Case Study Methodology to Monitor & Evaluate Community Mental Health Programs in Low-Income Countries

Case Studies Project
London School of Hygiene & Tropical Medicine

Alex Cohen[1]
Julian Eaton[2]
Birgit Radtke[2]
Victoria De Menil[3]
Sudipto Chatterjee[4]
Mary De Silva[1]
Vikram Patel[1]

May 2012

1. Introduction

1.1. *The Lancet* series on Global Mental Health,[1-6] the *PLoS Medicine* series on Packages of Care,[7-13] and the publication of the mhGAP Intervention Guide[14] provide substantial evidence of the effectiveness of pharmacological and psychosocial interventions for mental, neurological, and substance abuse disorders in routine health care settings in low- and middle-income countries. However, this evidence generally comes from research whose findings are not readily translated into clinical practice.[15-17] At the same time, there is a distinct lack of evidence on how effective treatments can be delivered in routine community or primary care settings in low-resource contexts.[18,19] Documenting and evaluating strategies that have been employed to implement mental health services – typically those that rely on non-specialist health workers or lay persons – is an essential task for the field of Global Mental Health.[20] Case studies (**see 1.2**) are particularly appropriate for undertaking this task in LMIC because they: a) can be conducted in community mental health programs that are already in place and where conducting clinical trials is not feasible, ethical or affordable; and, b) do not require extensive resources or large amounts of funding.

1.2. **Definition:** A case study is a detailed narrative account of a current phenomenon of interest. It can be about individuals, institutions, events, or processes.[21,22] The case study is distinguished from other research approaches in two ways. First, the case study methodology examines phenomena as they occur or exist in real-life contexts. Rather than attempting to isolate and then measure the effects of an independent variable on an outcome of interest – as is done in randomised controlled trials – a case study attempts to understand how and why the 'messiness' of local worlds bring about outcomes of interest.[23] Second, case studies rely on multiple sources of qualitative and quantitative evidence, e.g.,

[1] London School of Hygiene & Tropical Medicine
[2] CBM International
[3] Department of Social Policy, London School of Economics
[4] Sangath, Goa, India

surveys, interviews, document review, observation, and data extraction from records.[22] These multiple sources allow one to triangulate the evidence as one tries to gain an in-depth understanding of the phenomenon under investigation. In sum, a case study provides much more detailed information than other methods and makes it possible to offer a comprehensive account, using different perspectives, of a phenomenon by capturing what happened to bring it about. It also provides an opportunity to highlight, for example, a project's success, or to bring attention to a particular challenge or difficulty.

1.3. When is a case study appropriate? Case studies are appropriate for health programs that are already in place and where conducting clinical trials is not feasible, ethical or affordable. It can be a particularly useful technique for evaluating programmes with a broad reach of activities, including social and development activities, the outcomes of which escape some of the standard formal measurements used in healthcare evaluation. The method has enormous significance for public health because of the difficulty in translating research findings into clinical practice in routine settings.[15,16]

1.4. What is the goal of a case study? Conducting a case study is one method of investigating how a package of care has been implemented, to what extent it has met its stated goals, and why it has been either successful or unsuccessful. Such knowledge is essential when attempting to improve or reform existing services or to scale up services to a large population.

1.5. Case studies can be used to:

- delineate the models and strategies employed by programs;
- describe resource utilization;
- evaluate effectiveness;
- guide quality improvement;
- identify program strengths and weaknesses;
- identify questions in need of further investigation.

Thus, case studies should also be considered repositories of knowledge and experience that may be utilized to understand how community mental health programs in LMIC manage to function despite a wide range of challenges.[2,4] As such, a collection of case studies is a knowledge base that offers lessons of experiences in diverse settings and which may be used to guide development, quality improvement, or expansion of mental health services.

1.6. Limitations of Case Studies: The strengths of case studies have been described in terms of their real-world application; however these strengths come at the expense of certain limitations. A case study will not definitively answer why a program is or is not working, since causal attribution would require more structured scientific methods. The case study is hypothesis generating, however, and can give important lines of inquiry for investigation into questions of cause. In addition, case studies are limited by the data collection standards of the program under examination. If a program is measuring only process indicators rather than outcome indicators, then the case study will not be able to report conclusively on the treatment effectiveness of a given program.

1.7. **The Case Studies Project at London School of Hygiene and Tropical Medicine** was established in October 2008 with the goal of developing a methodology that would provide a process for the systematic documentation, evaluation, and comparison of community mental health programs in low- and middle-income countries (LMIC). To achieve this we have undertaken the following activities:

- Developed a set of topics that provide qualitative information about the histories of programs, the contexts in which they function, the strategies they follow to provide services within the constraints of limited resources, and the interventions offered;
- Identified of a set of indicators of program-level effectiveness, e.g., accessibility of services, human resources, medication supplies, financial management, case-finding strategies, establishment of referral networks, use of protocols and guidelines, medication supplies, organization of Self-Help Groups and Livelihood Programs, and functioning information systems;
- Conducted site visits to mental health programs in Nigeria, Ghana, Timor Leste, the Philippines, and India to pilot the methodology;
- Developed and, currently, piloting a routine data collection tool and database that will serve as a monitoring and evaluation system, and which will comprise an essential component of the case study methodology.

2. What to evaluate?

2.1. Our field experiences and piloting of the methodology have suggested that the following domains are of particular importance when conducting a case study to assess the effectiveness of programs. These domains, or the specific topics within them, should not be considered definitive. We expect that as the methodology is used, others will suggest changes or provide adaptations tailored for particular settings or programs.

When collecting this information, it is important to bear in mind the underlying questions: Is this program working? If so, why? And if not, why not? Which components are and are not working and why? Thus, when asking, for example, about the historical context in which the programme came into being, underlying those questions is a desire to explore how sustainable the program is likely to be, or whether there may be aspects in the leadership and management structure of the program that are influencing its effectiveness.

2.1.1. Domains of interest[3]:

2.1.2. <u>Context</u>

Domain 1 – Environment in which the program functions: Physical, sociocultural, socioeconomic and political environments

Domain 2 – Health system in which the program functions: Present general and mental health services, as well as alternative sources of care, available in catchment area

2.1.3. <u>History</u>

[3] A domain about client and family perceptions of services has not been included. Though these are essential issues, it is a domain that is not easily assessed. A reliable and valid assessment would require a separate research project that would, for example, require interviewing and/or surveying a representative sample of past and present clients, making certain to include clients with a range of disorders, as well as those who were adherent and non-adherent/did not maintain contact with the service.

Domain 3 – History of the program: The "when, where, why, what, who, and how" the program was established

2.1.4. Program model

Domain 4 – Program conceptual framework: Orientation of services and attitudes about evidence-based practice and evaluation

Domain 5 – Engagement with broader systems: Work in the political and international spheres

2.1.5. Program organization

Domain 6 – Program resources: Human, transportation, funding, other

Domain 7 – Program management: Organizational structure, finances, safety; plans for improvement and/or scaling up?

2.1.6. Client populations

Domain 8 – Client characteristics: Diagnostic categories, sociodemographics, treatment coverage

Domain 9 – Pathways to care: Patterns of help-seeking, case-finding, referral networks

2.1.7. Interventions

Domain 10 – Clinical interventions: Diagnosis, treatments offered, operational processes, protocols & guidelines, outcomes, methods of evaluation.

Domain 11 – Medications

Domain 12 – Psychosocial interventions: Interventions, prevention & promotion, protocols & guidelines, outcomes, methods of evaluation

Domain 12a – Self-help groups & livelihood programs

Domain 13 – Accessibility of services: location, provision of transportation, affordable fees, service hours, in-home services

2.1.8. Information system

Domain 14 – Information system: Relative availability of statistics on number of active clients, their clinical and social characteristics, their use of services, and clinical and functional outcomes.

3. Data Collection

Depending on the resources that are available for the case study, some or all of the methods discussed below may be used to collect information on the domains.

3.1. Semi-structured interviews

Much of the information that is required for the case study will be collected from semi-structured interviews with program administrators, staff, and, if possible, clients. The structure of the interviews should be guided by the domains, but not strictly. For example, some staff may not know the history of the program but can provide detailed information about clinical interventions. Other staff may be involved in the administration of Livelihood programs (e.g., management of loans) but may not be able to provide information about what Self-Help Groups do during their meetings or the collective activities that the group may be pursuing.

Group interviews, e.g., with members of Self-Help Groups or clients, can be a valuable and efficient way to collect information about specific services offered by the program.

If possible, it is preferable to collect information on the same topic from multiple people. In this way, the researcher may validate the information, obtain different perspectives about a topic, and fill in gaps where details are lacking.

Whenever possible, interviews should be audio-recorded and then later transcribed.

