

# **1.MENTAL HEALTH CARE IN LOW INCOME COUNTRIES**



# **1.1 Mental Health Gap Action Programme: Scaling up care for mental disorders within the community**

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Mental health is paramount to personal well-being, family relationships, and successful contributions to society. The World Health Organisation's objective in mental health is to reduce the burden of mental disorders worldwide. This is possible only by implementing effective prevention and treatment strategies integrated into health care systems. This paper briefly describes WHO's mental health Gap Action Programme and how this programme is attempting to scale up care for mental, neurological and substance use disorders within community settings.

Mental, neurological and substance use (MNS) disorders are major contributors to premature mortality and morbidity. The stigma and human rights violations directed towards people with these disorders compounds the problem, increasing vulnerability and accelerating and reinforcing the decline into poverty, as well as hindering efforts to rise out of poverty. Fourteen percent of the global burden of disease can be attributed to mental, neurological and substance use disorders. Almost 30% of all the noncommunicable disease burden is due to these disorders. Almost three quarters of all Disability Adjusted Life Years (DALYs) lost due to neuropsychiatric disorders are in low and lower middle income countries. The total number of DALYs lost in low income countries because of neuropsychiatric disorders is 2.3 times more than in high income countries.

However, the resources provided to tackle the huge burden of mental, neurological and substance use disorders have remained insufficient.

Almost a third of countries still do not have a specific budget for mental health. Of the countries that have a designated mental health budget, 21% spend less than 1% of their total health budgets on mental health. Figure 1 compares the burden of mental disorders with the budget assigned to mental health; it shows that countries allocate disproportionately small percentages of their budgets to mental health compared with their burdens.

The scarcity of resources is even greater for human resources presents the distribution of human resources for mental health across different income categories.

There is also inefficiency in the use of scarce and inequitably distributed resources. For example, many middle-income countries that have made substantial investments in large mental hospitals are reluctant to replace them with community-based and inpatient facilities in general hospitals, despite evidence that mental hospitals provide inadequate care and that community-based services are more effective.

Progress to organise services for people with MNS disorders thus needs to be accelerated, and allocation of more resources to these areas will be critical to this process.

### **Mental Health Gap Action Programme**

WHO aims to provide health planners, policy-makers and donors with a set of clear and coherent activities and programmes for scaling up care for mental, neurological and substance use disorders through the *Mental Health Gap Action Programme 13* to those who have a large proportion of the global burden of MNS disorders.

### **Strategies**

This programme is grounded on the best available scientific and epidemiological evidence on priority conditions. It attempts to deliver an integrated package of

interventions, and takes into account existing and potential barriers to scaling up care. The priority conditions identified by the above criteria for *mhGAP* are depression, schizophrenia and other psychotic disorders, suicide, epilepsy, dementia, disorders due to use of alcohol, disorders due to use of illicit drugs and mental disorders in children. These disorders are common in all countries where their prevalence has been examined, and they substantially interfere with the abilities of children to learn and with the abilities of adults to function in their families, at work and in broader society. The economic burden imposed by these disorders, includes loss of gainful employment, with the attendant loss of family income; the requirement for caregiving, with further potential loss of wages; the cost of medicines; and the need for other medical and social services. These costs are particularly devastating for poor populations.

Considerable information about the effectiveness of various interventions for the reduction of the burden of MNS disorders is now available. Although it is useful to determine which interventions are effective and cost effective for a particular set of disorders, this is not the end of the process. Other criteria need to be considered in decisions about which interventions to deliver, such as the severity of different disorders (in terms of suffering and disability), the potential for reduction of poverty in people with different disorders, and the protection of the human rights of those with severe MNS disorders. WHO is developing a model intervention package consisting of interventions for prevention and management for each of the priority conditions, on the basis of evidence about the effectiveness and feasibility of scaling up these interventions.

## **FRAMEWORK FOR COUNTRY ACTION**

*mhGAP* aims to provide a framework for scaling up interventions for mental, neurological, and substance use disorders. The framework takes into account the various constraints which might exist in different countries. However, the programme is only intended as a guide for action, and should be flexible and adaptable enough to be implemented according to the situation in different countries.

The approach described in *mhGAP* has been designed to be consultative and participatory, to take account of national needs and resources, and to build on existing programmes and services. *mhGAP* is being implemented by the WHO country offices, supported by headquarters and regional offices.

### **Political commitment**

Success in implementation of the programme rests, first and foremost, on achievement of political commitment at the highest level, and acquisition of the necessary human and financial resources. One way to achieve these prerequisites could be to establish a core group of key stakeholders who have multidisciplinary expertise to guide the process. Existing mechanisms to bring together relevant stakeholders should be assessed before the decision to set up a new group. Key stakeholders who need to be involved in the process include policy-makers, programme managers from relevant areas (such as essential medicines and human resources), communication experts, and experts from community development and health systems. The programme will need input from psychiatric, neurological, and primary care health professionals; social scientists; health economists; key multilateral and bilateral partners; and nongovernmental organizations (NGOs). Service users are also important stakeholders and their input will be essential.

