Community Mental Health

Implementation Guidelines

cbm

together we can do more

CBM is an international Christian development organisation, committed toimproving the quality of life of persons with disabilities in the poorest countries of the world. CBM works with partner organisations to support persons with disabilities in the developing world to access affordable and comprehensive health care and rehabilitation programmes, quality education programs and livelihood opportunities. CBM's vision is of an inclusive world in which all persons with disabilities enjoy their human rights and achieve their full potential.

Pictures:
CBM, Gonna Rota

Preamble

This guide is meant for use by Regional Offices, as well as CBM partner organisations and projects, who are considering establishing mental health services within their communities. The needs of people with psychosocial disabilities are complex, but the ability to intervene in constructive, practical ways that have a very positive impact on quality of life is now well established, and interventions can be very cost-effective.

This document aims to give guidelines for addressing psychosocial disabilities in practical ways in resource-poor settings. The guidelines it provides should be seen as a starting point, with the CBM mental health advisors or other relevant experts in various regions available to provide additional advice and support as necessary.

These guidelines are based on the experience and advice of the CBM Advisory Working Group for Community Mental Health: Dr. Birgit Radtke, Dr. Julian Eaton, Mr. Mike Davies, Dr. Istvan Patkai, Dr. Andrew Mohanraj.

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1. Introduction

No health without mental health

Conditions affecting the brain* are an important cause of disability and have a major impact on quality of life as well as on the social and economic viability of families and communities.

Many are chronic, causing long-term disability, and so feature prominently in measures of global disease burden.

CBM's vision of 'improving the quality of life of persons with disabilities in the poorest countries in the world' can only be achieved if this area is addressed. CBM and its partners should be at the forefront of ensuring that people with psychosocial disabilities are no longer marginalised as they have been for so long.

Mental health issues are relevant in many other areas of disability. For example, people with hearing impairment have a higher risk of some mental disorders conversely, people with some mental disorders have higher rates of cardiac problems.

Priority Conditions

Interventions that bring a significant improvement in the lives of people with psychosocial disabilities have been developed and shown to be successful so that we can now confidently include these in services.

In attempting to address these problems, there is a need to prioritise those areas where there is great need, and that can be effectively treated. The following conditions are common and disabling, but have effective, affordable interventions.

Depression – a condition mainly characterised by pervasive low mood. It stops people taking the usual interest in social activities and can recur for many years.
 – Over 5% of the population may have this problem at any time and up to 15% may experience depression in their lifetime.

Psychosis – this includes conditions such as schizophrenia and may involve hearing voices and holding very firm ideas not shared by others that can lead to unusual behaviour.
 – About 1-2% of the population have these problems.

> **Epilepsy** – a disorder of the brain where unregulated brain activity causes occasional uncontrollable outbursts (fits). These may involve abnormal movements, sensations or behaviours.
> – About 1% of the population have these problems.

All are already treated in a large scale on CBM-supported projects, and good outcomes have been recorded in practical settings in the lower income countries.

Dementia, alcohol and substance use disorders, suicide, and mental disorders in children are also highly prevalent and disabling as well as being associated with human rights violations. An established programme should try to offer effective interventions in these areas where relevant to their local population's needs.

Cost-effective interventions

There is a growing body of evidence for cost-effective interventions. While most studies are in high income countries, evidence is now available from poorer countries.

Pharmacological interventions
Currently, the high costs of newer psychotropic drugs makes their use inappropriate for resource-poor settings. Conventional drugs, however, represent a very affordable option for effective treatment of major mental health conditions.

Psychosocial interventions
There is good evidence for cost-effective non-medical interventions in some conditions. In depression and anxiety, simple psychotherapy is as effective as newer anti-depressants. Combined psychosocial and pharmacological interventions are more effective than medication alone in schizophrenia and bi-polar disorder (relapse prevention, compliance work etc). The major constraint is finding appropriately trained personnel to deliver these therapies.

See chapter 5 for more detailed discussion on treatments.

Service models

A different service will be appropriate in each environment, depending on local need and existing provision of care. In this document, three main practical models for provision of mental health services are outlined. Each option will work better in different contexts, but there are certain common principles and structures they all share;

➤ The great majority of clients will be seen in their home contexts

➤ Community support will be mobilised (families, community volunteers, churches, mosques)

➤ There is specific effort allocated to prevention, advocacy and awareness work with sensitivity to local culture

➤ Self-advocacy, and involvement of service users is central to the services

➤ Full social reintegration and quality of life are central to the desired outcome

➤ There is good liaison with other stakeholders and service providers in the community, government, humanitarian, private and faith-based sectors

➤ Systems are in place to allow good quality monitoring and evaluation

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* **Terminology**

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

Only when referring to the underlying disorder or to epidemiological findings do we speak of **neuropsychiatric disorders** which is a collective name for mental and neurological illnesses.

The term **'mental illness'** refers to disorders that affect an individual's cognition, emotion and/or behavioural control, and interferes with his or her ability to learn and function in the family, at work and in society, such as schizophrenia, depression, anxiety, dementia and others. The term **'neurological illness'** refers to conditions that affect the brain and nerves, the most common being epilepsy. Since most neurological disorders are surrounded by similar myths, misconceptions and prejudice as mental illness, they are considered together. The psychosocial disability resulting from neurological illness is often more disabling than the seizures themselves.

Intellectual impairment, on the other hand, has its onset in childhood; children can be born with an intellectual impairment or can acquire it in early childhood, for example through meningitis. It is a life-long condition and characterized by an

impairment of the skills related to intelligence such as lan-
guage, memory, motor and social abilities. **Intellectual dis-
ability** (also called learning disability, formerly called mental
retardation) is not considered in this policy since the needs of
people with intellectual disability and services needed are gen-
erally different from those of people with psychosocial disabil-
ities. Just like anybody else, people with intellectual disabilities
or developmental disorders can also have psychosocial disabil-
ities which require treatment.

This document aims to give guidelines for addressing psychosocial
disabilities in practical ways in different resource-poor settings. For
each model type, the appropriate circumstances of use, a basic out-
line of the model, and a practical example are given. A step-by-step
guide to implementation is then given, followed by chapters giving
more information on specific aspects of services such as treatment,
advocacy and training.

2. Models of Service Provision

Model 1 – Integration into Community Based Rehabilitation (CBR)

The appropriate model where:

➤ Local services do not address psychological, social or empow-
   erment issues (eg hospital services only)
➤ There is a well functioning CBR in existence that is ready to
   develop its services further
➤ Other local services do not adequately address the needs of
   people with psychosocial disabilities.

Community Based Rehabilitation (CBR) offers a well established sys-
tem for addressing a wide range of consequences of disability through
effective action at the community level. Many of the problems faced
by people with different disabilities are similar. CBR encompasses a
broad range of interventions making it an effective vehicle for
addressing the needs of persons with psychosocial disabilities.

These interventions primarily focus on the social sphere (see CBR
matrix below), with issues surrounding education, livelihood and
empowerment playing a major role in achieving the CBR principles of
encouraging participation, inclusion and self-advocacy. This is partic-

ularly relevant in the case of psychosocial disability given the high levels of exclusion and discrimination that they encounter. Health interventions also play an important role where appropriate to address the specific needs a person might have.

As with other types of disability addressed in CBR, field-workers have a clear role to play in the community, and seek support when an intervention is needed beyond their competency. In this case, this person needs to be someone with professional qualifications in mental health care. This may be a psychiatric nurse, a clinical officer with a diploma in mental health, a psychiatrist or a psychologist. The CBR model encourages interaction and partnership with local services, and it is good practice to make use of local resources for medical review and treatment.