3.2. Participant observation

The term "participant observation" is usually defined by anthropologists as long-term fieldwork in which a researcher immerses him/herself in a sociocultural setting and attempts to understand it from the perspective of the people who live in it – the so-called "native's point of view."[24] The term is used here to refer to short-term field work in which the researcher visits and observes the program in operation. This may include observation of clinical encounters, accompanying staff on visits to the homes of clients, sitting in on training sessions, and attending meetings of Self-Help Groups. In addition to observation, the researcher will have conversations with staff, clients, and families. Whenever possible, these conversations should be audio-recorded, although field conditions will, inevitably, constrict the extent to which this is possible. The researcher documents all of these activities by recording fieldnotes about everything seen and heard, as well as his/her personal reactions to the field experiences. As soon as it is possible, fieldnotes should be converted into the narrative accounts of the site visit.

3.3. Document reviews

Researchers should collect as many documents about the program as possible, as these are one of the main sources of quantitative data in the case study. Some programs may have published their work in journals. Documents may be obtained from the funder of the program or the program itself (e.g., annual reviews or thematic publications). Often, NGOs that operate programs will post information on the internet, although this is not always up to date or time-bound.

Bibliographic information about all of the documents should be entered into a bibliographic software database. If only hardcopies of the documents are available, the researchers should enter notes into the database. If the documents are in electronic form, the researcher should convert the documents into text files so that they can be included easily into the qualitative data analysis (see below).

3.4. Photographic images

Photographs are a powerful method of conveying the realities of the setting in which programs function, the clients and families who receive services, and the staff who deliver those services. At the same time, photographs can violate confidentiality if taken without permission. Therefore, researchers should make an effort to use photographs as documentation for case studies but only when the subjects give permission for their photographs to be taken.

3.5. Collation of routine statistics

If the program has a functioning information system or client files that are well-ordered and well-kept, the researcher should spend time collating the information. Statistics on the sociodemographics and clinical characteristics of clients, the interventions each of them is receiving, and how often each client is accessing services and treatments are essential to gaining a sense of whether a program is effective.

3.6. Before-after evaluation of client cohorts

Although documentation of processes and evidence from routine statistics are useful in the evaluation of programs, neither type of information can substitute for the evaluation of clinical, social, and functional outcomes of clients.[25] Therefore, and if the necessary funds and human resources are available, a simple before and after evaluation of client cohorts is a feasible method of assessing the effectiveness of a program to implement interventions that bring about improvements in the clinical, social, and functional statuses of clients. IN brief, this kind of evaluation would assess all new clients in a given period of time and then reassess each client at specific intervals after enrollment. For example, after enrolling a client, he/she would be assessed six months later and then again 12 months after enrollment. After all clients completed a year of treatment, the data collected during the assessments would be analysed to determine whether, on average, the clinical, social, and functional statuses of clients had improved.

4. Analysis

The qualitative data obtained from interviews and participant observation, assuming it is in word processing software files, can be analysed using any of the qualitative data analysis software packages that are now available. The domains of interest should serve as the basic framework for the analysis. If most of the documentary evidence is in computer files this, too, can be analysed in the same way.

Computers and computer software are not necessary to conduct the analyses. If hard copies of interview transcripts, narrative accounts of participant observation and other documents are all that is available, one can insert domain numbers in the margins next to relevant information. For example, if a document contains one or more paragraphs about the health system in which the program operates, the researcher can write **2.1** next to the information about the system in general, **2.2** next to information about other mental health services, and **2.3** next to information about alternative sources of care. After dong this, the task of collating information about each of the domains should be fairly straightforward.

Whatever method is used to analyse the qualitative data the goals are to: 1) collate the information about each of the domains; and, 2) inform the **synthesis** (see **4.1**). The second goal will be achieved, at least in part, through the identification of themes that recur within and across domains, key events that have shaped the program, and strategies that have been utilised to meet challenges.

The analysis of quantitative data will depend on the quality and extent of the data collected. Typically, it will be used for descriptive purposes, so simple analysis of frequencies and cross-tabulations will suffice.

4.1. Synthesis

After all the evidence has been organised and information about each domain supplied in the **Domain Tables**, the researcher should creating a **Timeline** of key events and **Major Achievements** of the programme. In addition, the research should conclude a **SWOT Analysis**, that is, statements about the **strengths** and **weaknesses** of the program, the **opportunities** that exist for improvement and/or expansion, **threats** to the program, the **lessons** offered by the experiences of the program, and topics in need of **more focused research**.

5. Ethics

The informants – program staff, clients, and families – must be assured that the information provided to the researcher will be used without their identities being revealed. Therefore, before the case study is initiated, the persons and organizations undertaking the study should apply for ethical approval from a qualified Institutional Review Board.

6. Options for conducting the case study

6.1. External evaluator

In this option, the case study is conducted by an evaluator who is not associated with the program under consideration. The evaluator might be from an academic institution, an intergovernmental agency (e.g., the World Health Organization), or an independent non-governmental organization.

The primary benefit of having an external evaluator conduct the case study is that it minimises the risk of bias, i.e. an independent observer will not necessarily have a self-interest in depicting the program in the best possible light, and therefore, will be less prone to overestimating its strengths and underestimating its weaknesses. This is of utmost importance. The case study must be a candid account of how a program functions, and the evaluator must avoid the temptation to overlook difficulties and challenges. Honest accounts of successes and failures both offer lessons about how to develop and operate community mental health programs, whereas artificial accounts of success prevents the possibility of learning from experience and may result in the continued use of ineffective strategies.[26]

A second potential benefit is that an external evaluator, especially one with extensive knowledge of community mental health programs in LMIC, will have a basis for comparing the program to the accomplishments or short-comings of programs in other settings. Because of this comparative perspective, an external evaluator is in a position to recognize that a program is not utilizing, for example, the best possible methods for staff training, case-finding, or obtaining consistent supplies of quality medications. Furthermore, the comparative perspective enables the external evaluator to make recommendations that are based on what has been achieved by other community mental health programs in LMIC.

There are, however, two limitations of utilizing an external evaluator. First, it is expensive. The evaluator must be paid for the time it takes to carry out the case study and her/his travel expenses for site visits must also be covered. Second, it is likely that an external evaluator will be given a limited amount time to conduct the study and, thus, there is the risk of information bias, i.e., only getting “part of the picture.”

6.2. Internal evaluator

It is also possible to have an internal evaluator, e.g., a program administrator or clinical director, undertake the collection of the information that forms the basis of the case study. In this case, the collection of information would probably best be done by simply filling out the dorms for each of the domains. The primary advantage of is that this strategy is less expensive. It would also be possible for a funding agency to ask multiple programs to undertake case studies at the same time.

There are at least four limitations to this approach. First, it is far more prone to bias, especially in regard to collecting information about less effective or weaker aspects of a program. Second, it will be difficult for program staff to be open and honest in expressing their opinions when being interviewed by an administrator. Third, program administrators may not have access to or experience in using the resources necessary for providing

information on, for example, the history of the program. Fourth, program administrators may not have experience with community mental health programs and, thus, may have difficulty posing the questions suggested by the protocol.

6.3. Representatives of funding agencies

A third approach would be to use the methodology to guide the collection and organization of information when members of donor organizations conduct site visits to community mental health programs that are potential or current recipients of funding. This is a reasonable option as long as those who conduct the site visits and collect the information are able to remain objective even though the organization for which they work has invested time, effort, and money into the programs under consideration. The risk of taking this approach is that an evaluator who is not independent of the funding organization might be reluctant to inform her/his employer that its funds have not been used well.

6.4. External supervision

The potential biases of the approaches outlined in **6.2** and **6.3** could be reduced if the collection of information was supervised at a distance (via the internet) by someone from an independent organization. Supervision also has the advantage of ensuring the consistency of information across multiple sites. An external supervisor might also be given the task of working with program administrators or members of the donor organizations to write narrative accounts about the programs.

7. Procedures: external evaluator

7.1. Preparatory phase

A. Contact program director and discuss the goals of the case study
    i. Send copy of domain forms
B. Obtain ethical approval for the study
C. Obtain and review documents about the program:
    i. From the program
    ii. From the donor
    iii. From the internet
    iv. From published literature
D. Consult with program director (or representative) to set dates for the site visit and to make a work plan, which should include:
    i. Interviews with administrators and staff from each aspect of the program
    ii. Field visits to sites where services are delivered
    iii. Observations of interventions
        a) Clinical encounters
        b) Psychosocial activities
    iv. Review of client records and information system

7.2. Site visits

We recommend that a minimum of two site visits be made to a program, ideally at least a month apart in time, so as to better ensure that what is being observed is representative of the program's operation.

A. Follow the itinerary as closely as possible
    i. Expect that the schedule will change
B. If possible, audio-record interviews
C. Photograph the settings in which program functions
D. Photograph staff, clients, and families
    i. But only if they give permission
E. While in the field, take notes about observations, program staff and clients, and the settings in which the program functions.
    i. As soon as possible, convert notes into narrative accounts of the experiences
F. Obtain copies of whatever documentary evidence is available, e.g., annual reports, manuals, pamphlets, posters, etc. These documents will be useful in collecting information about the 14 domains that we identify above.