### **Assessment of needs and resources**

A situation analysis should provide a thorough understanding of the needs related to MNS disorders and the relevant health care, and help to guide effective prioritisation and phasing of interventions and strengthening their implementation. Although available data might be limited (e.g. they may not be nationally representative or might vary in quality) information should be collected using existing sources as far as possible.

The situation analysis involves several tasks:

- describe the status of the burden of MNS disorders for the country, region, or selected population;
- identify human, financial and material resource requirements, taking into account existing health sector plans and development strategies;
- examine the coverage and quality of essential interventions, and any reasons for low or ineffective coverage;
- describe any current policies that are relevant to MNS disorders and the status of their implementation, any current spending on these disorders, and the principal partners involved; and
- synthesise the information to highlight important gaps that must be addressed for scaling up care for MNS disorders. SWOT analysis, to identify strengths, weaknesses, opportunities, and threats, is a useful approach for this task.

### **Development of a policy and legislative infrastructure**

A supportive policy environment aids the process of scaling up interventions for MNS disorders because policies define a vision for the future health of the population, and specify the framework to be put in place to manage and prevent priority MNS disorders. Policies need to be grounded in the principles of respect for human rights, and of fulfilment, promotion, and protection of those rights. When clearly conceptualised, a policy can coordinate essential services and activities to ensure that treatment and care are delivered to those in need, and that fragmentation and inefficiency in the health system are prevented. The Mental Health Policy and Service Guidance Package that has been developed by WHO consists of a series of practical, interrelated modules, designed to address issues related to the reform of mental health systems. This Guidance Package can be used as a framework to assist countries to create policies and plans, and then to put them into practice.

Actions required:

- draft or revise policy to set out its vision, values, and principles, its objectives, and key areas for action;
- incorporate existing knowledge about improvement of treatment and care and prevention of MNS disorders;
- involve all relevant stakeholders;
- work with other relevant sectors, and review other relevant policies; and
- develop means for implementation of the policy.

Mental health legislation is also essential to address MNS disorders. Mental health law codifies and consolidates the fundamental principles, values, aims, and objectives of mental health policies and programmes. It provides a legal framework to prevent violations, to promote human rights, and to address critical issues that affect the lives of people with mental disorders. WHO has developed the *Resource Book on Mental Health, Human Rights and Legislation*, which describes international standards for the rights of people with mental disorders; key issues that need to be considered and included in national mental health law; and best practice strategies for development, adoption and implementation of mental health law.

### **Delivery of the intervention package**

Decisions about how best to deliver the chosen interventions at health facility, community, and household levels are critical to ensure maximum impact, high quality, and equitable coverage of the interventions. Delivery of the package depends on the capacity of health services, available financial, human, and material resources, and the community context. Key considerations for delivery of services include:

- design of responsibility for implementing interventions at different levels of the health system;
- integration into existing services;

- development of implementation strategies for community, primary, and referral facility levels that will achieve high coverage of the chosen interventions;
- strengthening of health systems;
- improvement of links between communities and the health system;
- development of strategies to reach populations with special needs;
- development of strategies to deal with special situations, such as emergencies.

*mhGAP* calls for mental health to be integrated into primary health care. Management and treatment of MNS disorders in primary care should enable the largest number of people to get easier and faster access to services; many already seek help at this level. Integration of mental health into primary health care not only gives better care, it also cuts wastage resulting from unnecessary investigations and from inappropriate and non-specific treatments.

Health systems will need additional support to deliver the interventions. The drugs, equipment and supplies that need to be available at each level of service delivery need to be identified, and mechanisms for their sustained supply need to be developed. Appropriate referral pathways and feedback mechanisms between all levels of service delivery will need to be strengthened.

An epilepsy project in rural China has demonstrated delivery of services through existing systems, and integration of the model of epilepsy control into local health systems. The results confirmed that epilepsy patients could be treated with phenobarbital through local primary care systems by town clinic physicians and rural doctors with basic training.

The methods used in this project should be suitable for extension into rural areas of China, and perhaps to other developing countries.

In fact, after the success of the initial study, the project was extended with support from the central Government to include 34 counties in China, with 19

million people. One thousand five hundred local physicians have been trained and more than 10,000 people with epilepsy have been treated.

Delivery of a package of interventions will require fostering community mobilisation and participation, and activities that aim to raise awareness and improve the uptake of interventions and the use of services.

Planning for delivery of the intervention package also needs to incorporate populations with special needs (e.g. different cultural and ethnic groups or other vulnerable groups such as indigenous populations). The approach used for delivery of services must be gender sensitive. Gender differences create inequities between men and women in health status. In addition, gender differences result in differential access to and use of health information, care, and services (e.g. a woman might not be able to access health services because norms in her community prevent her from travelling alone to a clinic).