Occasionally, there may be a local general or psychiatric hospital with wards that are available for brief admissions of clients during acute illness or crises. Assuming that the standards are high, in a least restrictive environment, this can also be useful. In all cases where the CBR programme liaises with other partners, good communication is vital, particularly at hand-over points where responsibility for care changes.

A priority is to form a sustained, trusting relationship with the client and those around him or her. There are key mental health messages that they need to reinforce to clients and their families concerning prevention of relapse, coping with stress, avoiding provoking factors such as illicit drugs, improving family interaction and compliance with psychotropic medication. Field-workers should be trained to give useful feedback to medical specialists at regular medical reviews as well as supporting livelihood activities, education, advocacy and other social work.

Promotion of good mental health and prevention of mental ill health should also form a part of the programme's activities. Some significant risk factors that can be addressed in practical ways are domestic violence, physical and sexual abuse and use of alcohol and drugs. It is important that there is specific attention paid to vulnerable groups within society (such as persons with intellectual disabilities). Addressing some of the ways that they are discriminated against is a good way to reduce their risk of mental ill health. Women are particularly vulnerable because of issues such as domestic violence, the risks associated with unsafe childbirth and practices such as female genital mutilation. They are also more prone to the vicious cycle of poverty and mental ill health. Ways of ensuring a gender focus to a CBR programme's work include specifically consulting women in needs analysis and ensuring that issues that make them vulnerable (above) are addressed in the programme activities.
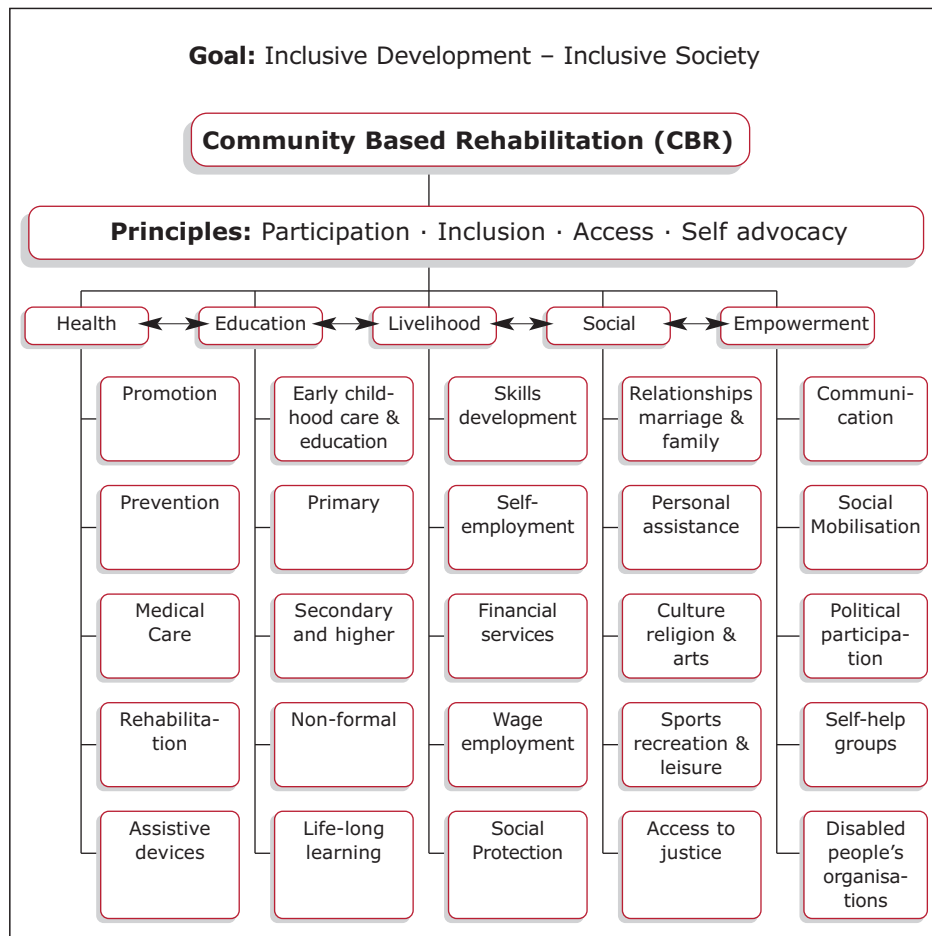
Stigma and discrimination against persons with psychosocial disability reduce their ability to be included fully in the social life of communities. This causes a double burden of suffering. CBR programmes must directly address the barriers that prevent full access to human rights at all levels of society. One of the most important ways of doing this is the development of opportunities for self-advocacy by supporting user groups and their own efforts to challenge the discrimination they experience.

Case Study

Garu Community-Based Rehabilitation
Upper Region East, Ghana

This CBR programme in northern Ghana has been responding to the needs of clients with psychosocial disability for many years, particularly those with epilepsy. It is a good example of an effective liaison between the programme and government services. The Ghana Health Service has a local community psychiatric nurse who devotes a proportion of his time to accompany field-workers from 5 zones to see patients at home on monthly visits. He also has a clinic at the local Primary Health Care centre, and is available to respond to emergencies in the community. Patients come there directly as well as being referred by field-workers between his visits to the field.

The CBR programme in turn is able to facilitate his work by making drugs available through a Drug Revolving Fund that provides quality, affordable drugs to his patients. His patients also benefit from being seen by experienced field-workers between his visits. They are able to reinforce the advice he has given, and to monitor progress, reporting any problems to him so that he can respond promptly.

Goal: Inclusive Development – Inclusive Society				
Community Based Rehabilitation (CBR)				
Principles: Participation · Inclusion · Access · Self advocacy				
Health	Education	Livelihood	Social	Empowerment
Promotion	Early childhood care & education	Skills development	Relationships marriage & family	Communication
Prevention	Primary	Self-employment	Personal assistance	Social Mobilisation
Medical Care	Secondary and higher	Financial services	Culture religion & arts	Political participation
Rehabilitation	Non-formal	Wage employment	Sports recreation & leisure	Self-help groups
Assistive devices	Life-long learning	Social Protection	Access to justice	Disabled people's organisations

The five main areas of intervention in CBR have direct relevance for persons with psychosocial disabilities;

Health – The majority of people with the priority conditions mentioned will respond very well to basic, first-line drug treatment as an important first step to full reintegration in society. They are also more likely to require physical medical interventions, either for consequences of neglect or abuse or for direct consequences of their psychosocial disabilities.

Education – While many major psychiatric conditions affect people from their late teens, epilepsy often occurs during the primary education years. Studies show that half of all lifetime cases of mental ill health begin before the age of 14 and children may already have serious problems at school before being diagnosed. Children and young adults are often forced to leave formal education when these conditions start, but once stabilised, should be helped to continue with education so as to achieve a level they could have reached without the illness.

Livelihood – Psychosocial disability usually has a devastating effect on the person being able to continue earning a living.

This has an impact on their status as well as their ability to support dependents. There is a well documented cycle between psychosocial disability and poverty.

Social – People with psychosocial disability are often not allowed to participate fully in society due to such discrimination. Engaging with such issues in communities in which clients live can dramatically improve their experience.

Empowerment – People with psychosocial disabilities are among the most marginalised in society. Stigma and discrimination towards this group results in high levels of persecution and human rights abuses experienced. Giving a voice to those affected is an important step in challenging ignorance.

