), we do not consider this to be mental illness unless a person stops being able to function well in their home relationships, work life, or social role.

It is possible to do many things that promote individual and Community Mental Health (CMH), and there is an important role for people and communities outside formalized care in promoting resilience, even in stressful circumstances. Mental health programmes ideally include preventive and promotional aspects, as well as addressing negative social attitudes.

The role of culture and the history of approaches to mental health care

Mental illness occurs in all societies, and usually at similar rates. But the way that it is understood and explained varies greatly across cultures. Often, because of changes in behaviour and thinking, it is thought to have a spiritual cause. Traditional healers and religious healers remain the first port of call for many people who become mentally ill in Africa, Asia, and Latin America. As health care workers we may wish to follow bio-medical approaches to treatment and care, but we need to recognize these spiritual dimensions and work with traditional healers if we want to develop an effective mental health programme.

The practice of medical psychiatry was introduced to many parts of the world during the colonial period. From the early 1900s this was usually through building asylums, often which were the then-accepted model of mental health care. But few effective medical treatments for severe mental illness were available until the 1950s. The 1960s saw a dramatic shift away from institutions, and by the 1980s, there was a strong consensus in favour of community-based mental health care. In richer countries, this move away towards care in the community has become the norm. But apart from a few notable exceptions, like the Aro Village System in Abeokuta in Nigeria in the 1950s, this process has not happened enough in many LMICs, resulting in huge treatment gaps. The institutional focus of mental health services often leads to abuses of human rights both in institutions, and in communities. People with severe mental illness can end up in prisons, chained, or locked up.

In some countries, asylums have become modern specialist centres, connected with university hospitals, but these few centres, and the small number of professionals, cannot begin to meet the needs of the many people needing access to care. Ideally, mental health services should be integrated into the publicly provided health care system, and should be geographically accessible. Integration of physical and mental services can increase access to care and ensure that people with combined physical and mental health problems can be seen at one location, which helps to reduce the stigma of mental illness. This integration is also effective at community level. For example, community health workers (CHWs) can raise awareness about mental health, recognize cases, provide care, and refer when needed, alongside their other tasks.

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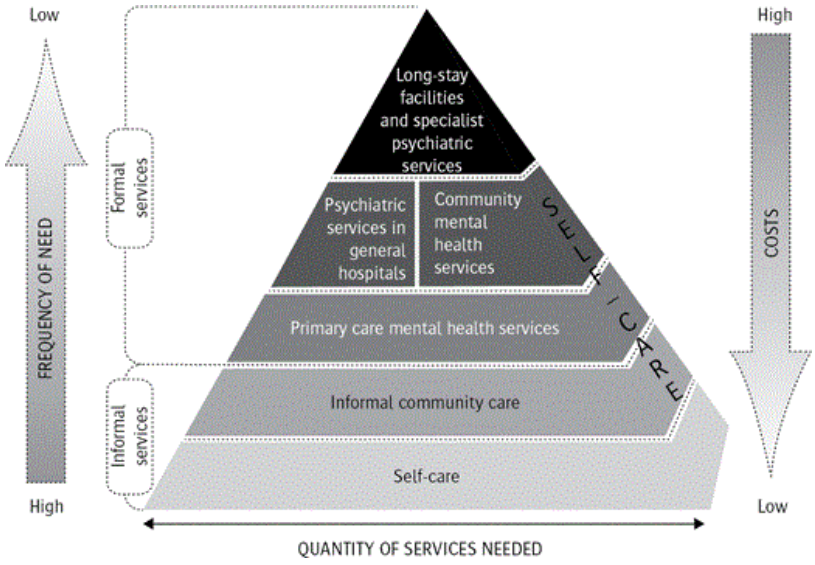
Essential elements of a community mental health (CMH) programme

This section outlines the *types of intervention* needed in programmes, as well as considering the way *they are organized,* to meet the mental health needs of community members. Box 24.2 It suggests some ways we can bring about improvements in health systems. These are widely relevant for any government-run mental health services, for private health care providers, and for local-level approaches through civil society organizations (CSOs). These groups can all play a role in meeting the needs of people with mental health problems (Figure 24.2).