### **Strengthening of human resources**

Human resources with adequate and appropriate training are necessary for scaling up all health interventions, and especially for MNS conditions, since care for these conditions relies heavily on health personnel rather than on technology or equipment. Most countries with low and middle incomes have few trained and available human resources, and often face distribution difficulties within countries or regions (e.g. too few staff in rural settings or too many staff in large institutional settings). The problem has been exaggerated by migration of trained professionals to other countries. Moreover, staff competencies might be outdated or might not meet the population's needs. The available personnel might not be used appropriately and many might be unproductive or demoralised. Infrastructure and facilities for continuous training of health workers in many low-income countries are lacking.

Development and upgrading of human resources are the backbone of organisational capacity building and one of the primary challenges of scaling up.

The goal for human resources is simple but complex to reach – to get the right workers with the right skills in the right place doing the right things.

For each intervention package, a specific category of health personnel is identified to take responsibility for delivery of the interventions at each level of service delivery. For example, primary health care professionals may be able to identify and treat most cases of psychoses with first-line antipsychotic medicines, whereas cases with bipolar disorders requiring maintenance treatment will need to be referred to a specialist. Access to health services can be improved by involving multiple cadres at various levels of the health system. Where doctors and nurses are in short supply, some of the priority interventions can be delivered by community health workers – after specific training and with the necessary supervision. For many priority conditions, delivery should be implemented with a stepped-care model, which consists of clearly defined roles for each level of care from primary to highly specialised care. This requires relevant training for each level of health professional.

Identification of additional skills that might be required by each category of health professional is also necessary. Skills might need to be strengthened, and new skills might need to be acquired. For example, primary health-care professionals could need training in psychosocial interventions for schizophrenia. The next step is to decide how these additional skills will be built.

Key actions include:

- appropriate pre-service and in-service training of different cadres of health professionals with curricula that are needs-based and fit-for-purpose;
- improvement of access to information and knowledge resources;
- development of supportive supervision; and
- development of simplified diagnostic and treatment tools.

In the short to medium term, in most countries, investment in in-service training will be needed. At the same time, early efforts should be made to strengthen the basic curriculum (pre-service training).

Strategies are needed to develop specialists, to manage and treat complex cases, to provide ongoing supervision and support to non-specialists, and to teach and train other health professionals.

### **Mobilisation of financial resources**

Most countries with low and middle incomes do not assign adequate financial resources for care of MNS disorders. Mobilisation of the necessary financial resources for scaling up is therefore an important task. Accurate costing is a necessary first step, to set realistic budgets and to estimate resource gaps, before resources can be mobilised. Different types of cost estimates will be required for different purposes. WHO has developed a costing tool to estimate the financial costs of reaching a defined coverage level with a set of integrated interventions.

Although the estimated investments are not large in absolute terms, they would represent a substantial departure from the budget allocations currently accorded to mental health. If the total health budget remained unchanged for 10 years, delivery of the specified package for mental health care at target coverage would account for half of total spending on health in Ethiopia, and 8.5% of the total in Thailand. Thus health budgets need to be increased, especially in low-income countries. Another important implication of this modelling exercise is that the delivery of mental health services needs to be changed. In particular, institutionally based models of care need to be replaced by community-based care, and more evidence-based interventions need to be introduced.

For sustainability, the marginal costs of strengthening the services for MNS disorders should be minimised by building on existing strategies and plans. Funding from governments will be required to deliver services for MNS disorders, and this will require that stakeholders argue their case determinedly.

If strategies for MNS disorders could be integrated with the governmental development plans for other sectors, sustained investment and resources for this area could be secured.

Resources for delivery of services for MNS disorders can be mobilised from various sources:

- The proportion of the budget allocated to these conditions within national health budgets could be increased. The *Mental Health Atlas* has demonstrated that almost a third of countries do not have a specified budget for mental health. Even those countries which do budget for mental health, allocate only a small proportion of funds to this area – 21% of them spend less than 1% of their total health budgets on mental health. Advocacy to encourage countries to increase this proportion will be important.
- Funds could be reallocated to the intervention package from other activities. If, in the short term, the percentage of the health budget that is allocated to mental health cannot be increased, it might be possible to reallocate resources from mental hospitals to community-based services, since evidence has shown that they are more effective and cost effective than hospitals.

External funding could be used. Since the health budgets of many countries with low or middle incomes are very low, scaling up of mental health care will typically require funding from external or donor sources.

Countries can access additional sums through special funding initiatives such as those provided through developmental aid, bilateral and multilateral agencies, and foundations. Identification of external resources – ideally within a time frame that can maintain momentum and reduce delays – is a key task for the scaling-up process.

A strategy for mobilisation of resources, based on assessment of needs and resources and plan of action, should be developed. WHO could support focal points for MNS disorders within countries to prepare proposals, to identify specific activities, and to fund the scaling up of services for MNS disorders.