    Particular attention should be given to the collection of information about the 10 indicators of program effectiveness that we identify below. Information should be collected about the inputs, processes, and outputs that are associated with each.

7.3. Analysis

A. Transcribe or take notes about audio-recordings of interviews.
B. Use software for qualitative data analysis to organize the information contained in the narrative account of the site visit, interviews, and the documentary evidence. Use domains and indicators from the protocol (see below) to guide analysis
C. Remain in contact with program administrators and/or staff so that it is possible to obtain information that is still needed

7.4. Report

A. When the analysis is complete, it will be possible to write a narrative account of the entire program or of specific aspects.
B. The report can be organized according to the domains and indicators of the protocol. In addition, one section of the report should be devoted to general impressions of the apparent strengths and weaknesses of the program. Another section might be devoted to suggestions for further investigation.

8. Procedures: internal evaluator

As noted above, an internal evaluator may be designated to collect the information that forms the basis of the case study. In turn, the administrator may appoint a staff member to help with the process. Collection of the information need not follow any specific procedure other than providing, as completely as possible, information on the domains. Collection of information should follow the guides provided below. The forms in the Appendix may be used to organize the information.

9. Procedures: member of the donor organization

If a member of the donor organization is conducting the case study, she/he can follow the procedures for an external evaluator.

10. Procedures: conducted under the supervision of someone from an independent organization

In this procedure, an internal evaluator or a member of the donor organization would collect information as described above and then send it to the supervisor from the independent organization. The supervisor would review the information and then respond, if necessary, with questions about missing information or about information that does, at least at face value, seem correct. The supervisor could also take on the responsibility of locating information in resources that are not available to the internal evaluator or the member of the donor organization. The supervisor might also take on the roles of analyzing any information that is not in tabular form and/or co-authoring narrative accounts of programs.

11. A final note

The following pages describe the 15 domains that provide a framework for the systematic collection of information about community mental health programs in LMIC. The information collected should constitute the foci for case studies of these programs, as well as making it possible to examine the effectiveness and sustainability of service delivery models or the strategies by which a program has been able to weather periodic challenges. The framework will allow for comparisons of service delivery models in a diversity of settings.

At first glance, filling in the forms can appear to be an overwhelming task, but that first impression should not prevent the process from proceeding. Obtaining complete information on all of the domains is the ideal, but it is unlikely that this can be achieved all the time. Furthermore, not all programs provide both clinical and psychosocial interventions, or all the possible forms of psychosocial interventions, i.e., Self-Help Groups and Livelihood Programs. Last, many of the domains can be completed by one or a few short statements.

We offer the manual and the forms as a work in progress. If you have suggestions about how they could be improved please contact Alex Cohen (alex.cohen@lshtm.ac.uk).

12. Acknowledgements

CBM International provided funding for the Case Studies Project and the work that went into the development of this manual and the domain forms.

A number of individuals took part in discussions that have informed the final product: Monica Brenes, Christina George, Crick Lund, Mario Maj, Jair Mari, Helen McColl, Andrew Mohanraj, Shoba Raja, Renato Souza, and Chris Underhill.

REFERENCES

1 Prince M, Patel V, Saxena S, Maj M, Maselko J, Phillips MR, et al. No health without mental health. Lancet. 2007; 370: 859-77.

2 Saxena S, Thornicroft G, Knapp M, Whiteford H. Resources for mental health: scarcity, inequity, and inefficiency. Lancet. 2007; 370: 878-89.

3 Patel V, Araya R, Chisholm D, Chatterjee S, Cohen A, De Silva M, et al. Treatment and prevention of mental disorders in low and middle income countries. Lancet. 2007; 370: 991-1005.

4 Jacob KS, Sharan P, Mirza I, Garrido-Cumbrera M, Seedat S, Mari JJ, et al. Mental health systems in countries: where are we now? Lancet. 2007; 370: 1061-77.

5 Saraceno B, van Ommeren M, Batniji R, Cohen A, Gureje O, Mahoney J, et al. Barriers to improvement of mental health services in low-income and middle-income countries. Lancet. 2007; 370: 1164-74.

6 Lancet Global Mental Health Group. Scale up services for mental disorders: a call for action. Lancet. 2007; 370: 1241-52.

7 Patel V, Thornicroft G. Packages of Care for Mental, Neurological, and Substance Use Disorders in Low- and Middle-Income Countries. PLoS Med. 2009; 6: e1000160.

8 Patel V, Simon G, Chowdhary N, Kaaya S, Araya R. Packages of Care for Depression in Low- and Middle-Income Countries. PLoS Med. 2009; 6: e1000159.

9 Mbuba CK, Newton CR. Packages of Care for Epilepsy in Low- and Middle-Income Countries. PLoS Med. 2009; 6: e1000162.

10 Mari JdJ, Razzouk D, Thara R, Eaton J, Thornicroft G. Packages of Care for Schizophrenia in Low- and Middle-Income Countries. PLoS Med. 2009; 6: e1000165.

11 Benegal V, Chand PK, Obot IS. Packages of Care for Alcohol Use Disorders in Low- And Middle-Income Countries. PLoS Med. 2009; 6: e1000170.

12 Prince MJ, Acosta D, Castro-Costa E, Jackson J, Shaji KS. Packages of Care for Dementia in Low- and Middle-Income Countries. PLoS Med. 2009; 6: e1000176.

13 Flisher AJ, Sorsdahl K, Hatherill S, Chehil S. Packages of Care for Attention-Deficit Hyperactivity Disorder in Low- and Middle-Income Countries. PLoS Med. 2010; 7: e1000235.

14 WHO. mhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized health settings: mental health Gap Action Programme (mhGAP). Geneva: World Health Organization; 2010.

15 Sussman S, Valente TW, Rohrbach LA, Skara S, Pentz MA. Translation in the health professions: converting science into action. Eval Health Prof. 2006; 29: 7-32.

16 Madon T, Hofman KJ, Kupfer L, Glass RI. Public health: Implementation science. Science. 2007; 318: 1728-9.

17 Tansella M, Thornicroft G. Implementation science: understanding the translation of evidence into practice. Br J Psychiatry. 2009; 195: 283-5.

18 Patel V, Araya R, Chatterjee S, Chisholm D, Cohen A, De Silva M, et al. Treatment and prevention of mental disorders in low-income and middle-income countries. Lancet. 2007; 370: 991-1005.

19 Cohen A. The effectiveness of mental health services in primary care: The view from the developing world. Geneva, Switzerland: World Health Organization; 2001.

20 Patel V, Prince M. Global mental health: a new global health field comes of age. JAMA. 2010; 303: 1976-7.

21 Yin RK. Case Study Research: Design and methods. Fourth ed: Sage Publications, Inc; 2009.

22 Neale P, Thapa S, Boyce C, editors. Preparing a case study: Guide for designing and conducting a case study for evaluation input. Watertown, MA: Pathfinder International; 2006.

23 Cohen A. Anthropological research for mental health service development in underserviced areas. WHO Meeting on Research for Change; 2002 December 3-6; Cape Town, South Africa; 2002.

24 Geertz C. "From the Native's Point of View": On the Nature of Anthropological Understanding. Bulletin of the American Academy of Arts and Sciences. 1974; 28: 26-45.

25 Craig P, Dieppe P, Macintyre S, Michie S, Nazareth I, Petticrew M. Developing and evaluating complex interventions: the new Medical Research Council guidance. BMJ. 2008; 337: a1655.