Box 24.2 Principles of health system reform to improve mental health care

- Services need to be locally accessible and, ideally, integrated into the general health care system, which is less stigmatizing and allows for better continuation of care and management of comorbidity.
- Clinical care should be offered by general health professionals as well as mid-level mental health professionals (e.g. mental health nurses, psychologists).
- This 'task sharing' approach implies a systematic shift in roles towards less-senior health staff in locations outside of large metropolitan cities having greater responsibility for frontline treatment.
- Psychiatrists and other senior professionals should engage in public health/system planning, and in training and supervision of other clinicians, as well as their traditional clinical role.
- Critically, other aspects of the health system need to be strengthened to ensure proper integration of quality mental health care, such as ensuring an adequate supply of medication, and the inclusion of mental health statistics in the routine health information management systems.
- Given the low priority that mental health usually has in the system, it is necessary to create strong management structures and to ensure ongoing advocacy, support, and resources for reformed systems.

Figure 24.2



The ideal service mix, focusing more on locally accessible services. In many countries, this pyramid is inverted, with almost all funds used at the specialist level.

The effects of mental illness can be seen in every aspect of people's lives: mental, psychological, and social.

Medical: mental illnesses have a major impact on physical health. For example, children with epilepsy are at risk from falling into fires and water, and people with schizophrenia die on average 15 years younger than their peers. In addition, where there is a need for medication, there is a risk of side-effects.

Psychological: as well as coping with the typical symptoms of mental illness such as low mood, unusual thoughts, or hallucinations, people often experience stigma and exclusion from social activities.

Social: family relationships, education, employment, human rights, interaction with the justice system, spiritual life, and involvement in religious and cultural pursuits can all be profoundly affected by mental illness.

p. 421 We have to consider all these factors together, because a purely medical approach will be incomplete. ↳ In addition, we must put ourselves into the shoes of someone with a mental health problem. What do they see as a successful outcome: reducing symptoms or also having an improvement in their social life? This approach, which encourages people to identify their own priorities, is called the 'recovery approach'. This approach in mental health is equivalent to the concept of communities owning their own futures, a key emphasis in community-based health care.

All these approaches to care work much better if they link as much as possible to the communities where
p. 422 people live, and take place within communities. For ↳ example, CHWs can address underlying issues which affect mental health, e.g. excessive alcohol or drug use, violence against women, child abuse, high levels of unemployment. In some cases, health workers need to visit patients at home when they cannot (or do not) seek care at a clinic. Good links between communities and services at all levels allows the health team to identify, care, treat, and follow up patients to prevent relapse.

Community members themselves are the best people to provide initial support for anyone who is distressed, has a mental illness, or requires support. Being a supportive family member or a good friend is important for helping people with mild or short-term mental distress. It is also useful for family and community members to work alongside professional care where there is more serious illness. There are many ways that health programmes can recognize and support the essential role of families and informal carers of people with mental illnesses. For example, programmes can teach them skills, inform them about their relative's illness, and even protect the mental health of the carers themselves (see Box 24.3).

Box 24.3 Case study 1: Supporting caregivers, and people with their own mental health needs

In low- and middle-income countries, family caregivers are the most important source of support for a family member with mental distress. Burans is a partnership project between the Emmanuel Hospital Association and the Arukah Network in Uttarakhand, India.[3] The Burans programme initially focused on providing information and support to people with mental distress and facilitating access to care. It quickly became apparent, however, that caregivers were critical in supporting their family members in all aspects of rehabilitation and recovery, and therefore needed to be formally included in the programme.

In collaboration with caregivers, Burans developed a programme component where community health workers facilitate the formation of caregiver support groups of between seven and ten caregivers living in a neighbourhood. These support groups meet weekly or fortnightly and follow a nine-week facilitated programme which builds caregiver knowledge and skills. It covers topics such as how to increase affected family members' engagement in self-care and household responsibilities, strategies to build and support positive new behaviours, and how to support their relative with getting the most out of talking therapy and medicines that have been prescribed. The modules also address ways caregivers can identify their own mental distress and keep themselves well. Caregivers describe this programme as very helpful and, for some, the changes have been transformational for both themselves and other family members. Formal evaluation of the programme is ongoing.

Finally, each of us has the capacity for self-help. With guidance and practice, we can improve our own mental health, become more resilient to stress, and aid our own recovery from mental illness. Some practical examples of self-help include getting adequate sleep, building positive relationships, having a good work-life balance, taking regular exercise, and avoiding alcohol or drug abuse.

Medical Care

It is essential in a mental health programme to be able to provide medical care since many of the most severe mental illnesses, e.g. schizophrenia or severe depression, as well as epilepsy cannot be effectively treated without appropriate medication. If a person is very unwell, psychological and social interventions may only be effective once symptoms have been stabilized. There is now good evidence for effectiveness of medical and psychological interventions in low-income settings, as well as guidelines on how packages of care can be effectively delivered.[4] Many guidelines specifically include community-based approaches.