## **Monitoring and evaluation**

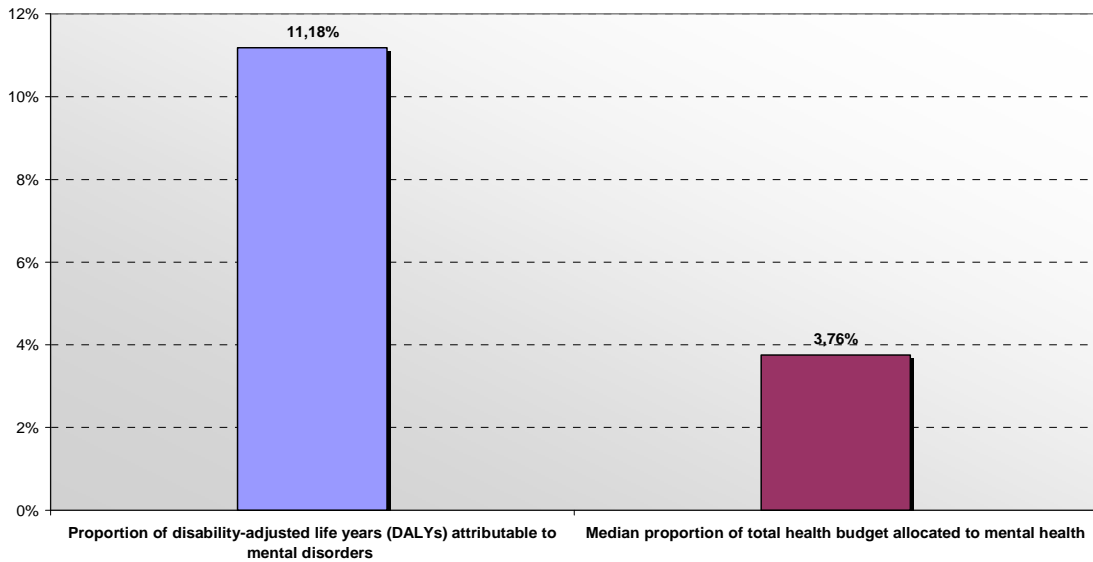
The phrase “what gets measured gets done” summarises the importance of monitoring and evaluation for the planning and implementation of the programme. The scope of monitoring and evaluation reflects the scope of the implementation plan. The process should incorporate selection of indicators and identification of tools and methods for measurement. Each country will need to decide which indicators to measure and for what purpose; when and where to measure them; how to measure them; and which data sources to use. Countries will also need to plan for analysis and use of the data.

## **Building partnerships**

Fundamental to *mhGAP* is the establishment of productive partnerships – i.e. to reinforce existing partners, attract and energise new partners, accelerate efforts, and increase investments to reduce the burden of mental, neurological, and substance use disorders. Scaling up mental health care is a social, political, and institutional process that engages many contributors, interest groups, and organisations. Governments, health professionals for MNS disorders, civil society, communities, and families, with support from the international community, are all jointly responsible for successfully undertaking this scaling up process. The way forward is to build innovative partnerships and alliances. Commitment is needed from all partners to respond to this urgent public health need.

## **Conclusion**

The paramount priority in the area of global mental health at this time is to provide treatment and care to people with mental disorders and support to their families. WHO's *mhGAP* attempts to do this by increasing the capacity of the existing health care system in delivering evidence-based care within the community using the primary health care system. This is likely to make care available to those who do not receive any.