26 Das V. Public good, ethics, and everyday life: beyond the boundaries of bioethics. Daedalus. 1999; 128: 99-134.

ABBREVIATIONS

APSRP – Asia Psychosocial Rehabilitation Program

CMD – Common Mental Disorder

HFRCMH – Holy Face Rehabilitation Center for Mental Health

LMHW – Lay Mental Health Worker

NGO – Non-Governmental Organization

SfPWD – Services for People With Disabilities

SHG – Self-Help Group

SMD – Severe Mental Disorder

Domain 1: ENVIRONMENT IN WHICH THE PROGRAM FUNCTIONS

		Examples	Source Material
1.1	**Location**	• City / District / Province / State / Country	
1.2	**Physical setting**	• Estimate the size (km^2 or sq mi) of the catchment area. Estimate, too, the size of the population in the program's catchment area. These can often be found in government documents posted on internet websites. Program staff may be able to supply this information, but, when possible, it should be corroborated by other sources. • Often, there is a discrepancy between the official catchment area of a program and the area actually served. If possible, indicate the communities in which most of the clients reside, and estimate the populations of those communities. • It would be worthwhile to describe the geography – natural and manmade – of the area, especially if it has direct consequences on how the program functions, e.g., Is the area prone to natural disasters? Are communities dispersed across a large area?	• Government documents posted on the internet • United Nations documents posted on the internet • Interviews with staff and direct observation
1.3	**Sociocultural attitudes**	• What are local sociocultural attitudes about and behaviors toward persons with mental illness? o Is there overt evidence of stigma and discrimination? Describe o Are practices such as chaining, caging, and other forms of abuse common? Describe • A comprehensive account of this topic could, by itself, be the focus of a large research project. For the purposes of the case study, gathering information from program staff will probably be sufficient.	• Interviews with staff and administrators • Documentary evidence, e.g., reports, journal articles, program or donor websites
1.4	**Socioeconomic measures**	• General impressions of the socioeconomic status of the environment can be obtained by observation (housing infrastructure, quality of the roads, etc.) and interviewing program staff. Socioeconomic data may be obtained from documents from the United Nations or National Governments. For example, the United Nations Development Programme provides a wealth of country-level data on its website (http://www.undp.org/). Local-level data may be found in government reports that have been posted on the internet. For example, the Human Development Network has published national and provincial development data for the Philippines (http://hdn.org.ph/2009/05/21/20082009-philippine-human-development-report-2/)	• Government documents posted on the internet • United Nations documents posted on the internet • World Bank documents posted on the internet • Interviews with staff and direct observation

		Examples	Source Material
1.5	**Political environment**	• This is a topic that could, by itself, be the focus of a large study. For the purposes of the case study, attention should be given only to those political factors that are of direct relevance to the lives of persons with mental illness. For example, information about national mental health policies may be relevant. Most often, however, funding of public health systems, in general, and mental health systems, in particular, will be of most relevance. Information about funding could also be included below, in the section "Health systems in which the program functions." • Does the country have a national mental health legislation, policy, or plan? When were these established? • State of human rights – indicate whether there has been any change since the establishment of the program (see **3.1**). • Are people with mental disorders subject to human rights violations, e.g., chaining, imprisonment for no reason other than being mentally ill, intolerable conditions in psychiatric facilities, abuse by biomedical practitioners or traditional/spiritual healers?	• WHO Project Atlas: Resources for Mental Health (http://www.who.int/mental_health/evidence/atlas/en/) • Assessment Instrument for Mental Health Systems (WHO-AIMS) (http://www.who.int/mental_health/evidence/WHO-AIMS/en/index.html • Journal articles

Domain 2: HEALTH SYSTEM IN WHICH THE PROGRAM FUNCTIONS

		Examples	Source Material
2.1	**General health services**	• Describe the general health system. o Is there a functioning public primary care system? o Are there secondary and tertiary facilities? o Do poor people have access to care, especially maternal and child health services?	• Interviews with staff and administrators • Documentary evidence, especially journal articles
2.2	**Mental health services**	• Describe the mental health services, if any, in the area. o Are there are psychiatric inpatient facilities in or near the program catchment area? If yes, what are the conditions in those facilities? o How many mental health professionals are in the area? How many work in the public sector? In the private sector? o Are psychotropic medications readily available and being used in primary care clinics?	National data: • WHO Project Atlas: Resources for Mental Health (http://www.who.int/mental_health/evidence/atlas/en/) • Assessment Instrument for Mental Health Systems (WHO-AIMS) (http://www.who.int/mental_health/evidence/WHO-AIMS/en/index.html Local data: • Interviews with staff and administrators
2.3	**Alternative sources of healthcare**	The presence of traditional and/or spiritual healers will often have significant consequences for a mental health program. o Do families frequently bring members who are ill with epilepsy or psychosis to healers before seeking the services of the program? o Do families and/or clients discontinue program services in favor of alternative sources of care? o What consequences do these actions have for those who are ill? o Does the program have a policy about working with alternative healers?	• Interviews with staff and administrators • Documentary evidence may be available • The best sources of information are interviews with clients, families, and healers but carrying out the interviews is probably more feasible as a funded research project.
2.4	**Basic health data**	• Collect data on such basic health measures as: o Infant mortality o Maternal mortality o Average life expectancy	• Government documents posted on the internet • United Nations documents posted on the internet • World Bank documents posted on the internet

Domain 3: HISTORY

			Examples	Source Material
3.1	**When was program established?**	• The year in which the program was established	The year the program started to function. Include information and timeline if there was a significant period of activity prior to the establishment of the program.	• Interviews with current and/or former staff and administrators • Documentary evidence, e.g., reports, journal articles, program or donor websites
		• The state of local and national mental health services at the time.[4] o What mental health services were available? Biomedical, psychosocial, or both?	Provide only a brief description. It is more important to provide detailed information about the current state of mental health services (see **2.2**).	
		• State of human rights in the country at the time.[5] o Did people with mental disorders have full rights as citizens? o Were people with mental disorders subject to human rights violations? o What was the legal position of torture survivors or other relevant groups? Was it possible for torture survivors to seek treatment without risking arrest? • Did the country have national mental health legislation, policy, or plan at the time? When were these established?[6]	Before Italy enacted new mental health legislation in the 1970s, patients in psychiatric hospitals were not eligible to vote or to receive welfare benefits. Human rights violations have been exposed as psychiatric hospitals in many regions of the world. Homeless persons with mental disorders are frequently subject to abuses, too. In many countries, people with severe mental disorders are jailed and not given proper treatment.	
3.2	**Where?**	See **Domain 1: ENVIRONMENT IN WHICH THE PROGRAM FUNCTIONS**		

[4] Include information on current local and national mental health services in Domain 2.
[5] Include information on current state of human rights in Domain 1.
[6] Include information on current state of legislation, policies, and plans in Domain 1.

			Examples	Source Material
3.3	**Why?**	• Key stimulus / defining moment for the establishment of the program • Did the program fill a gap in the existing health system?	There are many reasons why a program might be established: 1) the Indian Ocean Tsunami of 2004 prompted the establishment of mental health programs in India, Sri Lanka, and Indonesia; 2) exposure of human rights violations have resulted in reforms at a psychiatric hospitals; 3) the recognition of the burden of common mental disorders has prompted efforts to develop mental health services in primary care. Social and/or political forces often create the environments in which it is possible to establish programs: 1) the civil rights movement had an influence on deinstitutionalization and the development of community mental health programs in the United States; 2) political activism by health professionals in the anti-apartheid movement in South Africa lead to the establishment of the Trauma Centre for Survivors of Violence and Torture. Be certain to include information about formative periods of activity that preceded and influence the establishment of the program. Was the program intended to provide mental health services where none existed or for specific mental health services for unserved groups, e.g., such as persons with psychosis or victims of trauma?	• Interviews with current and/or former staff and administrators • Documentary evidence, e.g., reports, journal articles, program or donor websites
3.4	**What?**	• Was the program added to or embedded within an existing program or was it established as an independent entity?	Examples of the former are mental health services that have been added to Community-based Rehabilitation programs. Was the program established to "compete" with other services? For example, was the program established to provide community care as an alternative to existing institutional or out-patient care?	• Interviews with current and/or former staff and administrators • Documentary evidence, e.g., reports, journal articles, program or

			Examples	Source Material
3.5	**Who?**	• Who founded the program?	Was a charismatic leader the main driving force? • Franco Basaglia was the individual who was at the forefront of the mental health system reforms in Trieste, Italy and the radical changes in national mental health legislation. Did one or more specific organizations establish the program? • The Government of India established the District Mental Health Plan; NGOs, such as BasicNeeds and CBM have established a number of programs. What motivated the individuals or organizations to take action? • The Government of India took action because of demonstration projects that purported to provide evidence of the effectiveness of mental health services in primary care settings. • CBM established its mental health programs because of the committed advocacy of a handful of individuals who were in the organization.	donor websites
3.6	**How?**	• What was necessary to get the program up and running? • What resources were necessary? • From where and how were the resources obtained? • How long did it take?	The establishment of a program always requires human, financial, and other resources. Try to determine how many people worked on establishing the program and the size of the initial staff. Try to determine the financial resources that were required to initiate services. What other resources (buildings, autos, computers, medication) were necessary? From where and how were all these resources obtained. How long did it take to obtain the resources, to hire staff, to begin to offer services?	