It is often possible to use local medical services to provide this care on a referral basis. In some cases, it may be necessary to advocate for and support the local services to establish mental health care if it is absent. This has the advantage of creating local health resources for the wider community, and can simplify the requirements for a new programme, as medical licensing and provision of medication can be complicated and has legal requirements.

Additionally, as a Community Mental Health programme will be limited to outpatient services, good connections with more specialized services will be essential for the occasional patient, even if they are far away. Such services may be able to offer supervision, training, advice, or guidance on other aspects of
p. 423 programme ↳ management, e.g. medication availability, evaluation and research.[5]

If no local primary mental health care or psychiatric services can be found, it is necessary to establish an independent service with suitably qualified staff, e.g. psychiatric nurses trained in prescribing, a primary

care doctor, a psychiatrist. Such staff may well need update training on best practice and there are excellent resources available using the WHO mhGAP training.[2] Standard treatment guidelines or protocols are a good way of maintaining quality, consistency, and safety, and may include referral guidance as in a stepped care approach. If clinical staff are relatively junior or inexperienced, it is important that sufficient supervision is in place.

In order for any health care service to work well, we need to ensure that medicines are available and affordable, that good records are kept, and that patients can be referred when necessary. The WHO recommends the use of high-quality generic medicines (see Chapter 11). There is little added benefit in using branded drugs, and their high prices make them unaffordable in low-income settings (Table 24.1). Fortunately, a wider range of useful generic medicines is now available.

Table 24.1 A typical standard drugs list.

Drug	Form
Anti-Psychotic drugs	
Chlorpromazine	100 mg Tabs
Haloperidol	5 mg Tabs and 5 mg Injection
Risperidone	1–2 mg Tabs
Olanzapine	5 mg Tabs
Anti-Depressant drugs	
Amitriptyline	25 mg Tabs
Fluoxetine	20 mg Tabs
Anti-Epileptic drugs	
Carbamazepine	200 mg Tabs
Phenobarbital	30 mg Tabs
Phenytoin	50 mg Tabs
Sodium Valproate	100 mg Tabs
Injectable Depot Anti-psychotic drugs	
Fluphenazine Decanoate	25 mg Injection
Others	
Benzhexol (anticholinergic (side-effect) drug)	5 mg Tabs
Lorazepam (benzodiazepine)	1 mg Tabs

This table only shows available drugs and forms/dosages and is not a prescribing guide. Please ensure national guidelines are carefully followed.

Psychological care

While some conditions require medical treatment, many respond better to psychological (talking) therapies. Even those people who do need medication may well benefit from psychological therapies as well, so we need to make this available. There are three main ways in which talking therapies can be used.

1. *Counselling skills* and *good communication* are needed by any health team members who are dealing with patients, carers, and community members.

Treating people with respect, good listening skills, and being able to communicate messages and ideas well make a huge difference in how well people respond to care. Good communication can help to make an accurate diagnosis, as well as increase the likelihood of people returning for follow-up care. In addition, learning these skills helps community members to offer peer support to relatives and friends.

2. Advice and education (*psycho-education*) is an important part of any programme.

Alongside any medical or psychological treatment, there are some essential messages for the patient and carer on how to improve their health. For example:

- preventing relapse (how to avoid falling ill again);
- how to take medication safely and manage side effects;
- what to do in an emergency;
- how to avoid causes of stress or triggers for epileptic seizures;
- how to care for a family member with dementia; and
- how to manage difficult behaviour.

These messages would normally be given routinely during appointments or community visits, possibly with appropriate literature to reinforce them.

3. Specific therapies should be used when there is evidence to support them.

For example, specific therapies have been shown to work well for panic attacks, anxiety, obsessive compulsive disorders, and depression. However, it can be difficult to find suitably qualified staff and to organize ways ↳ of delivering these therapies. This will often mean that people will first need referral before they can access these treatments.

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Some basic techniques can be taught to non-specialist HCWs or even to community members, e.g. problem solving and relaxation techniques. There is also evidence that some specific techniques can be effectively used by community workers (see Box 24.4). A number of effective ‘low-intensity’ scalable interventions, often delivered to groups, are now becoming available. These can address a wide range of problems and therefore do not depend on an exact diagnosis.