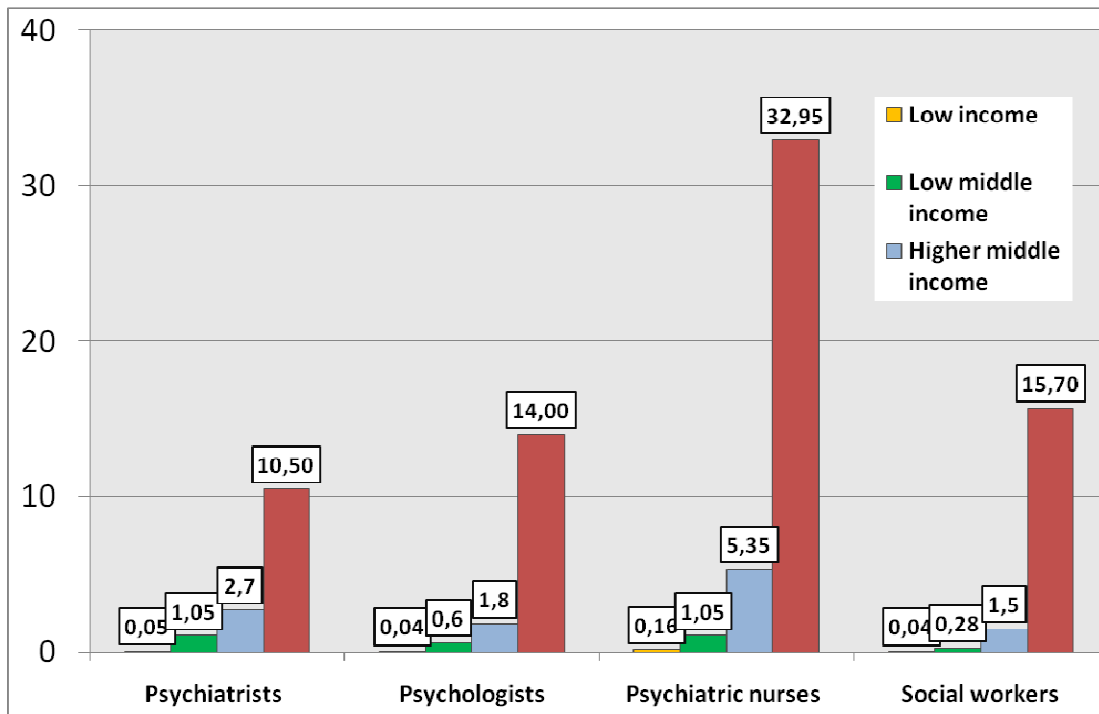


### Burden of mental disorders and budget for mental health

■ Source: <http://www.who.int/healthinfo/statistics/bodprojections2030/en/index.html>

■ Source: *Mental Health Atlas*, WHO, 2005

### Human resources for mental health care in each income group of countries, per 100 000 population



Source: *Mental Health Atlas*, WHO, 2005

## 1.2 Putting the Community Back into Community Mental Health: The Role of the Community Worker

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### **Introduction**

Community mental health has become virtually equated in the minds of many with primary health care. Against the backdrop of long-term institutional care, which has been the mainstay of mental health services in some countries for decades, primary care treatment seems the panacea. In many developed countries, community care came to the forefront in the 1970s in tandem with a

push towards deinstitutionalisation, spearheaded in Italy by Franco Basaglia. In much of the developing world, however, the move towards community care is a recent development, which is to be celebrated. The World Health Organisation (WHO) has been a driver of the community mental health agenda, forming the Global Forum for Community Mental Health in 2007 and publishing a number of reports promoting community care.

BasicNeeds is a founding member of the Global Forum for Community Mental Health and has ten years of practical experience of delivering mental health in the community. As of December 2008, BasicNeeds has helped 67,995 people with mental illness or epilepsy in 9 countries to live and work in their communities. BasicNeeds currently operates in four African countries (Ghana, Kenya, Tanzania, Uganda) and four Asian countries (India, Sri Lanka, Lao PDR and Nepal). The organisation was established in 1999 by Chris Underhill (co-author of this chapter) and uses an intervention, called the Model for Mental Health and Development, which can be easily replicated so as to reach large volumes of people in need. The BasicNeeds Model adopts a participatory rights-based approach to mental health which it delivers in five interwoven modules: capacity building; community mental health; sustainable livelihoods; research; and management. Through the community mental health module, rather than provide services directly, BasicNeeds mobilises psychiatric clinicians from the public sector and health volunteers from the community to coordinate weekly or monthly mental health clinics in outpatient primary health centres and follow-up care in people's homes.

In 2008, BasicNeeds conducted a review of the community mental health module of its Model, which highlights the practical learning from ten years implementing mental health in developing world communities. The qualitative study, *Practice of Community Mental Health: Seven Essential Features for Scaling Up in Low and Middle Income Countries*, assembles data from 19 focus group discussions, 22 key informant interviews and 16 observational sessions in Sri Lanka, Kenya, Lao PDR, Uganda, Tanzania and Ghana in search of the key

components to a successful community mental health intervention. One of the main conclusions of the study's principle investigator, Shoba Raja, is that a key and under-recognised component to successful community care for mental health is the community worker. "Community based workers fulfil a crucial role in delivering community mental health services. Their role needs to be further defined, including through legislation, to ensure they are earning appropriate salaries and receiving requisite training for their work."

Despite the growing global popularity of community-based models for mental health, the role of the community in community mental health remains ill-defined. In the experience of BasicNeeds, many groups of people within the community play important roles in a person's recovery from mental illness. A separate chapter of this book will examine the role that users play in their own recovery and mental health advocacy, using the example of Ghana. Other key players from the community include village leaders, religious leaders, traditional healers, teachers, and community workers. The following chapter focuses specifically on the role of the community worker in delivering mental health treatment, drawing on material from the *Practice of Community Mental Health* study, the BasicNeeds *Impact Report 2008*, and data and materials collected by the skilled research officers embedded in each of BasicNeeds' programmes.

### **What is the Role of the Community worker in Mental Health?**

Although primary care services are essential to mental health, community care does not stop at the clinic. One of the main settings for community mental health is in the community itself, which is to say in people's homes, in meeting places and in the streets. As the *Practice of Community Mental Health* study points out: "The primary health clinic may serve as a home base for [community mental health], but a chain of activities occur from the home to the village to the hospital. Diagnosis and prescription activities may happen at primary health clinics but follow-up visits and supporting services often occur within the village or the home of the user."

While the role of users and families in care is emphasised in most mental health policy documents, the community worker most often goes unduly ignored.