Model 2 – Integration into Primary Health Care (PHC) services

The appropriate model where:

➤ There is an existing PHC network in existence that does not currently address mental health
➤ Government is an effective partner (e.g. policy states that mental health should be part of PHC services, or there is a local specialist hospital willing to support such work)
➤ Advocacy within government may lead to greater resource allocation to mental health services
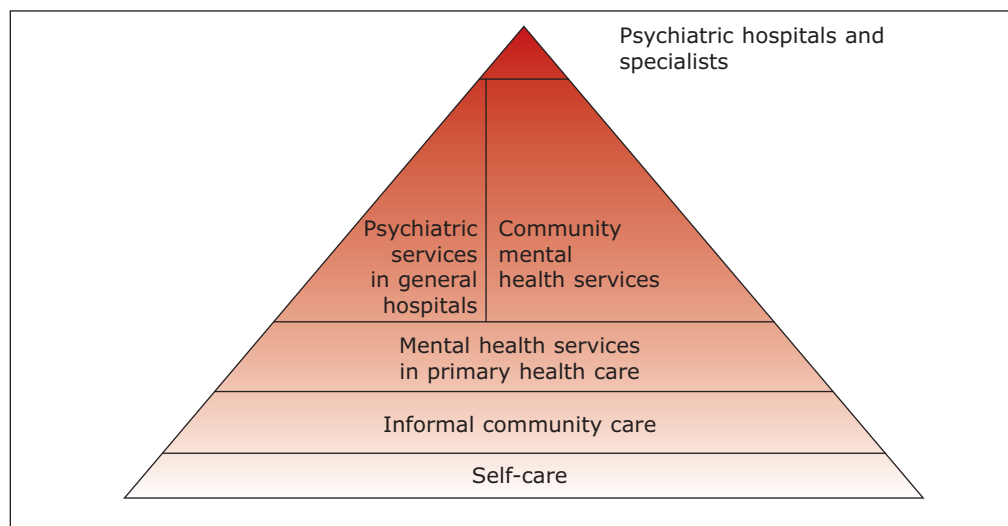
Good quality community-based services (with some support from local general hospitals) have been shown to be the most effective form of mental health care. Building capacity into statutory services has significant advantages in terms of sustainability and increasing awareness of mental health service needs in the government sphere.

The most common method of incorporating mental health into existing PHC services involves training staff (e.g. general nurses) in additional mental health skills. This has been done in several major projects, but it is often difficult to impart enough knowledge and skills to already busy nurses who may not prioritise mental health. An alternative, which offers a higher standard of care is to have a dedicated mental health professional (e.g. Community Mental Health Nurse or diploma doctor) as a staff member of PHC clinics. This allows development of skills (including prescribing where the law allows) and time to devote to clients who often have complex needs, particularly by travelling to their homes.

In order to develop these services, strong partnership is needed with relevant government departments, and clear allocation of responsibilities agreed.

Distribution of health-care provision at different levels

Psychiatric hospitals and specialists

Psychiatric services in general hospitals | Community mental health services

Mental health services in primary health care

Informal community care

Self-care

Case Study

Amaudo Itumbauzo Community Psychiatric Programme (CPP), Nigeria

The CPP was set up in partnership between Amaudo, a Nigerian non-governmental organisation, and local government primary health care (PHC) services in south-eastern Nigeria in 1993. It has gradually grown so that it now covers three states, with services provided by community psychiatric nurses (CPN) in 60 local PHC areas.

The nurses use motorcycles to reach clients in communities and to provide social, medical and basic psychological interventions. The accessibility of the service is key, with clients' costs kept to a minimum by provision of drugs through the Drug Revolving Fund, and reducing the need for travel to reach services. The nurse is supported through a system of volunteer village health workers whose main role is recognition, referral, and monitoring of cases, as well as community education and awareness-raising.

Sign-board showing CPP as collaborative project between government and CBM-supported project, Amaudo Itumbauzo

Community-based volunteers

In order for the level of grass-roots coverage to be adequate, it is essential to have a community-based cadre of workers who support the mental health professional. These are likely to be volunteers (Village Health Workers, Community Health Extension Workers etc) but need to be co-ordinated (and resourced) to attend regular meetings for training and reporting. They may be the same people used by other community health programmes (e.g. vaccination, child and maternal health), or dedicated only to mental health work. They are an important conduit for community education and anti-stigma, human rights and advocacy work in communities.

Model 3 – Specialist Community Mental Health (CMH) programmes

The appropriate model where:

➤ There are no effective local services for a particular group's needs
➤ A partner wishes to set up specific services for the mentally ill (e.g. intervention for homeless mentally ill or people with alcohol problems)
➤ There is a gap in existing government services so that mental health care is not provided

Most projects start at the point of perceived need in the community, and it is often these most severely ill people whose needs are seen as a priority to be met. There are many good examples of projects set up to meet specific needs, for example those rehabilitating mentally ill people found on the streets. Though CBR is a priority area for CBM, there are some circumstances where persons with complex needs are best served by dedicated mental health programmes. The experience and enthusiasm of these partners is to be valued, and can be a great asset in addressing gaps in services.

These services should still follow universally accepted principles of best practice. The ideal services for delivery of mental health care has the vast majority of people looked after in the community, but may include a small number of beds in general hospitals for brief admission of the most seriously ill cases or emergencies. A service should be designed to direct the majority of resources to community-based work rather than an institution, and include principles of inclusion, participation, and self-advocacy. In this way, good quality

services in a community can be developed, and may incorporate wider CBR principles with time.

Holy Face Centre, Philippines

Case Study

Holy Face Rehabilitation Project for Mental Health, Tabaco, Luzon Island, Philippines

In 2004, with CBM technical and financial support, the Brothers of Charity set up the Holy Face mental health programme in Tabaco, Philippines, a region with no services for people with psychosocial disability. The Holy Face Centre now provides a temporary home and respite/rehabilitation centre for up to 30 people with acute psychiatric disorders, and more importantly, provides and promotes community-based support services for over one thousand people with psychiatric disorders, living at home. Family and community are encouraged and enabled to play an active role in supporting the programme, and to de-stigmatize mental illness, by showing that former patients can play an active and contributory role in community life. Holy Face, together with local partner agencies, conducts regular home visits to monitor progress of clients, to educate the community about mental health issues, and to advocate with local officials for greater local government awareness and support. There is a "revolving-door" policy at the Holy Face centre. Those who feel they need help can always return to the centre for respite, consultation and counselling, with support from a volunteer local psychiatrist, a social worker, psychiatric nurses and the Holy Face staff. The Brothers of Charity believe in doing things "with the people", and not "for them". The number of people helped over the last few years has greatly exceeded expectations, and the results - measured in terms of formerly mentally ill people now productively involved in community life and work, and public attitudes, has greatly exceeded CBM's original expectations.

3. Practical steps to implementing services

Responding to needs in a practical way

When considering the prospect of developing community mental health services, it is necessary to survey what needs there are in the relevant population, and what resources are already available to address those needs. The details of how the project will fit into the local setting can then be planned, and the necessary activities to implement the project started. Evaluation is an important process that should be built in from an early stage. With time, evaluation results can be used to help the project better meet the needs of clients.

Feasibility checklist

The following resources should be available, accessible or able to be developed before a service can start to be built:

	Resource	Check ✓
1	Partner willing to take on mental health as an area of work.	
2	Existence of a needs assessment and situation analysis showing appropriateness of interventions in mental health care.	
3	Competent management team enthusiastic about addressing mental health in their service.	
4	Presence or willingness to participate, of a mental health medical supervisor (psychiatric nurse or interested general medical practitioner) able to prescribe drugs	
5	Access to support for supervision and advice in complex cases. May include access to appropriate general hospitals for brief admissions if necessary.	
6	Adequate local supply of medication, or capacity to provided internally if necessary (eg. Drug Revolving Fund)	

7	Availability of adequate staff (administrative and field staff), and resources for their appropriate training. Staff should have basic counselling skills.	
8	Good liaison with local community, ideally with a network of community-based volunteers.	
9	Time and transport for community visits by field staff.	
10	Allocation of time and resources for advocacy/awareness work, and for a prevention programme.	
11	Be able to facilitate education, skills acquisition and livelihood development once clients are stable (internally or through mainstream services).	
12	Appropriate staff, buildings, vehicles and practical resources for smooth running of project.	