Domain 4: PROGRAM CONCEPTUAL FRAMEWORK

			Examples	Source Material
4.1	**Orientation of services**	• What services does the program offer? • Biomedical treatments or psychosocial interventions, or both? • Are services geared toward individuals or families or both? • Does the program undertake activities to address the need for social inclusion or economic development of its clients? o Describe each • Changes over time in program's orientation to treatment and prevention	• Biomedical treatments or psychosocial interventions, or both? • Are services geared toward individuals or families or both? • Does the program undertake activities to address the need for social inclusion or economic development of its clients? • Does the program organize user groups and/or livelihood programs? (include descriptions below in **Domains 12 and 12a**)	• Interviews with current and/or former staff and administrators • Documentary evidence, e.g., reports, journal articles, program or donor websites
4.2	**General principles of equity**	• Do the program administration and staff consider such issues as access and acceptability?	Issues of equity, acceptability, access, and affordability are critical in assessing whether a program is meeting the needs of clients and potential clients. • Are these issues thought about and actively addressed? • Do service users and families have a voice in decisions?	• Interviews with current and/or former staff and administrators • Documentary evidence, e.g., reports, journal articles, program or donor websites
4.3	**Evaluation**	• Staff attitudes about evidence-based practice • Staff attitudes about evaluation of services	Does the program restrict itself to only using evidence-based practices? Is the program open to having its services evaluated by assessing the clinical, social, and functional outcomes of clients?	• Interviews with staff and administrators

Domain 5: ENGAGEMENT WITH BROADER SYSTEMS

			Examples	Source Material
5.1	**Does the program work at the systems level?**	• Relations with public mental health system, e.g., local health centres; local schools; local hospitals; other service providers • List and describe activities of each o What brought about these activities?	In Northern Ghana, BasicNeeds does not provide care but, instead, facilitates clients' access to care through support of community psychiatric nurses that are based at district hospitals. In the Philippines, HFRCMH trains local government health workers to recognize and refer persons with mental disorders. In Nigeria, the NGO Amaudo advocates for government psychiatric nurses to be placed at PHC level services, and then supports them in their work with training, supervision and access to medication.	• Interviews with staff and administrators • Documentary evidence, e.g., reports, journal articles, program or donor websites

5.2	**Does the program work at the systems level?**	• Relations with public mental health system, e.g., local health centres; local schools; local hospitals; other service providers
		  o List and describe activities of each
		  o What brought about these activities?
			In Northern Ghana, BasicNeeds does not provide care but, instead, facilitates clients' access to care through support of community psychiatric nurses that are based at district hospitals.
			In the Philippines, HFRCMH trains local government health workers to recognize and refer persons with mental disorders.
			In Nigeria, the NGO Amaudo advocates for government psychiatric nurses to be placed at PHC level services, and then supports them in their work with training, supervision and access to medication.	

5.3	**Engagement with local, national, and international policy makers**	• Influence on policy or clinical practices at district, national or international levels? • To what extent has the program been a catalyst for change? • What brought about this engagement?	The Bellary District (Karnataka, India) Mental Health Program in the 1980s had and continues to have a profound influence on public mental health programs in India. Unfortunately, there is little evidence that the Bellary model delivers effective services. Franco Basaglia's work in Italy has been influential in Italy's national mental health polices and has served as a model for program development in other countries, especially in Latin America.	

Domain 6: PROGRAM RESOURCES

			Examples	Source Material
6.1	**Human**	• Number • Qualifications • Unsalaried community supporters/low-pay staff o Positive and negative experiences • How are staff treated by their superiors and administrators?	List the staff who work in the program and provide their professional and educational qualifications. In addition, describe whether the program has specific criteria for hiring staff and how those criteria were determined. For example, low-level professionals hired because the program cannot afford to pay more or because more highly qualified staff are not available? Many programs rely on unsalaried and/or low-pay staff. Provide information about whether that has been an effective strategy. For example, CBM reduced its support for field workers in Abuja, Nigeria in the expectation that the Archdiocese would make-up the difference. This has not come to pass and the field workers are demoralized. It would also be useful to collect, if possible, information about how staff salaries compare to what staff might make if they were working elsewhere. Are there specific challenges to recruiting and retaining staff? Describe. Does the program offer on-going training in clinical and psychosocial interventions? Training might be in the form of periodic reviews of procedures for recognition and management of mental disorders, regular review of the status of clients, and opportunities to participate in conferences or meetings. Training might also take place on-the-job. For example, in the APSRP, the Community Volunteers always attend the community clinics and get to observe the program psychiatrists conduct clinical interviews and provide supportive counseling to clients. One may assume that observation of clinical interviews helps Community Volunteers identify potential clients when visiting households in the catchment area. It may also improve their ability to provide clients with support during follow-up home visits. Does the program provide lay mental health workers with supervision by mental health specialists? This might take the form of regular (weekly or monthly) meetings with specialists to discuss the management of difficult cases. These meetings also provide general support to lay workers and help to prevent burn-out. Ideally, the specialists would be available for consultation in the event of an emergency. How staff are treated and does the program have reasonable expectations about work responsibilities. For example, are staff expected to stay long hours even if not being paid for the extra work? Are staff appreciated by administrators? Are staff accomplishments recognized?	• Interviews with staff and administrators • Program records

			Examples	Source Material
6.2	**Transportation**	• Do staff have access to the means of transportation that are required to deliver services to large catchment areas or remote locations?	Community programs will, almost always, require vehicles to transport staff to clinics, to conduct supervision, to make home visits, or to consult with Self-Help Groups. Therefore, transportation is a key resource because without it the functioning of the program is severely limited. Provide information on the number of vehicles (specifying type, age, and working condition); whether the vehicles are appropriate for the terrain; and whether the program has sufficient funds for maintenance and petrol. In addition, ask whether the program has enough vehicles to meet its objectives: 1) Must staff share access to the vehicles and, if yes, to what extent does this inhibit their ability to carry out work in the community? 2) When staff do not have access to vehicles, it is possible for them to carry out other essential duties? 3) Are vehicles generally in working order when needed? 4) Are the vehicles safe to drive (functional seat-belts, tires with reasonable amount of treads, spare-tire, unbroken windows)? Is the use of the vehicles closely monitored? Are the vehicles sometimes unavailable because one or more are being used by a staff member or an administrator for personal business? Must staff use their own vehicles for work? If yes, does the program reimburse them? Because of poor road conditions, asking staff to travel means putting them at risk for injury or death. The use of motor-scooters and motorcycles are particularly dangerous. Therefore, does the program insist that staff use helmets? Does the staff assess whether the use of motor-scooters and motorcycles are appropriate? For example, some staff may not feel comfortable driving such vehicles. Poor road conditions make travel by automobile a somewhat hazardous practice, too. Does the program insist on the use of seat-belts? Some programs are in settings with public transportation. Provide information about the use of public transportation by staff and clients. Provide estimates of the amount of time staff spend in transit commuting to the program and delivering services in the community.	

6.3	**Funding**	• Sources of funding
		  o Initial
		  o Current
		  o Future
		• Security of funding
		• Evidence of local support
		  o Financial
		  o In kind
			Document the sources of funding on which the program relies. If it receives local support, e.g., from municipalities, local religious institutions, indicate the form of the funding, how much is given, and the length of the commitment.
			In kind funding might be in the form of workers seconded to the program or a local government providing transportation to a clinic.
			Document, too, the security of each funding source, e.g., what is the duration of the funding and what are the chances that it will be renewed?	

			Examples	Source Material
6.4	**Other**	• What other resources does the program have?	Does the program own buildings or other property? For example, HFRCMH is located on 10 acres of land that was once the site of a coconut plantation. There are several buildings on the property. Does the program have computers, printers, and access to the internet? Does the program give staff mobile phones or must staff use their own? Does the program reimburse staff for phone expenses? Anything else?	

Domain 7: PROGRAM MANAGEMENT

			Examples	Source Material
7.1	**Organizational structure**	• Who manages day-to-day operations? • Is there an executive body that has ultimate authority for decision-making processes?	A simple organizational chart that indicates how the program is administered the relationships among the various positions. It is important to include <u>all</u> positions in the organization: administrators, clinical staff, and support staff. Support staff may include drivers, clerks, janitors, cooks, etc. Document and describe significant changes in the organizational structure of the program. Frequently, these changes come about through financial crises and it is useful to know how the program has responded and whether the changes made were effective in meeting the challenge.	• Interviews with staff and administrators • Documentary evidence, e.g., reports, journal articles, program or donor websites
7.2	**Finances**[7]	• How does the program manage its finances?	Having funds does not guarantee they will be used effectively. Therefore, it is important to document how a program manages its funds. This entails at least two steps: 1) How does a program budget for its expenses? Is this done in a manner that leaves enough for essential services and does not allocate too much for less necessary expenses? 2) Does the program have accounting procedures to ensure that the funds are being used as intended? Does the accounting system allow for periodic external audits?[8] Are staff salaries always paid fully and on time, or are there periods when the program has insufficient funds to meet this obligation? To ensure sufficient funds in the future, is the program actively engaged in fund raising?	
7.3	**Safety**	• Is staff safety adequately addressed in policy and practices? • Are staff provided with health insurance or other benefits?	Some programs, especially those in post-conflict regions or those that work with survivors of violence and torture, must function in settings that are not safe because of criminal or political violence. Some programs may work in areas that are infested by disease or have recently experienced a natural disaster. In all of these cases, it is critical that programs try to protect staff safety. For example, are there rules about when staff should not travel alone? Does the program employ security guards for its offices?	
7.4	**Plans for improvement and/or scaling up?**	• Is there a set of goals and expected results? • Is there a strategy/long-term plan to achieve goals?	Has the project undergone a process of critically reviewing its services and strategically planning for the future? How has that come about? What methods have been/are employed in planning and assessment? Does the program have a Monitoring & Evaluation system in place? (see **Domain 14**)	

[7] This is not intended to be an audit of a program's finances. Rather, it is an overview of how the program manages its finances.