Community workers are instrumental to delivering the BasicNeeds Model for Mental Health and Development and they exist across all the country programmes. BasicNeeds has trained and is presently working with 2,928 community workers in the six focus countries of this study. Who they are, what they do, how they are trained and paid differs, however, according to the context on the ground. The following information draws from six countries where BasicNeeds operates: Sri Lanka, Kenya, Lao PDR, Uganda, Tanzania and Ghana.

### Who are community workers?

Community workers are members of the community without formal training in health. They are sometimes called “community volunteers” or “community health workers” or even “village workers”.

The job of a community worker is not confined to the health sector. Indeed, they are often involved in poverty reduction programmes and other areas

relating to determinants of health rather than specific health interventions.

Community workers are usually recruited from large government programmes or from other NGOs and work on a per diem basis.

#### **Role of Community Workers in BasicNeeds**

*Village volunteers are the key persons to motivate people with mental health problems to come to the outreach clinics. – BasicNeeds **Lao PDR***

*Our rural programme relies heavily on government trained and managed community volunteers. Partners with a wide network of volunteers, paralegals, human and justice committees more readily take on mental health awareness and advocacy. – BasicNeeds **Kenya***

*Community volunteers have the responsibility to identify and provide mentoring for young carers and most vulnerable children to cope with the difficult situation they live in. The formation of 20 new self help groups is also a major change that has resulted from their work. – BasicNeeds **Tanzania***

*Community workers have supported mentally ill people and people with epilepsy and families to understand the medications prescribed and take them as directed. This can be described to have brought about a reduction of defaults in taking medications, including under- and over-dose. – BasicNeeds **Ghana***

*Volunteers often address all people with mental illness as their relatives and friends using pronouns such as ‘Uncle’, ‘Brother’, ‘Sister’ and ‘Grandpa’. This makes people with mental illness to feel that volunteers are close to them, and builds their self confidence. – BasicNeeds **Sri Lanka***

*Unlike officials in hospitals, these sisters (volunteers) treat us like friends and support us to do work together.’ - Neil Chaminda, 28 year old service user in **Sri Lanka***

Community workers can be men or women and encompass a broad range of ages with basic levels of literacy. In the BasicNeeds Asian programmes in Lao PDR and Sri Lanka, community workers are predominantly women (86% and 83% respectively), whereas in the African programmes, they are predominantly men (in Ghana), or are equally divided between men and women (in Kenya). The average age of community workers is 30-50 in Ghana, and ranges from 20-45 years in Tanzania. In the Sri Lanka and Tanzania programmes, recovered service users form a significant contingent (20% and 5% respectively) of the community workforce. Users are often happy to do this work, having benefitted from it themselves.

### **What do community workers do?**

There is a broad range of activities conducted by community workers, including many key functions on the continuum of mental health treatment. It is these workers who do the active case-finding of people with mental illness or epilepsy in their communities and refer them to the clinic. They also help set up the clinic, ensuring that the venue is in order and supplies are on hand. The more literate community workers also register service users and take down their family history. Following clinic visits, community workers conduct home visits, during which they discuss the role of medication with users and carers and they check on the individual's overall progress, both in terms of health, livelihood and social integration. The BasicNeeds programme in Ghana credits community workers with high rates of medication adherence (see text box). During home visits, community workers also perform a service comparable to that of counselling, by listening to people's concerns, identifying a problem and helping them to arrive at their own goals and solutions.

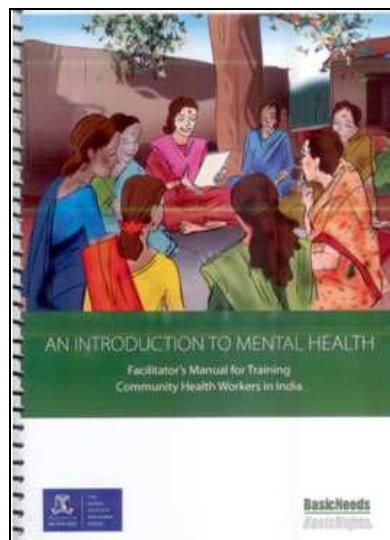
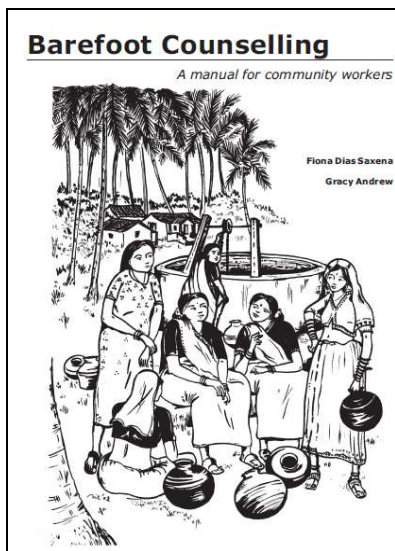
In addition, community workers play a crucial role outside of health-specific interventions. They facilitate the operation and documentation of self-help group meetings in Ghana, Kenya and Tanzania. They also support the horticultural projects of programme participants in Ghana and Sri Lanka.