Which type of service?
Having decided that there is need, that the need is not adequately met by local available services, and that the resources can be found within the CBM partnership, it is necessary to decide on a framework within which the service will function. The simplest way to work is to build capacity in already existing services – e.g. a CBR programme or local PHC services. The objective that the service seeks to meet may be a general service or more specific, such as a response to a natural disaster.

In the next section, an example of a plan for implementing a new service is given.

Practical guide for developing community mental health (CMH) work

This guide is best used as a framework. Each area is different, and working with the CBM regional office and Mental Health Advisor is advisable.

Step 1:   Needs assessment and stakeholder analysis

It is necessary to judge likely need in the specific catchment area of a proposed programme. National statistics offices or international organisations like WHO may be able to give prevalence data for particular regions or countries. Whether good quality statistical data is available or not, the priorities of the local population are the most important consideration when planning services.

In practice, most projects start on a small scale, and grow as resources allow. It is likely that the total population with need will not be found in the early stages of the programme, but coverage will improve as the project becomes established. This organic growth has the advantage that it allows experience to develop, and partnerships and alliances to build gradually. This is an asset later as a programme becomes larger in scale. With a responsive evaluation system in place, this can also be a good way of ensuring that the service meets more subtle local needs rather than just responding to numbers.

Areas with high risk factors such as extreme poverty, large displaced populations or in a post-conflict situation would expect to have a higher prevalence of psychosocial disabilities.

Task 1:   Establish a small mental health team to take over responsibility for designing and implementing mental health work in your project.

In small projects this may be only one person instead of a team. In projects that develop mental health together with the government or other agencies teams should be mixed. Support from and involvement of the project leadership is essential.

Task 2:   Review CBM's mental health policy and national mental health policy and legislation if existing.

The project's mental health work has to be consistent with CBM policy and national policy. If there is no national mental health policy and/or legislation one of the project activities to be included should be advocacy for the development of a national MH policy. This task is essential for developing an overall vision: What is CMH work setting out to achieve?

Task 3:   Identify stakeholders and consult with them.

The mental health team needs to make a list of all relevant stakeholders at different levels (community, district, region, national) according to the project's coverage area and to start a consultation process. The findings will influence on which needs to focus, who it is aimed at etc.

Stakeholders for CMH to be taken into account may be:

➤ People with psychosocial disability in the community and in user groups
➤ Carers and family members in the community, and those organized in groups
➤ Community leaders (political, spiritual, teachers, traditional healers and others)
➤ Community organisations and agencies (for example schools, women's group)
➤ Community Health/Village Health Volunteers
➤ Senior staff and general health workers in local PHC and hospitals
➤ Drug suppliers (government and private)
➤ Mental health professionals (psychiatrists, psychologists, psychiatric nurses)
➤ Mental health associations
➤ Public authorities at different levels (health authorities, school authorities, etc)
➤ Political leaders at different levels (community, district, region, national)
➤ Spiritual leaders at different levels
➤ Non Governmental Development Organisations (e.g. in health, disability, human rights)

Stakeholder consultation exercise, Nigeria

Step 2:   Situation analysis

Task 1:   Find out which health services and community resources already exist.

The mental health team finds out which health services exist at community and regional level with the potential for including community mental health work. The team finds out which specialists may be involved as resource persons for training and which specialist services exist for referral at regional and national level (secondary and tertiary level).

The list of existing resources will differ between projects and countries and might comprise for example:

➤ Community volunteers and health workers in PHC
➤ Current and recovered users of CMH services
➤ Family members of persons with psychosocial disabilities
➤ Traditional healers
➤ Psychiatrists of a near-by mental hospital, psychiatric nurses in clinics etc
➤ GPs with interest in mental health work or social workers with psychiatric expertise
➤ Psychologists working in an NGO working with children.
➤ Psychiatric consultant in the capital or staff of a national research institute
➤ CBM mental health advisor

Task 2: Make contact with existing health services and find out how effective they are.

The mental health team should make site visits to clinics and hospitals to get to know their staff, their interest and motivation for mental health work and current ways of working in CMH. As far as possible, problems in accessibility, acceptability and effectiveness should be identified. This contact may be the first step in seeking ways of collaborating in future services.

Task 3: Get information about supply of psychotropic drugs.

The team should get a list of available psychotropic drugs of the country and compare it with the CBM list of essential psychotropic drugs and consult with health services and users about accessibility, acceptability and affordability.

The accessibility and affordability of psychotropic drugs will vary widely between countries. The team should find out problems with drug supply and sustainable ways of guaranteeing a reliable drug supply, preferably through the public health sector. Advocacy measures may be necessary to achieve this goal. Alternative ways should only be sought if drug supply through the public health sector is not viable. In this case only psychotropic drugs from CBM's list of psychotropic drugs should be provided, though the Mental Health Advisor may advise further.

Step 3: Planning and implementation

Task 1: Identify priority areas of CMH work.

The team brings together information gathered during needs assessment and situation analysis and decides on priority areas for CMH work to begin with. They should take note of CBM priority areas.

Task 2:   Start small.
As the field of mental health is very broad it will be imperative to prioritise. Priorities should build upon what works best and on revealing needs as experiences with CMH increase. CBM priority conditions should be noted. This also refers to resources allocated to CMH, which should increase as experience and client numbers grow.

Task 3:   Identify objectives
The team should set objectives in accordance with the general project objectives (in the case of pre-existing CBR projects) and/or the CBM mental health policy. These should be acceptable to the project partner.

Task 4:   Identify project activities to be implemented
Typical activities to be planned and implemented will generally comprise:
➤ Treatment and psychosocial rehabilitation in the community
➤ Prevention
➤ Information, education, and communication (IEC) for awareness raising about mental health and reduction of stigma
➤ Advocacy and development of self-help groups
➤ Training and staff development

Task 5:   Identify roles and responsibilities of staff and stakeholders
The team assigns each activity to a specific group or person of staff, so that responsibilities are clear.

Task 6:   Identify indicators
Indicators are set for objectives. These should follow Project Cycle Management methodology (be Specific, Measurable, Achievable, Realistic and have a Time-frame). Criteria for success can be built in if appropriate (CBM criteria are available as a guide).

Task 7:   Plan and organise training
During needs and situation analysis, training needs and gaps in knowledge will have become clear at all levels. Locally available resource persons for training can be approached for a working relationship in training and supervision. Often it will be necessary to first allay fears that the new service will be in competition with existing services in order to gain the active collaboration of local mental health professionals.

Task 8:   Identify and address potential barriers and implement monitoring measures
During the implementation, barriers will become obvious and new needs may manifest themselves. The team should be aware of these

in order to address obstacles early when they arise. Apart from the gathering of information about outcome indicators, regular monitoring measures implementation of activities and is very helpful in early identification of problems. The team should design simple instruments for monitoring of activities that gather relevant information monthly.

The following is an example for planning and implementation of a CMH component for a CBR project. Because of different regional and national characteristics implementation of similar projects may vary considerably between different countries. The following subdivisions of treatment, prevention, rehabilitation, IEC, advocacy and training is done to give a structure but some cross-over is unavoidable.