Domain 8: CLIENT POPULATIONS

			Examples	Source Material
8.1	**Diagnostic categories**	• Psychosis • CMDs • Epilepsy • Substance abuse	At the most basic, programs should be able to report the number of active clients in each of these categories. However, most programs do not have information or record keeping systems that make it possible to extract these statistics. In the absence of an information system, it will be necessary to rely on imprecise sources of information: 1) annual reports usually indicate the number and types of clients treated in the previous year; 2) log books of newly enrolled clients may provide information about diagnoses; 3) records of medications distributed will suggest the kinds of disorders being treated; and 4) staff impressions will provide a rough estimate of the disorders being treated.	• Information system • Client records • Interviews with staff and administrators • Documentary evidence, e.g., reports, journal articles, program or donor websites
8.2	**Sociodemographic characteristics**	• Age • Gender • Social class • Educational status • Cultural or ethnic identities • Other: o Homeless persons o Prison populations o Asylum seekers and refugee populations	Determining the sociodemographic characteristics of clients requires an information system. In the absence of such a system, it will be necessary to rely on the sources of information suggested for the determination of diagnostic categories being treated. At the very least, ask staff about the sociodemographic characteristics, asking specifically about age, gender, social class, cultural or ethnic identities, etc. Be as specific as possible: Among clients with psychosis, are there more men than women? Among clients with CMDs, are there more women than men? Does the program provide services to any specific sub-populations? Etc.	
8.3	**Changes over time in client characteristics**	• Changes in diagnostic profiles of clients or sociodemographics	A range of factors – e.g., improvements in case finding, increased resources, migration – may have consequences for the distribution and frequency of client characteristics overtime. These changes may be indications of program strengths or weaknesses.	
8.4	**Estimates of treatment gap[9] (by diagnostic category)**	• What percentage of the total number of potential clients are receiving services from the program?	Determining the extent of treatment coverage requires three pieces of information: 1) Number of clients with a specific disorder – see above. 2) Estimate for prevalence of that disorder – There are many sources of data on the epidemiology of mental disorders. However, it is not necessary to be locate data on the epidemiology of a specific disorder in a specific location. The WHO publication, *Disease Control Priorities related to Mental,*	• Available epidemiological evidence (e.g., journal articles, WHO reports and websites; Global Burden of Disease Study; World Mental

[9] Even external evaluators with access to extensive electronic resources may have difficulty locating the information necessary to complete this section.

			Examples	Source Material
			Neurological, Developmental and Substance Abuse Disorders (http://whqlibdoc.who.int/publications/2006/924156332X_eng.pdf) provides prevalence data on a range of disorders. 3) Population estimate for the catchment area of the program – It may be possible to obtain data from government documents that are available on the internet. Staff may be able to provide populations estimates, too. Once these data the following calculation: Multiply the population estimate by the expected prevalence and compare it to the number of clients with that disorder who are receiving services. For example, a program has a catchment area with a population of about 100,000 and is providing services to 100 individuals with psychosis. It is estimated that psychosis has a prevalence of 1-2% in most populations. Therefore, one can assume that 1,000 to 2,000 people with psychosis are living in the catchment area, many times more than are being followed by the program.	Health Survey) • Population estimates fro government sources of program staff

Domain 9: PATHWAYS TO CARE

			Examples	Source Material
9.1	**Patterns of help-seeking**	• Where/with whom do clients/families seek care first? • Average duration of illness prior to seeking care? • What prompts care-seeking? • Use of multiple providers?	To obtain a detailed understanding of help-seeking behaviors for mental disorders would require a separate and substantial research project and which would entail systematic sampling of individuals with a range of mental disorders and the administration of quantitative surveys and in-depth qualitative interviews with clients and families. Such a project is usually beyond the scope of more general case studies. Nevertheless, it is important to obtain a general understanding of how clients and their families seek care. Such knowledge will guide strategies for case-finding, establishing referral networks, and maintaining consistent follow-up of clients. Determine the types of care available to people in the catchment area of the program: biomedical (specialist and non-specialist; public and private), traditional and spiritual healers, other sources of care (e.g., pharmacists). Then estimate the relative frequency with which people seek care from these sources. Of most relevance to the case study is an understanding of the extent to which the program's services interact or are in competition with the alternative sources of care. Individuals and families often "shop" for care with multiple providers and it is important to understand how and why they do this. Such an understanding may be useful when trying to maintain on-going contact with clients.	• Interviews with staff and administrators • Documentary evidence, e.g., reports, journal articles, program or donor websites

			Examples	Source Material
9.2	**Pathways to care & Case-finding**	• How do clients come to receive services from the program? • Do clients present themselves to services or are they identified in the field? Or both?	There are 3 general pathways by which clients come to receive services from the program: **Case-finding:** Many programs, especially those with a CBR orientation, will ask LMHWs to conduct some form of case-finding. The effectiveness of case-finding is based, first of all, on the training given to LMHWs about conducting house-to-house surveys, interviewing strategies, and how to recognize possible cases of epilepsy, SMD, and CMD. Case-finding may also entail following up when informed about an individual living in their catchment area and in need of services. Programs should develop manuals/information sheets that contain the protocols and guidelines for these tasks. Case-finding is time consuming and, because of other work responsibilities (e.g., follow-up of existing clients or work in other areas of CBR) LMHWs may not have much time for case-finding. "Sufficient" is not an exact term. Therefore, assess whether periods of time are designated for and actually devoted to case- finding. Disorders with dramatic or frightening symptoms (e.g., seizures) or aggressive behaviors are more likely to be brought to the attention or recognized by LMHWs. Therefore, it is important that training emphasizes the need to be alert to symptoms that are less obvious but are also indicative of mental disorders that require treatment. **Outreach** activities may include awareness-raising workshops or meetings with the general public or specific groups, e.g., police, health workers, teachers, government officials. Outreach may also take the form of occasional campaigns that might include radio shows or putting up posters about mental illness. A third form of outreach might include periodic meetings with key informants, e.g., religious leaders, who are in close contact with people in the community and, as a result, may hear about individuals who are in need of mental health services. **Word of mouth:** In many programs, direct case-finding is not the greatest source of clients. Word of mouth, e.g., people who were successfully treated telling others about the service, is most important. If that is the case, is it possible to provide any details about this? For example, does the program keep records about how people come to be aware of the services being offered? Assess whether the program, using any of these techniques, is identifying cases in sub-populations, e.g., religious or ethnic minorities, homeless persons. Assess equity of services, i.e., whether all segments of the catchment area population have equal access and are receiving services. However, a precise measure of equity of services will only be possible if a program maintains an information system that can routinely generate statistics about the sociodemographic and clinical characteristics of clients. In the absence of an information system it will be necessary to rely on anecdotal evidence and whatever information is available about client populations (See **Domain 8**).	

			Examples	Source Material
9.3	**Referral networks**	• Does the program refer clients for other services they might need? • Is it possible to refer clients to other services they might need? • Do clients take advantage of the referrals?	Clients and their families will frequently be in need of a range of medical, legal, and social services. For example, women who have been sexually abused or have experienced domestic violence will require medical and protective services. Children who have experienced brain damage because of untreated epilepsy will require special education. Individuals in the throes of acute psychotic episodes may require hospitalization and specialty services. Families that cannot afford to buy medications need social services. Therefore, it is essential that CMHPs establish referral networks with, when possible: primary, secondary and tertiary health care services; alternative healers; social service agencies, NGOs, etc. For the case study, it is important to document: 1) What happens when a client is in need of a service that cannot be provided by the program? and, 2) how quickly are clients seen by those other organizations? The program should also be certain that other organizations are aware of and can make referrals to the program. For example, has the program contacted local hospitals or psychiatric facilities so that discharged patients can be followed in the community? Has the program worked with alternative healers so that they will refer individuals for biomedical care? Maintaining the referral network requires regular contact with the other organizations. Does the program make a point of doing this or is contact only in the event of a referral? To assess the efficiency of the referral network would require separate research. In the absence of that, it will be necessary to rely on impressions of staff or, better yet, review of client records to determine if referrals are being made to other organizations or if clients are coming to the program because they were referred by another organization. It is important to document the absence of a referral network, and to indicate what types of referrals are most needed.	