And in some instances, such as Sri Lanka (see text box), socialising with community volunteers has had recognised benefits on the wellbeing of service users. Indeed, although livelihoods and socialising are not health-specific interventions, they have a powerful impact on the mental health of programme participants.

### **What training do they have?**

The training of community workers is variable. In many instances, community workers are enlisted in government programmes or are on the roster of large NGOs, such as the Red Cross, so they benefit from the training provided through those programmes. BasicNeeds provides specific training to all community workers in how to identify mental illness and epilepsy, how to manage the illness from home, and the links between poverty and mental illness.

At least two important resources exist and are available online for those interested in training community workers in mental health. The most recent of these is a training of trainers manual *An Introduction to Mental Health: Facilitator's Manual for Training Community Health Workers in India*, produced by researchers from the Nossal Institute for Global Health at the University of Melbourne in conjunction with BasicNeeds. The Nossal-BasicNeeds manual provides training in mental health first aid for all major mental disorders (common and severe), as well as basic counselling skills, and was pilot-tested in Maharashtra, India. Another very useful document is a training programme called *Barefoot Counselling*, designed by researchers at the Sangath Clinic for child and family mental health in Goa, India. *Barefoot Counselling* is written in simple English and provides training in counselling for depression and anxiety.



### **How many are there?**

As of June 2009, BasicNeeds was working with 2,928 community workers across six countries, not including India, which tracks its data separately since becoming independent. The ratio of service users to community workers is variable, but does not accurately reflect the “case-load” of a given community worker, since community workers are engaged in a number of different activities.

Sri Lanka is by far the BasicNeeds programme with the most volunteers. BasicNeeds has trained 1,912 volunteers in Sri Lanka in community mental health. These individuals report back to the field officers of BasicNeeds’ implementing partners. On average, a volunteer cares for 2-5 people with mental illness living near their house. Ghana is the country with the lowest ratio of health workers to participants (other than Uganda, which has stopped using health workers: see the challenges section below). Community workers in Ghana work with 15 participants each month and see each participant in their case-load, which averages 60 people, about three times in a year.

Jun-09	Service Users	Community workers	Ratio
<b>Lao PDR</b>	538	148	4
<b>Sri Lanka</b>	3,246	1,912	2
<b>Ghana</b>	17,462	138	127
<b>Uganda</b>	2,576	0	NA
<b>Kenya</b>	2,298	514	4
<b>Tanzania</b>	4,290	216	20
<b>Total</b>	<b>30,410</b>	<b>2,928</b>	<b>31</b>

### **How are community workers funded?**

Appropriate funding is fundamental to the success and sustainability of any community worker programme. Although they are often referred to as “volunteers,” community workers are not and should not be volunteers in the sense of unpaid workers. BasicNeeds recompenses community workers differently from country to country, however in general they provide a per diem stipend of £1-£5 (as shown in the following table). Community workers complement their BasicNeeds per diem with contributions from other government and NGO programmes. Governments typically pay with in-kind contributions, called “tokens,” which include t-shirts, bags, lunches and occasionally a bicycle.

There is no fixed rate for NGO stipends, which creates what one BasicNeeds employee qualified “a situation of competition between NGOs” for the best community workers. Such competition, or free-market, is arguably beneficial to the quality and recognition of community workers.

## Community Worker Wages

Country	Local currency	GBP (£)	Other
<b>Ghana</b>	30 cedis/month for an average of 6 full days of work	£12.6	"Tokens of appreciation" from the government
<b>Kenya</b>	200 shillings/day	£2.0	"Tokens of appreciation" from the government
<b>Laos</b>	0	£0	Reimbursement of transport
<b>Sri Lanka</b>	Volunteers: 0 Animators: 1,000 rupees/day	£0 £5.4	Volunteers receive reimbursement of transport Animators receive per diems
<b>Tanzania</b>	2,500 shillings/day	£1.2	"Tokens of appreciation" from the government

The Asian programmes are an exception in this practice of compensation with BasicNeeds Lao PDR and Sri Lanka offering no financial remuneration for community workers.

One BasicNeeds officer in Sri Lanka speculates that motivation for the work comes from a combination of factors: *“In Sri Lankan villages, people help each other during difficult times and this may be an extension of the same mind-set. Also, most volunteers are women and this may be giving them an opportunity to interact with like-minded people and also a way of socialising.”*

Sri Lanka has two categories of community worker, the volunteer and the more skilled animator. Community animators organise village consultation meetings, set up mental health clinics and support users with livelihoods projects, and they are paid £5/day.

### What are the challenges?

Managing a cadre of community workers is not without challenge. Foremost of these is the challenge of sustaining motivation in a context of limited remuneration. Joyce Kingori, BasicNeeds Programme Manager in Kenya notes that some community workers *“have expectations beyond what the project can offer. They expect cash, in-kind gifts, identification badges etc.”*

Similarly, Vipula Dasanayake, Project Coordinator in Sri Lanka, notes that *“In Tsunami affected areas, lots of NGOs had been working with big projects and they paid money for volunteers. With that practice, some volunteers became money-oriented in those areas.”* Indeed, the cash and in-kind contributions are a primary incentive for many people to take on the role. They both defray the costs of living and contribute to community recognition, which is a key reward in the absence of financial recompense.