Example; Objective of project: Improve the quality of life of people with depression, especially of women and people with disabilities

Area of action	Activities	Who is responsible?	Additional support needed?
Treatment	Identification of people with depression	Community volunteers, project staff, users, families	Training
	Diagnosis	GP with psychiatric training, PHC	Training
	Initiation of treatment	GP with psychiatric training, PHC	Training
	Physical health check	General health workers, PHC	Awareness raining and attitude change
	Drug supply	General health workers, PHC	Advocacy at higher levels for securing reliable drug supply
	Follow-up of treatment compliance and side-effects	Community volunteers, project staff, psychiatric nurse	Training
	Individual counselling	Community volunteers with help from psychiatric nurse	Training
	Self-help groups	Psychologist, users, families	Psychologist
	Referral for special problems	Psychiatrist at tertiary level	Motivation to work in community
	Family counselling	Psychiatric nurse, community volunteers (users, families)	Training
	Peer counselling	Service users, families	Training
Prevention	Health promotion in mother and child clinics	Community volunteers, project staff (users and families)	Training

Area of action	Activities	Who is responsible?	Additional support needed?
	Relapse prevention	Community volunteers, project staff (users, families)	Training
	Prevention of violence against women	Community volunteers, project staff (users, families)	Collaboration with a NGO fighting against violence
Rehabilitation	School integration of adolescents with disability	Community volunteers, project staff (users, families)	Awareness raising and attitude change for teachers
	Vocational training for people with depression	Staff of training centre (public) to integrate people with depression	Awareness raining and attitude change for staff
	Livelihood activities for people with depression	Community volunteers, project staff (users, families)	Training
IEC (information, education, communication) to reduce stigma and change negative attitudes	Develop attractive materials for IEC	Project staff, users, families	Professionals in social communication
	Awareness raising in community and women's clubs	Community volunteers, project staff, users, families	Training, materials for IEC
	Radio campaign about depression	Community volunteers, project staff, users, families	Access to community radio
Advocacy	Self-advocacy through user groups	Users, families	Training
	Advocacy for mental health legislation	Project staff, users, families, alliances	Training
	Join existing network with other agencies	Project staff	
Training	Adapt existing training materials to the local context	Project staff, local MH professionals	CBM adviser
	Schedule and organize training for different groups	Project staff	Mental health professionals for training

Step 4:   Evaluation

How well is the CMH project/CMH component working?

Measuring the outcomes of programme interventions is important if we are to justify expenditure of time, and financial and human resources.

Rather than just being something that is done at the end of an intervention or project, evaluation is a process. It provides a powerful, dynamic tool for allowing clients to be heard, to build knowledge about the environment, and to mould programmes to be more responsive to the real needs they set out to address.

Task 1:   Plan evaluation from the beginning when you are designing the project
The team has to plan evaluation from the beginning as an integral part of the project design in order have the information necessary for evaluation and to keep track of progress. If you want to find out how well your project is working you generally have to compare the current state (for example after 3 years) with the state of beginning which is your baseline. If you have not collected information before starting you won't have the information for that comparison.

Task 2:   Define the criteria and define the terms of reference (ToR) for evaluation
The team has to define each criterion so that it is clear which aspect of the mental health project is to be measured. For each aspect, a definition of a successful outcome is outlined.

ToR are specific questions posed for evaluating the project: What main and specific aspects of the CMH project need to be evaluated? Which instrument is most appropriate? These measures should aim as far as possible to be broad, so as to capture a picture not only of impact on impairment, but the effect on overall functioning. CBM has a focus on improving quality of life, and there are now useful, practical ways of measuring how interventions have influenced quality of life. This may be specific to disability arising from mental illness, or a tool covering all clients in a cross-disability project.

Choosing of ToR depends on difficulties found and the resources available. Some investment in training, in time and travel costs will be necessary. Dependent on your resources you might decide instead to have a focus group discussion with a limited number of users and their families about satisfaction with the project.

Task 3:   Compare with the baseline
The progress of a project can be evaluated by taking measures at baseline and after a defined time period. These can then be compared to see if there has been improvement.

Task 4:   Set a time-frame for evaluations
Generally, projects are recommended to have routine monitoring every 6 to 12 months with participation of project staff, users and families. An external evaluation with a person from the outside can

be very helpful and bring new perspectives but will take place less often (for example every 3 years) or at special points of the project cycle.

4. Training, Awareness and Evaluation

Human resource skills need to be considered so as to ensure a high quality of service provision. Ideally these staff should be local (aware if cultural issues) and stable (not frequently changing once trained). While some skills are specific to particular groups, some are universal and should be expected of all staff – for example awareness of basic human rights issues and psychosocial counselling skills.

There are four main levels to consider;
➤ the specialist mental health professional
➤ general health workers
➤ staff in the service (field-workers etc)
➤ community volunteers

Specialist mental health expertise

It is necessary to have a key professional to work as an adviser to the service. Ideally, this input can be accessed from local services, for example government services. This is a good way of minimising costs to the project and ensuring sustainability. It is also a good way of building local capacity, increasing the level of awareness of mental health issues in statutory services and increasing the skills of mental health professionals. Working in CBR or community mental health often requires a change of attitude for mental health professionals. They must learn to move away from their traditional dominant role and be ready to work together with non-professionals such as users, families, communities, PHC personnel and CBR volunteers.

If it is not possible to partner with local services in this way, it may be necessary to employ the key professionals in a service. This may be a psychiatric nurse or similar grade with the capacity to prescribe and supervise drug treatment and basic psychosocial counselling skills. The advantage of employing someone rather than referring all cases is that they will be able to offer more time, and undertake community-based work, getting to know clients and their families better.

This grade of health professional is a vital resource to utilise in training other staff. They will benefit from supervision, and access to further training and conferences builds knowledge as well as morale.

General Health Workers

The majority of people with psychosocial disabilities will be seen in general medical services both when they present and for follow-up. Mental health is often under-emphasised in medical and nursing training, so this should be improved by liaising with universities. Brief update training and access to backup from specialists can quickly improve the quality of care offered by general doctors and nurses in their everyday practice.

Project staff

Within partner programmes, it is project staff who have the most contact with clients. These staff (e.g. field-workers) should have a basic grounding in principles of working in mental health during their basic training. They should also have regular supervision from the mental health professional working with the service. This should take place during joint community work (home visits), but should also include times set aside for training and discussion. Good counselling skills are important for all areas of their work.

Community Volunteers

Awareness-raising and public education is an essential component of work in this area. In many cultures, mental disorders are not perceived as treatable, and so services, even where available, are not made use of. An increased awareness of the issues will not only work to reduce stigma, but to increase utilisation of services. One of the most powerful methods to start to raise awareness is to establish community volunteers with a particular role to play in bringing important health and social messages to their host communities. Many services will already have such a network, and a mental health element can be incorporated into their work. Consistent work by community volunteers is more effective than one-off campaigns, although a well planned campaign can be a useful way of concentrating efforts in an area, for example when a new project is starting.

As well as awareness-raising in their communities, they are also useful in finding and referring new cases, and monitoring progress of those in the service. They can be given training in peer counselling, illness prevention advice, recognition of early signs of relapse, and how to contact the service in case of emergency.

Criteria for choosing Village Health Workers

➤ Position of respect in the community
➤ Stable in the community (unlikely to move away)
➤ Basic literacy
➤ Equal balance of men and women
➤ Even distribution throughout catchment area
➤ Have shown themselves to be committed to the work

Awareness-raising exercise by community volunteers in Nigeria

Capacity-building

Giving local people the tools to improve the quality of life of their peers within existing national structures is an important principle. As well as doing this through staff of partner projects, there is a place for supporting the development of certain people outside of the projects. These people may be alliance partners (for example in government ministries), or may be individuals seen as having the potential to invest the skills they gain in their sphere of influence. This could be professionals in mental health or related fields, religious leaders or traditional healers. They may be used by CBM on an occasional basis (for example in Teams of Competence for project evaluations).