Box 24.4 Case Study 2: Care for post-natal depression in Pakistan

In low-income countries, perinatal depression affects one in five women, and is associated with infant malnutrition, and lasting effects on both physical and psychological health. A team at the Human Development Research Foundation in Pakistan decided to adapt a proven treatment for depression for the local setting.[6] The Thinking Healthy Programme (THP) aimed to reduce perinatal depression in low socio-economic settings and improve health outcomes in children through using an adaptation of cognitive behaviour therapy (CBT) delivered by CHWs.

In partnership with primary care clinics, CHWs supported mothers from pregnancy to one year after birth. Participants received 16 sessions of the evidence-based approach that combined talking therapy with activities to improve maternal well-being, ways in which mother and children related, and social support for mothers.

The intervention cost was under US$10 per woman per year, and led to recovery in three out of four women treated in a randomized controlled research trial. There were also significantly better health outcomes for their children. The THP is now available as a WHO manual.[7]

Social care

Those with mental health problems will often value support to help get back to a more normal social life, e.g. employment, marriage, etc. It is important that these aspects of people's lives are part of our CMH programme. This is usually best done by members of the health team liaising with others involved with the same people (such as community-based workers).

Examples of things we can do:

- Visit schools to advocate for a child to be re-admitted after her epileptic seizures no longer occur because of treatment. This may include educating the teachers and students that epilepsy is not contagious and teaching them the basics of how to manage an epileptic seizure if it occurs.
- Work with a family to encourage them to take their family member with schizophrenia for treatment, rather than chaining them in the village.
- Persuade the police to recognize that a person's mental illness played a role in behaviour that resulted in arrest, thus making sure they are treated, rather than imprisoned.

Although all people should receive education, support, and advice at clinic visits, carers who are particularly struggling may need extra home visits, e.g. a family with an elderly relative with dementia whose behaviour is difficult to manage. In addition, we must pay attention to the high risk of human rights or other abuse, and where this is found, take appropriate action. There are now some helpful tools to help ensure our programmes are respectful of human rights.[8]

Community-based rehabilitation (CBR, see Box 24.5 and Chapter 23) is a particularly effective model for ensuring all relevant aspects of patients' needs are considered.[9] It focuses on social inclusion and empowerment, but also ensures that there is relevant access to medical care, education, livelihood assistance, and other support where necessary. Many CBR programmes will have field workers with training and experience in this comprehensive approach. Where this is the case, disability associated with mental ill health is not very different from any other.

Box 24.5 Case Study 3: Integration of mental health into community-based rehabilitation (CBR)

In the Upper East Region of northern Ghana, the Presbyterian community-based rehabilitation (CBR) programme in Sandema recognized that the large population of people with mental illness and epilepsy were not accessing care. Many experienced stigma and discrimination and there were high rates of abuse, including by some traditional healers. The only medical treatment was too far for most people to reach, and even there, medication was expensive and the relapse rate was high.

The programme therefore decided to integrate support for people with mental conditions into the CBR programme. They trained the fieldworkers to raise awareness in communities, and to recognize mental health problems. Self-help groups (SHGs) of people with psychosocial disabilities were established with the aim of providing mutual support, and enabling people to re-integrate in the community, both socially and economically. Initially, they invited a psychiatric nurse to visit occasionally, but later the SHGs advocated with local political and health leaders to open a mental health clinic in the local primary care centre, and to make affordable medication available. Now they access care near their community, and have a powerful collective voice.

Extended role of the community health worker

Especially important is the work of CHWs who are well placed to know the day-to-day challenges and needs of those in their community.

For the work of CHWs to be safe and effective in the support of those with mental health issues, we need to clearly define their role and the resources needing to back them up. They also require careful training, supervision, and teaching about how and when to refer patients if their needs become too great to cope with.

p. 425 The CHW's role might include:

- *Medical aspects*:
  - identifying and referring people with mental health needs, and helping them to access appropriate services;
  - planning their treatment with them, and considering what to do if the illness gets worse;
  - educating people and their families about the illness and how to stay well, including the importance of taking medication as prescribed; and
  - following up clients at risk of relapse, especially when they miss clinic appointments.
- *Psychological aspects*:
  - developing long-term trusting relationships with families, and providing basic counselling and messages about maintaining good mental health; and
  - if properly trained, provide psychological treatments such as problem management, or behavioural activation therapy.
- *Social aspects*:
  - addressing social issues that worsen mental health, e.g. gender-based violence or family conflict;

- community awareness-raising about mental health and human rights;
- setting up self-help groups (SHGs) or ensuring that people with mental health problems are included in other community groups; and
- making sure that people with mental illnesses or psychosocial disabilities benefit from the same rights as other people, e.g. social welfare benefits, education, employment.