Domain 10: CLINICAL INTERVENTIONS

			Examples	Source Material
10.1	**Diagnosis**	• Who determines diagnosis? • According to ICD or DSM criteria? Or, broader categories?	Specify who determines the diagnosis for a new client and the criteria used to make that diagnosis.	• Interviews with current staff and administrators
10.2	**Treatments offered**	• List treatments available • Provided by whom? • Where are treatments given? • Does the program have the capacity to provide emergency treatments, e.g., to those in the midst of an acute episode?	As defined here, clinical interventions are either psychopharmacological medications or forms of psychotherapy as delivered by a mental health specialist with post-graduate training, i.e., psychiatrist, psychologist, a psychiatric nurse, social worker. List the available medications in Domain 12. List and describe where treatments are given, e.g., client homes, outpatient clinics, community clinics. Many programs are not able to provide treatment to individual in the midst of an acute psychotic episode. Indicate whether this is true of the program being investigated. Explain why the program can or cannot provide emergency treatment. Often this is due to shortage of human resource but could also involve lack of transportation or lack of training.	
10.3	**Operational processes**	• Intake • Treatment schedule • Follow-up • Attention to side-effects? • What is done about those not returning for care? o Is there a system for finding and attempting to re-engage client? • Discharge o Criteria? o Follow-up?	Describe the intake process or how new clients are enrolled once they have been identified as in need of an intervention. Describe how clients are followed over time. For example, do field workers keep track of clients in the community? Are clients only seen during routine clinics? Does the program attempt to find and re-engage clients who have not returned for services? If yes, describe these processes and attempt to assess effectiveness. Does the program have criteria for discharging or discontinuing services to a client? If yes, describe. Does the program have a policy about following-up clients who have been discharged or who are no longer receiving services?	

			Examples	Source Material
10.4	**Protocols & guidelines**	• Does the program have protocols and guidelines for its clinical interventions? • If yes, have these been borrowed or have they been developed specifically for the program?	Does the program utilize explicit strategies in the process of delivering clinical services? If yes, describe the protocols and guidelines that have been put into place. If no, are there other methods by which the quality and consistency of case-finding, diagnosis, and treatment are maintained. The recent publication of the WHO mhGAP intervention guide (http://www.who.int/mental_health/mhgap/evidence/en/index.html) provides programs with evidence-based clinical information that may be used with little or no adaptation to local settings. The CBM Implementation Guidelines (http://www.cbm.org/article/downloads/54741/C_Mental_Health_Guide_lay.pdf) is also useful. Having protocols and guidelines does not ensure that they are followed. Specialist support and supervision of staff will help to keep clinical interventions consistently evidence-based and of high-quality. Accepted clinical practices may be revised. Therefore it is important that protocols and guidelines are periodically revised. The WHO and CBM guides may be used to assess whether a program's methods, whether explicit or not, meet international standards. However, assessment of adherence to protocols and guidelines requires systematic reviews of the methods being employed for case-finding, diagnosis, and treatment. One method would be to have outside evaluators assess the methods being employed and whether, in their opinions, the methods are of high quality. Such assessments require more resources and time than are generally available for a case study. Therefore, for the purposes of a case study, it is most important to document whether the program has protocols and guidelines and the extent to which they are being implemented.	
10.5	**Methods of evaluation**	• Has the program established a process for evaluating the effectiveness of clinical intervention?	If yes, describe the process and how what is learned is put into practice. This does not refer to carrying out clinical trials or statistical analyses of client outcomes. Rather, it refers to whether programs periodical review clinical practices. This might take the form of occasional case reviews or discussions among staff or regular consultations with psychiatrists.	
10.6	**Outcomes**	• Are the clinical interventions being employed effective in improving the lives of clients?	Unless the program is regularly assessing and documenting the clinical, functional, and social statuses of clients (see Domain 15), it will not be possible to definitively evaluate clinical interventions. Anecdotal evidence should be used cautiously.	Statistics from information system

Domain 11: MEDICATIONS

			Examples	Source Material
11.1	**Purchasing policies**	• List of medications used • Are other medications available locally but are not used by program? Why? • Costs of each • Adequacy, consistency, and quality of the supply? • Does the program only prescribe medication, but does not provide it?	How does the program list of medications compare to the WHO Essential Drug List? (Sections 5 & 24: http://www.who.int/entity/selection_medicines/committees/expert/17/sixteenth_adult_list_en.pdf) Document the method by which programs determine which medications will be purchased. What criteria are used? Price? Ease of purchase? Demonstrated efficacy? Does the program have strategies for the purchasing of medications? Are purchases based on anticipated needs for the next month, three months, six months? From what sources are the medications purchased? Local manufacturers? Foreign manufacturers? Local pharmacies? What, if any, criteria are used to choose a source? Cost? Document whether the program attempts to monitor the quality of the medications being purchased. Usually, this will take the form of buying from trusted sources, but it would be useful for programs to stay alert to the possibility of medications being of poor quality. Review of medication records should indicate the overall adequacy and consistency of supply. It is important to ask staff and administrators about this because they may report problems that will not be revealed only by looking at the records. Document whether the program has implemented methods of inventory control. At its most basic this entails keeping careful records of what is being dispensed. Records should indicate whether there have been any shortfalls in supplies. These records will also serve to alert the program to theft of the medications. Programs should also have contingency plans for those times when medications are needed but are not available from the usual sources. Programs need to be certain that the medications on hand are not past the expiry date. Is there a dedicated budget line for the purchase of medications? Are funds for purchasing medications consistently available when needed? How are these funds managed? The effectiveness of medications may be significantly reduced or eliminated entirely if the medications are not stored and protected against heat, contamination, humidity, etc. Storage facilities should also be secure to protect against theft. For those programs that prescribe medications but do not supply them to clients, where do clients go to fill their medications? What are the chances that the medications in this facilities are not of good quality or are not available consistently?	• Interviews with staff and administrators • Medication purchasing records

Domain 12: PSYCHOSOCIAL INTERVENTIONS

			Examples	Source Material

12.1	**Interventions**	• Type of intervention:
		  o Individual
		  o Family/carer support
		  o SHGs
		  o Livelihood programs
		• Targeted groups
		• Provided by whom?
			List any other psychosocial interventions provided by the program. These may include supportive counseling, home-visits by LMHWs, prevention and promotion activities, advocacy, problem solving, organization of peer support, community workshops, advocacy, occupational training, etc. For each activity, provide as many details as possible.
			For SHGs and livelihood programs, see **Domain 12a**.
			Document the personnel who lead each of these activities and whether any of the interventions are targeted for specific groups of clients or potential clients. It is important to provide details about how groups are supervised.
			Attention should be given to whether the programs provide support for caregivers and efforts should be made to document the challenges faced by caregivers.
				• Interviews with staff and administrators
				• Visits and interviews with members of the groups

12.2	**Prevention & promotion**	• Does the program support and/or operate prevention and promotion activities?	• Does the program work with and support families so that mentally ill family members are not abused? • Does the program train police so that they do not necessarily use violence when dealing with a person in the throes of an acute psychotic episode? • Does the program hold community meetings or workshops in an effort to improve public attitudes toward mental illness? o Describe each • Does the program have activities regarding prevention of alcohol abuse, sexual and physical violence, and suicide prevention? • Does the program have activities addressing child and mental health? Are these activities conducted in schools? Assess the extent to which the program addresses negative social attitudes and behaviors. These could be through educational or awareness workshops in the community, advocacy campaigns, legal actions (e.g., to address human rights abuses), or trainings for government officials (e.g., police, health authorities).	
12.3	**Protocols & guidelines**	• Does the program have protocols and guidelines for its psychosocial interventions? • If yes, were these borrowed or were they developed specifically for the program?	Does the program utilize explicit strategies in the process of delivering psychosocial services? If yes, describe the protocols and guidelines that have been put into place. If no, are there other methods by which the quality and consistency of interventions are maintained. The CBM Implementation Guidelines (http://www.cbm.org/article/downloads/54741/C_Mental_Health_Guide_lay.pdf) is a useful resource in assessing protocols and guidelines.	

			Examples	Source Material
12.4	**Outcomes**	• Do the psychosocial interventions improve the lives of clients in terms of overall quality or, more specifically, socioeconomic status?	Unless the program is regularly assessing and documenting the clinical, functional, and social statuses of clients (see Domain 15), it will not be possible to definitively evaluate psychosocial interventions. Anecdotal evidence may be used cautiously. Systematic assessment of the economic outcomes of these interventions – for clients and families – requires separate research.	
12.5	**Methods of evaluation**	• Has the program established a process for evaluating the effectiveness of psychosocial interventions?	If yes, describe the process and how what is learned is put into practice. This does not refer to carrying out clinical trials or statistical analyses of client outcomes. Rather, it refers to whether programs periodical review psychosocial practices. This might take the form of occasional case reviews or discussions among staff.	