An empowered user group, given the opportunity to criticise the project, is an important first-step on the path to a service that truly achieves its purpose of serving their clients well. It is of benefit to build capacity for more effective self-advocacy by service users with appropriate training, but it is also important to ensure that Disabled People's Organisations remain autonomous. Over-reliance on finan-

cial or personnel support from an outside agency should be avoided as it can be disempowering and create dependence.

Summary of training needs of different personnel

Staff Cadre	Minimum training	Further Training	Topics
Mental Health Professional	Doctor or Nurse with professional higher training qualification in psychiatry	Supervision External courses Conferences	Community-based work Networking and advocacy Public mental health
General health workers	Doctor or nurse with basic professional qualification Other health care workers with completed basic training	MH as part of basic training Internal or external courses in aspects of mental health care. Supervision of practice	Counselling skills and psychosocial rehabilitation
Project Staff (eg field-workers)	Completion of secondary school. Completion of internal introductory training course	Supervision of work. Regular training in aspects of basic community care of people with mental illnesses	Counselling skills and psychosocial rehabilitation How to refer appropriately
Community Volunteers	Basic short course in awareness-raising, recognising, referring and monitoring mental illness in their communities.	Regular brief refresher training (eg 6-monthly), Supervision and feedback of their work	How to access to specialists if needed How to support clients and their families

5. Treatments, Promotion and Prevention

A good mental health service should be holistic. This means that social and talking interventions as well as medication have a balanced role to play. There should be resources and personnel to deliver these treatments (within the project or in the mainstream services) according on the needs of the clients.

Social interventions

Psychosocial disabilities can have a major impact on the life of the person with the problem and those around them. When considering treatment, it is vital to explore how the person will be able to reintegrate into the society around them. In the case of those who have been ill for a long time, issues to be addressed might include livelihood (skills, employment, income), education, accommodation, family relationships, and legal issues. These issues can only be addressed by engaging with the client, their families and the wider community, sometimes over a prolonged period of time. Some estab-

lished systems for treatment of psychological problems in communities such as churches or traditional healers can be engaged with to learn from their skills, and to ensure that dangerous and abusive practices are challenged.

Ways of delivering social interventions include self-help groups, community networks of stakeholders in mental health, and building alliances with social care providers such as government social welfare departments or relevant NGOs. It is important that the clients are empowered to make their own decisions about their care, and do not feel coerced into particular decisions by those around them (autonomy). This is particularly important for persons who may not be accorded high status in society such as women, children, or persons with disabilities. On occasions, discrimination must be challenged, or communities educated about the rights of the individual.

Psychological interventions

All staff dealing with patients and families need to be skilled in talking sensitively about their problems. This includes listening to them carefully, showing concern, and being able to try to help them think through their problems. These psychosocial counselling skills should be taught routinely to staff of projects working in mental health. As well as these general skills, there are also specific talking therapies that are useful in treating certain problems. Specific advice is helpful in alcohol abuse, stress, sleep disturbance, sexual and relationship difficulties and coping with side-effects of drugs. There are also therapies (such as Cognitive Behavioural Therapy) that have proven efficacy in mild and moderate depression, anxiety, panic attacks and phobias. These can be taught to be effectively delivered by clinicians, either as sole treatment, or in combination with social interventions and medication. These interventions may only be possible if suitably skilled practitioners are available.

At a community level, basic peer counselling can be taught so that the natural capacity for communities to deal with problems and heal themselves is strengthened.

Medication

Without drugs, services would be very limited, and would not provide an adequate and comprehensive response to needs, particularly for persons with severe and enduring conditions like schizophrenia and depression. One of the biggest challenges to providing services for persons with mental illness and epilepsy using community services is that of ensuring a regular, adequate supply of appropriate, safe, and affordable medication.

While many services in high-income countries now use newer drugs, there is strong evidence to show that older drugs are at least as effective as the new, more expensive, varieties. Many newer drugs are not available in poorer countries. The greater availability of the older drugs also means that there is less risk of them suddenly no longer being available – something that can be dangerous, for example in the treatment of epilepsy.

A list of essential drugs for treatment of common and severe mental disorders is supplied below, with typical prices. These are generally very low, and compare well with treatment of other conditions. The major hurdle to affordability is the chronic nature of some mental disorders, resulting in long-term costs.

Drug supplies
Ideally, once prescribed, drugs would be accessed by clients through the normal routes (usually private or hospital pharmacies). This is much more sustainable and builds local capacity to help people with psychosocial disabilities. It may be necessary to engage with the government or local business to develop this capacity. In some countries this may not be possible either because the drugs are not locally available or the quality is not reliable. Where this is the case, it is necessary to supply the drugs through the service itself. One successful method for doing this is the Drug Revolving Fund (DRF). A regular supply of drugs is available to clients at just above cost price (very low for the essential psychotropic drugs). The income from sales of these drugs is used to purchase more. Some programmes make a small profit from this process, helping sustainability of the programme.

Prescribing
Given the lack of general and specialist doctors, services often need to make arrangements for other health professionals to provide medical assessment, review and prescribing. Who they are will vary in different areas, but it is usually a local general doctor interested in mental health, a psychiatric nurse, or a medical officer allowed to prescribe, depending on the local legislation.

In community mental health programmes, field-workers or social workers play a central role in referral, follow-up support, and monitoring of clients. They need to call in specialists for particular expertise. Just as referrals are made to hospitals for acute medical or surgical interventions, clients with psychosocial disability can use local specialist medical services where they exist.

It is important where drugs are involved that clear boundaries of professional competence are respected. Staff who are not qualified

should not prescribe. The problems of unqualified staff being drawn into prescribing (due to emergencies or the financial gain that can result) is well recognised and must be addressed. Methods to deal with this include good training, clear job descriptions, protocols for dealing with particular situations, ensuring good communication and access to advice, careful monitoring of the Drug Revolving Fund and financial scrutiny.

A well managed system of providing essential drugs to those who need them is an important step in ensuring that other rehabilitation work (education, livelihood etc) has the best chance of succeeding.

Drug (Tablets)	Price per tablet	Typical monthly treatment cost
Chlorpromazine 100mg	€0.02	€1.20
Haloperidol 5mg	€0.02	€1.20
Trifluoperazine 5mg	€0.02	€1.20
Amitriptyline 25mg	€0.02	€2.40
Fluoxetine 20mg	€0.10	€3.00
Benzhexol 5mg	€0.01	€0.60
Chlordiazepoxide 10mg	€0.05	€2.10 for 2 weeks
Diazepam 5mg	€0.01	€0.14 for 2 weeks
Phenobarbitone 30mg	€0.01	€0.60
Phenytoin 100mg	€0.03	€1.80
Carbemazepine 200mg	€0.03	€1.80
Sodium Valproate 200mg	€0.12	€10.80
Drug (Injections)	**Price per injection**	**Treatment Cost**
Fluphenazine Decanoate 25mg (Long acting injection)	€1.20	€2.40 per month
Chlorpromazine 50mg	€0.30	€0.60 one-off
Haloperidol 5mg	€0.30	€0.60 one-off
Diazepam 10mg	€0.30	€0.30 one-off

Typical prices of essential psychotropic drugs

Those who cannot afford to pay

It is necessary to devise a system for those who cannot afford even the low price of these drugs. Psychosocial disabilities in the main

income earner can be devastating for poor families, and this needs to be recognised and addressed when it occurs. Options include a charitable fund which is drawn upon for this purpose, or selling the drugs at a rate to most people that allows a surplus to build up so those who need to can have drugs for free. In most developing countries families take care of relatives' medical needs very seriously, and should be encouraged to consider long-term medical treatment of their family member as their responsibility.