In some countries, CHWs are already being given a more extended role, including diagnosis and initiating or following up medical treatment. There is huge potential in this as CHWs become an increasingly important part of health systems; however, there is an important need to establish clear guidelines for treatment and adequate support mechanisms. Even if this is formally the case, it is often necessary to ensure training and skills are up to date, and support is available, e.g. supervision and medication supply. Senior health workers like nurses and doctors should also consider psychological and social aspects of care when formulating treatment plans.

Important tasks at community level

There are a number of activities we can do at a community level to improve mental health and reduce the risk of mental illness. Specific evidence-based ways we can promote mental health and prevent illness include:[10]

- Help to change community attitudes.

Many negative beliefs and myths reinforce the stigma and discrimination experienced by people with mental health problems. By improving attitudes, we can promote better inclusion into community life. CHWs can be effective in changing negative attitudes, but there is good evidence that people who have
p. 426 experienced mental health problems themselves are the most effective ↳

p. 427 ↳
change-makers. Awareness campaigns in mass media, or using posters and leaflets or public talks, are a valuable way of correcting wrong attitudes, and informing people about new or existing services available in the area, and also that treatment can be effective when it continues to be taken regularly.

The most important thing is to show that people with mental illnesses can participate in all aspects of community life. This can be done by, for example, inviting them to participate in activities like livelihood programmes or community celebrations, and to join disability rights organizations and community groups. Language can often reflect and reinforce negative attitudes, and it is a good idea to examine whether language used to describe mental illness is unintentionally insulting. Even a programme name that is inclusive and implies that mental health problems are common and can be experienced by anyone, can reduce stigma, e.g. Programme for Stress Reduction.

- Reduce suicide rates.

Suicide is a common cause of death in many places, and rates increase in highly stressful environments. Rates can be lowered by reducing access to the means of suicide (e.g. reducing access to guns, or locking pesticides in a central store) and by reducing stress (e.g. lowering student workload, allowing students to
p. 428 retake exams quickly if they fail). Two other things are known to ↳ help: encouraging people to talk about how they feel so they can seek help, and encouraging the media to reduce coverage about the methods that people use in suicide.

- School-based life skills education.

Helping students to think about their emotional well-being, and teaching them to cope with problems constructively is known to improve long-term mental health.

- Early life interventions.

The environment that infants experience has a long-term effect on both their mental and physical well-being. We can identify and support mothers who are depressed or struggling to cope (see Box 24.4). We can help mothers to interact with their children in supportive ways. Similarly, when parents of children who have behavioural and emotional problems can learn skills for adjusting behaviour, family relationships and child mental health both improve.

- Reduce alcohol use.