Domain 12a: SHGS & LIVELIHOOD PROGRAMS

			Examples	Source Material
12a.1	**SHGs**	• Does the program organize SHGs?	How many members? What are the criteria for membership? Does the SHG collect dues? How are the SHG finances managed? How are the funds used? What are the benefits of membership? How often do groups meet? What is done at meetings? Do the groups undertake collective activities? Describe Having established SHGs, does the program provide them with support? If yes, document the following: What does the CMHP do to remain engaged with the SHGs? Does the CMHP initiate activities in which the SHGs participate? Does the CMHP help the SHGs manage their funds?	• Interviews with staff and administrators • Visits and interviews with members of the SHGs and livelihood programs By visiting with and interviewing members of the SHGs and participants in livelihood programs, it will be possible to collect anecdotal evidence of the benefits of these activities. For example, members of SHGs in Northern Ghana reported how being in the group was associated with improved well-being for care-givers and clients alike, improved adherence to treatment, and greater patience and tolerance toward persons with mental disorders.
12a.2	**Livelihood Programs**	• Does the program operate Livelihood Programs? • What are the criteria used for granting loans? • What are rates of loan repayment? • What are the nature of occupational training and apprenticeships?	Does the program provide loans? How much are the loans? What is the interest rate? What are the criteria for applying for loans? What is the procedures for approving loans? How are the loans used? Are the loans being repaid? Does the program provide opportunities for apprenticeships? If yes, describe the types and the terms under which apprentices work. Does the program oversee the apprentice program to be certain that clients are not being exploited? Does the program provide occupational training? Does the program provide tools to clients so that they can begin a small business, e.g., dress-making, wood-working? How does the program decide who will be given tools? Some CMHPs provide loans so that clients/families can undertake economic activities, e.g., buying seed for farming, establishing a petty retail business, making and selling soap, raising livestock, buying and selling grain. Describe, in detail, eligibility for obtaining a loan, the criteria by which loans are granted, the range of loan amounts, the terms of the loans (repayment schedule and interest rates), how the loans are used, and how the program is funding the loans. In regard to funding of loans, has the program obtained a one-time grant and expects that repayments with interest will lead to increased funds, or is there another strategy for making the loan program sustainable? Some programs provide clients the opportunity to become apprentices to tailors, weavers, etc. List the apprenticeship opportunities and describe the arrangements under which clients work as apprentices. Some programs offer occupational training for clients. For example, cooking and massage classes have been offered by a program in the Philippines. Describe	

			Examples	Source Material
			why those occupations were chosen for training, and the training sessions that have been offered. Has the program established links with state or private enterprises that may support the SHGs or livelihood programs? How does the program manage its livelihood program? Does it help with financial management? What is the decision making process for the approval of loans? Does the program keep careful records of loans, repayments, and subsequent loans? Does the program have oversight of the apprenticeships? Does the program make regular visits to the work sites to assess clients' progress? Does the program actively help clients to put their occupational training to use? If yes, describe. If clients have been placed in jobs with state or private enterprises, does the program provide on-going support to help clients remain employed? Systematically assessing the effects of SHGs and livelihood programs on care-givers and families would require independent research. Ideally, CMHP would have outcome measures of clients' functional statuses, e.g., the Global Assessment of Functioning, which would make it possible to conduct more systematic assessments of whether membership in an SHG or participation in a livelihood program improves functional status. Measuring the economic effects of livelihood programs would require programs to regularly collect economic data about clients and their families. At the very least, it would require data on how many families successfully repay initial loans and then go on to obtain and repay subsequent loans.	

Domain 13: ACCESSIBILITY OF SERVICES

		Examples	Source Material
13.1	**Location**	Accessibility refers to the ease with which clients can take advantage of the services provided by the CMHP. If the CMHP services are based in a clinic, the distance that clients must travel to the clinic will be a determining factor of who will access the services. For example, records at HFRCMH suggest that people in nearby communities are more likely to be clients than people who live farther away. The scheduling of services may also be a barrier, e.g., if services are only offered during times when people are working, or if services are offered infrequently, e.g., monthly community clinics. Clients may be discouraged from regular attendance if it is necessary to wait long hours before being seen or if the staff of the program are not welcoming.	• Interviews with staff and administrators • Observations
13.2	**Provision of transportation**	Distance by itself is not the only factor. Expense of transportation can limit clients' and families' access to services. For a period of time, HFRCMH offered day hospital services for individuals with severe mental illnesses. This service was discontinued, however, when HFRCMH was forced to discontinue its daily van service and clients stopped coming to the facility which is about 12km from the center of Tabaco City.	
13.3	**Affordable fees?**	Cost of services may be a significant barrier to accessing services. APSRP does not charge clients for clinic visits or medications. SPWD charges clients for medications but this does not seem to be a significant barrier. In contrast, HFRCMH must charge for outpatient visits, medications, and inpatient services. Two local municipalities partially offset these costs for some residents, but anecdotal evidence suggests that costs pose significant barriers to accessing services.	
13.4	**Service hours and schedules that match client needs?**	Does the program offer its services at times of the day, or on days of the week, when it is convenient for clients?	
13.5	**In-home services?**	In the event of an emergency or in the case of an individual who cannot travel, it is useful for a program to be able to provide in-home services.	
13.6	**Follow-up?**	One measure of the accessibility of services is a high follow-up rate of clients. Staff impressions of follow-up may be informative, but a more definitive answer is possible only if the program maintains an information system.	

Domain 14: INFORMATION SYSTEM

		Examples	Source Material
14.1	**Information system**	• Who is collecting the data? • In what format is it being recorded? • How is it being stored, e.g., paper files, on computers, in databases? • Procedures for generating reports from the data • To whom is the information sent, e.g., funding agency? • Does the funding agency have specific requirements for data collection and reporting?	• Review of records or information system
14.2	**Specifics**	What information is being collected? Can the program easily generate descriptive statistics about clients and their use of services? Assignment of a unique ID is the key to all client information systems. This could be a number or a combination of numbers and letters. The only requirement is that each client's ID is unique. • Information collected at enrolment: o Age o Gender o Marital status o Occupation o Diagnoses o Clinical status o Functional status o Prescribed treatment o Other physical problems o Referral to other services? o Date enrolled • Information collected at subsequent clinical contacts: o Clinical status o Functional status o Prescribed treatment o Referral to other services? o Date of contact Entering client data into a computer database is the ideal method of storage. If this is not feasible programs are free to devise their own filing systems. The only requirement is that the data can be reviewed easily. Having collected the information it should be possible to aggregate the data to produce program-level data: • Number of new clients each month • Number of clients seen each month	

		Examples	Source Material
		• Clinical characteristics of clients (see **10.1**) • Sociodemographic characteristics of clients (see **Domain 8.2**) • The interventions/treatments that clients are receiving • Rates of follow-up: average number of times that clients are seen before leaving the service due to attrition or being formally discharged • Estimates of effectiveness in reducing symptom severity and improving functioning over the course of treatment The information system should also provide the basis for establishing a registry of clients who have not returned for services and require active follow-up. An information system is only as good as the data being collected. Therefore, it is important that CMHPs regularly review whether all the data are being collected on a regular basis. At its most basic, this entails checking that all the required fields are being filled in. Checking on accuracy is more difficult but the quality of the data can be ensured by periodically reviewing a sample of clients' records. Once the information system is established, it must be regularly maintained. If computerized this means that data are being input and backed-up according to schedule. In addition, it would be worthwhile to periodically generate statistics to ensure that the database is functioning. If the system is comprised of paper files, these should be checked periodically to see if individual records can be located easily.	

SYNTHESIS

Timeline of key Events

Major Acheivements

SWOT Analysis + Lessons & Needs For Future Research

Internal aspects of a program	**Strengths**	Examples: well-trained staff, consistent and adequate supplies of high-quality medications, a diversity of psychosocial interventions
	Weaknesses	Examples: inadequate numbers of staff, poor fiscal management, lack of referral networks, lack of community involvement
External aspects of a program	**Opportunities**	Examples: establishing links with local specialists and institutions, lobbying local governments for funding, working with local NGOs
	Threats	Examples: shortage of funding, political or social instability
	Lessons	Does the experience of one program hold lessons for existing or potential programs? Does the experience of a program suggest strategies for scaling up? For example, is reliance of low- or unpaid staff viable? What are the challenges of integrating mental health services into a community based rehabilitation program?
	Additional Research	Conducting a case study often leads to the identification of questions in need of separate, focused research projects. The identification of such questions is an important outcome of a case study. Examples of questions include: What do clients and care-givers think of the services? What are the family level and community level benefits of Self-Help Groups? What are the reasons for non-adherence among the clients?

Key events: List in chronological order the key events in the history of the program: events that lead up to its establishment, as well as significant changes, that the program has undergone since its establishment.

Major Achievements: List in chronological order those achievements that have had an Impact on the immediate community, local or national mental health systems, local or national mental health policies and legislation, reduction of stigma.