Promotion

Health promotion is the process of enabling people to increase control over, and improve their health. Empowering people to improve in their own mental health reduces the burden of mental illness for individuals and at the community level.

Promotion of good mental health involves providing information about;
➤ Behaviours that are risk factors for psychosocial disabilities such as use of drugs or alcohol
➤ Activities that encourage good mental health such as maintaining good family relationships and a good balance between work and leisure time.

The routes for delivery of this information may be through the general media using radio or TV programmes about health, or newspaper articles. Another route is by targeting health staff and teaching them to give these messages during contact with patients. There is good evidence that encouraging general doctors to give a simple message about the dangers of drinking alcohol to excess is effective in reducing such behaviour in their patients.

Schools are good places to give this information, as it is an opportunity to encourage people at an early stage to make informed, healthy choices about their lifestyle. It is also an efficient and convenient forum for addressing a whole section of society and be confident of having achieved a good level of coverage in a geographical area. Many mental health problems can start during this period.

Other specific groups such as women should be deliberately targeted as they may not have the same access to information as others. People with disabilities need to have access to information available to others (eg Braille information leaflets), but also may need specific information related to their particular needs (such as the risk of addiction to certain drugs they might be prescribed for pain relief for example).

Prevention

Prevention of mental conditions that cause psychosocial disability associated with them is better than responding to them after they have started. Addressing social risk factors for psychosocial disability such as poverty, inadequate health care provision (especially for child-birth), domestic violence and sexual abuse will reduce the number of people who develop mentally disorders. Many of these issues can be effectively addressed at a community level (though social aspects of CBR programmes for example). Activities at government level, such as increasing the price of alcohol has also been shown to be very effective at discouraging unhealthy behaviours.

Most illnesses are more effectively treated if identified early. This is also the case with mental and neurological illnesses. The general public and those working with vulnerable groups such as children can be made aware of how to refer those they have concerns about. Easy referral and accessible services improve the chances of those who do have problems having a good recovery (secondary prevention).

Even with good primary and secondary prevention, there will be some people who develop long-term disabilities. The aim in this case should be to limit the degree of disability as much as possible, for example with good quality rehabilitation services, aimed at inclusion of those who have been excluded from society because of their psychosocial disability.

6. Advocacy and human rights

Discrimination at all levels

People with psychosocial disabilities are among the most marginalised in societies around the world. The person may lose the rights and status they would otherwise have. Sometimes they are blamed for their condition, and traditional treatments can sometimes be painful and degrading. Their marginalisation and low status can lead to physical and sexual abuse.

Containment, for example by chaining or imprisonment is often resorted to in environments where adequate treatment is not available. This is expressly prohibited under the Universal Declaration on Human Rights. Provision of accessible treatment is therefore probably the most powerful tool for restoring dignity and status to someone with a severe and enduring mental condition such as schizophrenia. It is the foundation upon which accessing other human rights can be built. Claiming the right to treatment and encouraging

governments to take responsibility for this is a key component of an effective programme.

The twin Track approach

Discrimination can happen at all levels of society. Many people with psychosocial disabilities find it difficult to find work or education, to be respected as full members of their communities, or to find a marriage partner. This structural discrimination must be addressed at many levels. It is for this reason that CBM advocates a 'twin-track approach'. This means that we should be working in practical ways at the community and government level to ensure that persons with disabilities are included in social and state services and, and at the same time provide disability-specific interventions empowering persons with disabilities where they have particular needs.

'Nothing about us without us'

At both levels, it is essential that all such work is primarily aimed at enabling those with disabilities to speak for themselves and to be heard. This self-advocacy is not only better in principle, but is more effective.

Disabled Peoples' Organisations (DPOs) have a central role in setting the agenda and directing change in the field of advocacy and human rights for people with disabilities. Even where other DPOs are relatively advanced, these organisations are often non-existent or in their infancy in the field of mental health.

Helping to establish user groups and consulting clients should be a standard activity of partner projects. Encouraging the development of independent networks for mutual support and a united voice for advocacy is an important role that CBM and its partners can play.

Removing chains from person with schizophrenia, Nigeria

Working at community level

Even if people are able to access services and have the symptoms of their mental illness reduced, they are not able to fully participate in society if the stigma is such that they are not accepted as valid members of society. Stigma also affects families across generations, institutions that provide treatment, and mental health workers. Workers in programmes should be confronting discrimination, ignorance and negative attitudes in their work, particularly addressing problems encountered by clients in their daily lives.

There is good evidence (though mostly from richer countries) to show that campaigns aimed at educating and changing attitudes of the general public are effective, and can have a positive impact on quality of life. Public awareness programmes challenging stigma should be a part of programmes with a mental health component. Techniques to challenge attitudes include;

➤ Grass-roots education (such as use of community volunteers in plays about discrimination and human rights)
➤ Talks in churches/mosques, schools, nurse/doctor training programmes etc
➤ Involving persons who have experienced mental health problems is a particularly powerful way of doing this
➤ Using the media such as radio, TV and newspapers

The most powerful way that we can effect change in projects is by demonstrating non-discriminatory practice in our own projects. This includes ensuring access to resources (for example microfinance schemes within CBR), employing persons with psychosocial disability, and ensuring their inclusion on advisory bodies.

The legal environment

About one third of all countries in the world (half in Africa) have no policy relating to mental health. A national policy framework is an important first step in ensuring compliance with some of the UN conventions in government and civil society structures. Most legislation includes some provision for legal involuntary admission to hospitals for treatment, sometimes with little legal redress for the person being admitted. Some user groups argue that such legislation is discriminatory, and the official position of a particular project on the local legislation should take into account views of all stakeholders, including users of services.

The Convention on the Rights of Persons with Disabilities was adopted by the UN General Assembly in 2007. It includes mental and intellectual impairments as "Persons with disabilities include those who have long-term physical, mental, intellectual, or sensory impairments...". The Convention is one of the first "legally-binding" tools in this area. This provides a powerful resource with which advocacy with government agencies and other key stakeholders can be supported.

CBM actively advocates a 'human rights approach' to disability and development, so the legal environment should not be ignored. It must be remembered though, that policy change is only the first step in practical action for change that will actually affect disabled persons and the communities around them. Structures that restrict persons with disabilities from full participation are firmly established and must be addressed in practical ways in a consistent manner.

Demolishing these structures demands lobbying for policy change, and fighting for implementation of good law (through litigation if necessary). Specific awareness-raising among those who implement law (police, magistrates etc) is a necessary step as in most countries this does not follow legislative change. Education of users about their rights under the law, and the general public of their responsibilities under the law also helps to ensure maximal use is made of positive legal provision.

Action should be at all levels

Rights and Dignity of
Persons with Disabilities

International initiatives...

...local initiatives: Local Support Group in Latin America

7. Emergencies and mental health

Projects that are well established in communities are well placed to provide support in the event of emergencies. CBM's particular focus on people with disabilities allows us to address one particularly neglected area; the effect of disaster situations on those with disabilities. When resources of communities are stretched, and already fragile infrastructure collapses, the needs of vulnerable members of society are often not met.

There are many potential psychological consequences of a major disaster on the individuals affected. Attempts to cope with the psychological impact can lead to inappropriate behaviours such as excessive alcohol use, aggression or self-harm. In some cases it can lead to diagnosed mental disorders such as post-traumatic stress disorder. People who already have mental disorders such as schizophrenia or depression are particularly vulnerable to relapse in these times of stress.