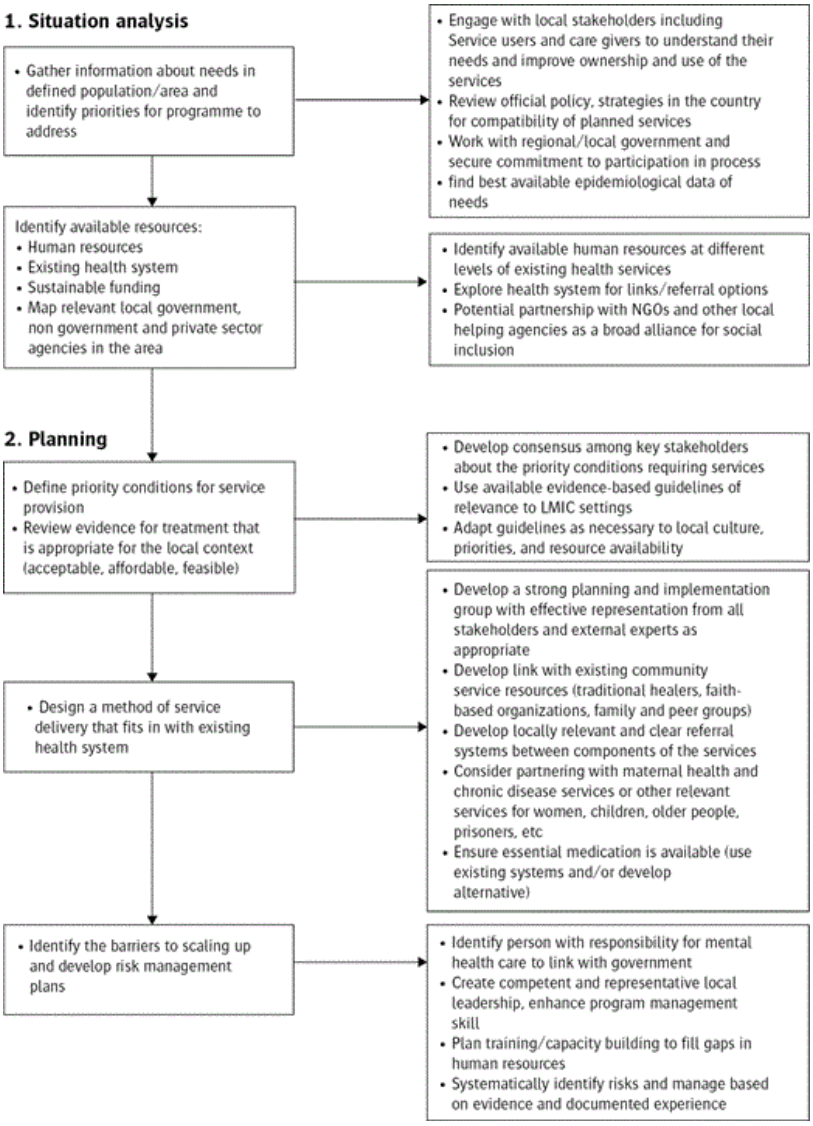
We can ask people about their alcohol use and give simple advice. This should include explaining about dangerous levels and practical ways to drink less. Reducing access to alcohol, including raising prices and reducing advertisements, is also known to be effective.

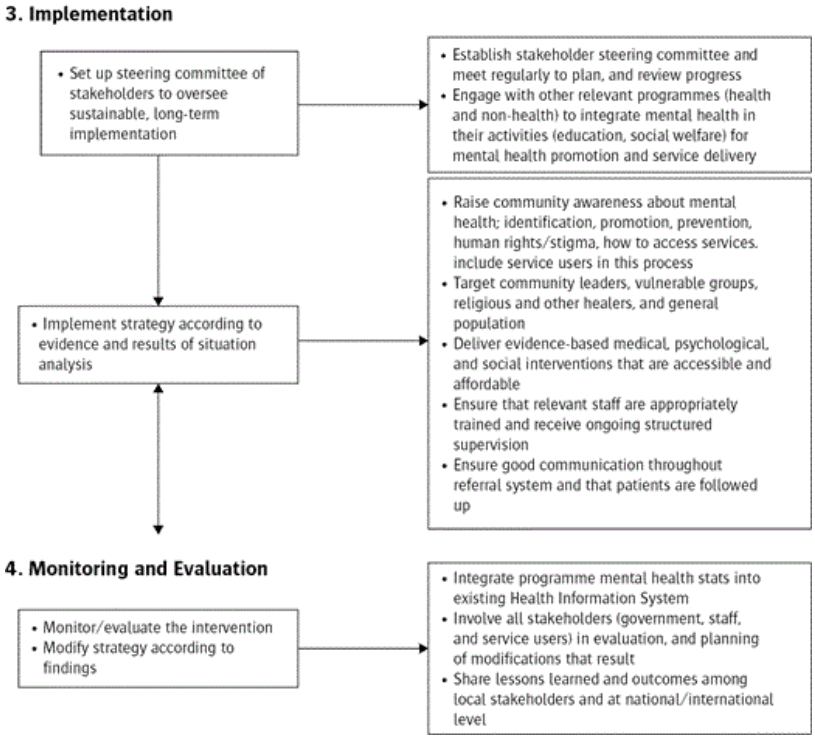
Empowering service users

People with mental health problems are often a very marginalized group. Those who are most people living with disability, e.g. those diagnosed with schizophrenia, have often been given little choice about their own lives; in many places this is still the case.

Self-help peer groups can provide support and encouragement, and even work together on livelihoods, i.e. ways in which both income and self-confidence can be generated. They can form the basis for advocacy. These groups can allow members to share their preferences about how they live in their communities—something always denied to them. For too long, those with mental illness and other disabilities have been deprived of any choice about how they are treated. We need to challenge the idea that people with disabilities cannot make decisions about their own treatment or understand and give consent for medicines and other support (Box 24.5).

Figure 24.3





Steps in developing community mental health programmes.

Ensuring that care is continuous and integrated

Many mental illnesses are long-term (chronic) conditions that tend to vary in severity over time (relapsing and remitting). For these problems, continuity of care is especially important. This is best ensured by providing review, follow-up, and access to medication as close to patients' homes as possible.

Keeping the costs of medication down is also essential, as most people in poorer countries pay for their own medicines. Care for long-term conditions can be especially difficult for families to afford. Ways of reducing medication costs include rational prescribing (see Chapter 11), using generic rather than branded versions, and using government pharmacies where they are cheaper.

With any chronic condition, but particularly with severe mental illness, regular follow-up care is vital. It must be made as easy as possible, but there also needs to be a system for recognizing when a patient has not attended for follow-up appointments, and contacting them to find out why. Apart from the cost and inconvenience, it is common for people to abandon treatment once they start to feel better.

An important factor that leads to patients stopping medicines is unpleasant side effects of medicine. The cure may feel worse than the problem. It is important that team members in a CMH programme are familiar with the common side effects, know which ones require more urgent action, and have helpful strategies to help patients persist with taking medicines (see *Where there is no psychiatrist* in 'Further reading and resources').

In some situations, patients can be followed up in outpatient clinics, as many will need to attend regularly, perhaps every month. In reality, however, there may be only one or two practising psychiatrists in the whole

district or country. Additionally, the expense and inconvenience of travelling to the clinic can make it almost impossible for patients to attend.

Therefore, health care centres clearly should be as close and accessible to communities as possible. When clinicians visit communities and patients in their own homes, they can better understand the difficulties and constraints people face, and the reasons why some clients do not attend the health centre. This leads to the growing idea that mental health services and chronic non-communicable diseases should be integrated to make the best use of resources; it also shows the value of the holistic primary health care approach. If people with mental distress primarily get care through general services, they are not stigmatized. We need to help patients to have a 'single record' that all those caring for the patient are able to see. This can be done through use of a family folder system (see Chapter 13).

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What we need to do

Assess the situation

Health programmes must respond to the needs of the community, but as discussed in previous chapters, we must also ensure that the community understands its own assets and abilities. There are more details on how we do this in Chapters 2 and 6.

When it comes to mental health needs, we need to analyse the situation carefully in some detail. Firstly, we must discover the type and the extent of mental health needs in the community, which are often hidden. Secondly, we must assess those resources that are available in the community, or within its reach given support and training. Table 24.2 gives some guidance and more detail.

Table 24.2 Information to consider as part of situation analysis.[11]

Context	Population demographics. Health indicators. Social indicators
Need for care	Prevalence of different conditions. Current proportion of people accessing care. Risk factors for mental illness in the target area.
Policy and legislation	Political support. Mental health policy and plans. Mental health legislation.
Human resources	Personnel at different grades and locations • availability for programme/costs.
Health system infrastructure	Administrative structures for health. Services providing mental health care • at different levels of system. • public and private, NGO. • in specialist and general health care.
Health information system	Indicators that should be collected by services for health system, and to measure expected impact.
Community	Local beliefs about mental illness • cause, treatment and stigma. • community and family support. • discrimination and abuse. Traditional care availability and its use.
Other sectors	Availability of welfare, livelihood support, special education, access to rights, justice system.
Key stakeholders	Health system leaders, mental health professionals, potential service users, community and traditional leaders

There may be a variety of organizations in a community with a role to play in mental health. These include government services, CSOs, disabled persons' organizations (DPOs), advocacy organizations, and groups working in other sectors, e.g. education. All these stakeholders should be involved in the analysis and planning. This brings a greater understanding of the situation, but it also helps them to contribute and to own the change process. Full participation also allows co-ordination of efforts and avoids confusion and duplication.

We therefore need to set up a steering group or action team that represents a wide variety of people. This gives greater buy-in and makes integration of the programme activities into the wider system more likely.

Plan with all groups involved

The situation analysis is likely to highlight a wide range of needs, and we will need to decide on priorities, bearing in mind the available people and resources. It is also helpful carefully to consider barriers that may make it harder to implement our plans, i.e. perform a risk analysis. Having done this, a programme of activities can be developed to address these priorities.

We should include the following:

- Understanding what services need to be delivered at each level of a health system, e.g. community, health post, referral centre, and evaluating tasks that each member of the team might be able to do. See Chapter 1 on the important topic of task shifting.
- Preventing mental illness and promoting good mental health are always top objectives.