Disaster preparedness

Good preparation can do a lot to reduce the suffering after a disaster. As experts in health, disability and development, CBM partners can be valuable members of government disaster preparedness committees and programmes. Such alliances should be growing in most countries through the efforts of UN agencies such as the Inter-Agency Standing Committee (IASC). If they are not, then they should be started. In this way, we can ensure that the needs of those with mental health problems as well as persons with other disabilities are considered.

A timely and appropriate response

A mental health response is now accepted as part of the standard range of interventions in immediate post-disaster situations. Many communities are in fact very resilient even in the face of great stresses. Care must be taken that attempts at emergency intervention take into account well established cultural coping strategies.

a) **Acute emergency phase; The most helpful intervention in the early stages is to support the usual social support systems that come into play during any period of distress.**

This may mean initially focussing on shelter, safe drinking water and food, security, family reunification and other essential services to provide an environment where people can start to grieve properly. Good inter-agency communication is essential, as overlapping or inappropriate work can do more harm than good.

For those who are expressing distress, 'psychological first aid' can be offered. This is non-intrusive emotional support, protection from further harm, provision of basic requirements, and establishment of social support networks. Local people should be trained in advance in these skills if possible.

Distributing building materials to existing clients of projects in Bicol, Philippines after major typhoon and landslide, March 2007.

b) Post-emergency phase; It is in the months following the event that the small proportion of people with post-trauma problems who need more focused intervention can be identified and helped.

Identify those in need. This may be through existing structures or special services set up following the emergency. It is important to ensure that 'invisible' groups are included – remote areas, prisons, homeless persons.
Treatment is appropriate to the need. This may be a series of counselling sessions with a qualified person who is aware of the local culture. In some cases medication may be indicated. Those with serious long-term mental illness should be followed up as their usual care systems may have broken down (including drug supplies).

As with all cases at this stage, appropriate care should be provided through the established services. Where these are poor, building them up should be a priority.

c) The long-term; Good quality services can emerge from areas that have suffered disasters.

Ensure that following the disaster, local resources are used and developed rather than temporary parallel structures. Long-term plans should be made from an early stage.

Work towards development of sustainable structures that are resources for the long-term. Those with long-term problems resulting from the disaster are best served in a comprehensive service that also meets the needs of the rest of the population. In many cases these problems will require the same treatment.
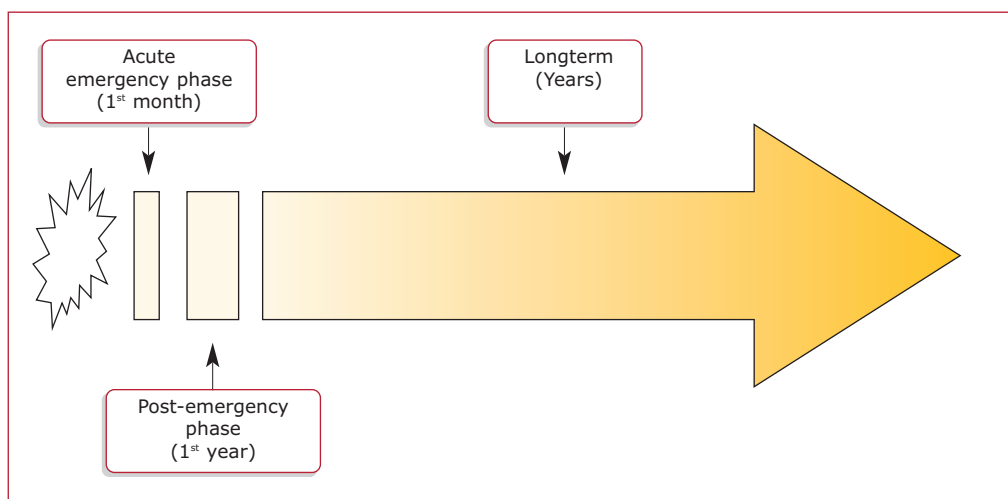
Phases of a timely and appropriate response

8. Resources

These resources and many more, are available for free on the internet. CBM Mental Health Advisors are also available for advice in some regions.

1. Training Manuals

1.1 Helping People with Mental Illness – A mental health training programme for community health workers – David Richards, Tim Bradshaw and Hilary Mairs
The University of Manchester, UK, 2003

These materials are designed so that an ordinary person who has done the course can use them to train other people.

1.2 Mental Health and Human Rights – community education manual
Amaudo UK, 2008
A course for addressing human rights issues with a community education programme. Particularly designed for training village health workers/community extension workers.

2. Practical Resource books

2.1   Where There Is No Psychiatrist – A mental health care manual
      – Vikram Patel
      The Royal College of Psychiatrists, Gaskell, 2003
      A very helpful reference for field and nurse-level staff giving
      practical advice about management of clients in the community.

2.2   Epilepsy – A manual for medical and clinical officers in Africa –
      Dekker, P.A.
      Revised edition, 2002. Secretariat ILAE/IBE/WHO Global Cam-
      paign against Epilepsy
      http://www.who.int/mental_health/media/en/639.pdf
      This manual has been prepared to help those people who are
      responsible for the primary health care of clients with epilepsy
      and who may be working in the rural areas.

2.3   WHO/IASC Guidelines of Mental Health and Psychosocial sup-
      port in emergency settings
      www.who.int/hac/network/interagency/news/mental_
      health_guidelines/en/index.html

2.4   Essential Skills for Mental Health Care, Jim Crabb and Emma
      Razi, BasicNeeds, 2007
      A clear and comprehensive basic manual for mental health care
      workers at all levels. The focus is on medical and psychological
      treatment (rather than a rights-based, advocacy approach).
      Though written for the African context, its emphasis on practi-
      cal and simple interventions will make it useful in other low
      income countries.

3. Journals, Periodicals, Newsletters

3.1   Developing Mental Health
      International Community Trust for Health and Educational Serv-
      ices (ICHES)
      www.icthesworldcare.com/devHealth.htm and can be posted
      free of charge

"Developing mental health aims to serve those working, in any
capacity, to relieve the condition of people who are mentally ill in
developing countries." - Prof. A. Smith

3.2   World Psychiatry
      Official Journal of the World Psychiatric Association (WPA)
      www.wpanet.org/publications/journalwpa.html

4. Technical Papers, Reports, etc.

4.1   The World Health Organisation has published many important guidelines, documents and reports. All available from the WHO mental health website; www.who.int/mental_health

4.2   The World Health report 2001, Mental Health: New Understanding, New Hope.

4.3   WHO Mental Health Gap Action Programme (mhGAP), 2008

4.4   Lancet Series on Global Mental Health, 2007
www.thelancet.com/online/focus/mental_health/collection
An important collection of current evidence for the importance of scaling up community mental health services.

4.5   UN Convention on the Rights of Persons with Disabilities
www.un.org/disabilities/

5. CBM Resources – Policy, guidelines etc

5.1   Available on the CBM Intranet under Mental Health Resources, or from Mental Health Advisers

5.2   Disability and Development Policy. CBM, 2006

5.3   Project Cycle Management Handbook. CBM, 2007

5.4   Mental Health Policy. CBM, 2008

5.5   Criteria for Success in Mental Health Disorders. CBM, 2008

5.6   Guidelines on Child Protection, CBM, 2008

6. Other web resources

There are many groups advocating in the field of mental health. Some are run by persons with psychosocial disabilities, some by others (such as carers or professionals).
Opinions and priorities vary widely among these groups.

Global Forum for Community Mental Health
www.gfcmh.com

Movement for Global Mental Health
www.globalmentalhealth.org

World Network of Users and Survivors of Psychiatry (WNUSP)
www.wnusp.net

World Federation for Mental Health (WFMH)
www.wfmh.org

World Association for Psychosocial Rehabilitation (WAPR)
www.wapr.info

BasicNeeds
www.basicneeds.org

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together we can do more

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