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- ↳ Using local resources and partnerships to increase our impact and efficiency.
- Integrating mental health into wider health and social care as far as possible. This means avoiding a separate, vertical programme (or silo) that suggests mental health is in some way unique, which can reinforce stigma.

Plans must be realistic, practical, and need to include funding, human resources, management, supervision, and monitoring and evaluation (M&E).[12] Plans need to be structured in a clear way with timelines, clear allocation of duties, and the people responsible for those duties named. Having these practical details in place makes it easier to keep the whole programme accountable. If a plan is agreed by all partners in advance, it is more likely to succeed. Getting support from as many stakeholders as possible at this stage is likely to reap rewards during the implementation phase.

Implement the programme

Implementation will need competent staff and good leadership. We may need to enhance skills, provide leadership, coaching, and learn from good practice elsewhere. We need to ensure there is continuing professional development and build the capacity of the whole team. Ideally, this would also involve staff in services outside the programme, e.g. PHC nurses and doctors who might be the first point of contact for patients, social workers, etc. Also, we must not forget pathways to care, e.g. traditional healers and religious leaders.

Good guidelines for implementation and training materials now exist for different grades of worker, e.g. under the WHO's excellent mhGAP programme (see 'Further reading and resources').

There are three other issues we need to prioritize:

1. Sustainability.

This is a key issue from the start. We need to integrate CMH care into existing structures as much as possible. Although we may have a strong team running the programme, management structures for mental health at national and district levels are often very weak and require support and encouragement in order to back up local services. This requires communities and teams to lobby policy makers and others to include mental, neurological, and substance use disorders into health systems.

2. Vulnerable groups.

We must pay special attention to any group that has higher mental health needs, e.g. single women head of households, women after delivery, socially excluded groups, and as capacity allows, migrants, displaced persons, and prisoners. This can be done by deliberately looking for them and seeking to understand their specific needs. Sometimes we will discover them when we are doing our initial survey, or they may come to light when CHWs become more involved in the community. We should consider partnering with others who have particular skills, e.g. in child and maternal health, chronic diseases, HIV, neglected tropical diseases (NTDs), services for older people, and prisoners. Other chapters in this book give more information on these groups.

3. Advocacy.

People who have experienced mental illness can become powerful advocates for change, especially when working as part of a team (for a similar approach advised by programmes working with HIV, see Chapter 20). Our health programme must foster a strong voice for advocacy by empowering service user organizations. We also need to follow human and civil rights approaches and help people claim the services and benefits that should be provided by government (see Box 24.5).

Monitoring and evaluation (M&E)

Any health programme requires regular oversight and adaptation to make it work well. Routine and systematic monitoring of a programme is essential to keep activities aligned to its original objectives. Periodic evaluation, taking into account information that has been routinely collected, allows for assessment of progress and responding to any problems identified. Such M&E is also used to keep programmes and services accountable to those who are funding work. An important addition to this is giving a voice to those who are using services, and taking their feedback seriously.

The process of M&E of programmes should begin during the initial design of the programme, so that its expected impact is clear, and can be used as a guide for M&E.

Examples of useful information to measure are:

- Basic service use statistics.

Numbers of men, women, boys, and girls who use the service, e.g. every month, plus a list of their diagnoses. Providing this information to government health authorities allows them to measure coverage of mental health services and shows the importance of the programme.

- Service quality.

Whether the staff are delivering the care in a way that helps patients to get better. This can be done by observation, checking knowledge gained after training, and by asking patients if they are satisfied with their care. This can be made 'semi-quantitative' by them numbering questions from 1 to 5, 5 being the best.

- Resource availability.

Whether all the key resources are in place, e.g. if medication is available, whether the right staff are in place all the time, and whether quiet and confidential rooms are available to see patients.

- Mental health outcomes.

There are useful questionnaire tools that can be used to identify people with mental illness, e.g. SRQ 20, PHQ9, GHQ12 (see http://researchonline.lshtm.ac.uk/7829/), and to measure the extent of disability, e.g.

WHO DAS 2.0 (see http://www.who.int/classifications/icf/more_whodas/en/).

Using specific and validated tools is important to measure outcomes and impacts of programmes.

Not only will M&E help focus on providing for the needs identified in the community, but it will also allow lessons learned to guide others, as work in this neglected area of health and development is scaled up elsewhere.

Further reading and resources

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