The *Practice of Community Mental Health* study cautions that community workers did not work as well in Uganda because of “difficulty creating incentives.” Indeed, the Uganda programme had to stop using community workers, as it did not have a budget line for them. Tina Ntulo, Programme Manager for Uganda, describes the competing priorities between budgets for medicines and human resources:

*“The last time we interfaced with a Village Health Team was in 2006 during the DFID project. We paid them a stipend of between 2–4 GBP a month. There were 178 of them and the total cost of maintaining them came to about 612 GBP per year. The Big Lottery Fund Community Mental Health budget line for 2008 has 3,636 GBP. Drugs alone take up two thirds of this amount, not to mention fuel to get to the clinics and pay for the psychiatric personnel. So we do not work with the Village Health Team anymore.”*

The absence of financial incentives for community workers from the Village Health Teams also made them less effective in their work. Shoba Raja reports: *“It became apparent that follow up visits were not occurring in the Sembabule district as the volunteers were not provided with an incentive.”*

The challenge arising from budget constraints in Uganda had an unexpected positive effect, however, in eliciting user-led activism. Self-help groups in the Sembabule district stepped up to fill the service gap. The Bulamu Kwejjanjaba Mental Health Association (BUKA) group appointed a ‘village mobiliser’ in each village to monitor and follow up with members who missed clinic visits, counsel new participants and support carers.

The role of the community worker was replaced by users acting as “village mobilisers” in combination with radio announcements to inform people about clinics. The example from Uganda echoes the success of BasicNeeds in Sri Lanka and Tanzania in employing service users to perform the functions of community workers. More work is needed to determine the best procedure for involving recovered service users so that it can be adopted as a practice more widely.

### **Where do community workers fit into our understanding of global mental health?**

The idea of using community workers to promote community health and empower individuals is not novel within the field of health, but it is innovative within global mental health. The field of HIV has long embraced community workers as an essential part of the treatment network. Indeed, the *World Health Report 2004*, which focused on HIV, devoted part of a chapter to the role of community workers.

It argues that “community health workers have functioned successfully in small-scale nongovernmental programmes, as well as in large-scale national programmes integrated into the public health system” (chapter 3).

The concept of using community workers for treatment has more recently been referred to as task-shifting, referring to the shifting of certain responsibilities from health professional to lay-workers. In 2008, PEPFAR, UNAIDS and the WHO jointly published a set of guidelines on task-shifting for HIV: *Treat, Train, Retain: Task-Shifting rational redistribution of tasks among health workforce teams*.

The primary driver behind the move towards task shifting is the desire to scale up services in a context of limited resources.

There is no reason that mental health cannot benefit from the same practices as HIV and also promote wide-spread use of community workers. Indeed, the WHO suggests as much.

In 2001 the WHO produced a ground-breaking report *Mental Health: New Understanding New Hope* in which they put forth a “new paradigm” for mental health based in the community. The report contains ten recommendations, including to “give care in the community” (recommendation 3). The report makes mention of the need for community workers, which it calls “health workers,” although at a modest level, saying that the “shift towards community care requires health workers and rehabilitation services to be available at community level, along with the provision of crisis support, protected housing, and sheltered employment.”

In the intervening period between 2001 and now, a considerable amount of expertise has been developed regarding what a community worker should be doing. The recently published, *Mental Health Gap Action Programme (mhGAP): Scaling up care for mental, neurological, and substance use disorders* (2008) is ground-breaking in that for the first time the WHO is promoting a specific set of “priority interventions” for mental health care globally. MhGAP frames community care along three levels: “health facility, community and household,” and it clearly articulates a treatment role for community workers. “*The shortage of human resources demands pragmatic solutions. Community workers – after specific training and with necessary back-up, e.g. phone consultations with general practitioners – can deliver some of the priority interventions.*”

MhGAP frames community mental health within a context of empowerment, a word that features several times throughout the document.

On a global scale, a further document has been released by the WHO and WONCA which gives a number of case studies on the interaction of the community in the delivery of primary health care.

In seeking to define who community workers are and what their contribution is, we note in passing that the WHO-WONCA report defines the community sector as one outside the formal system of healthcare.

*“Informal community care comprises services provided in the community that are not part of the formal health and welfare system. Examples include*

*traditional healers, professionals in other sectors such as teachers, police, and village health workers, services provided by nongovernmental organisations, user and family associations, and lay people.*” By contrast, primary care is said to encompass all the basic components of treatment, such as diagnosis, prescription and follow-up. In short, according to this report, treatment in the community is treatment in the primary care clinic. At BasicNeeds, we tend to see the community worker as an integral contributor to the recovery of the person with mental illness, making contributions to treatment (mobilisation, organisation of clinics, motivation), family support and other important areas, such as livelihoods.

## **Conclusion**

Community workers are a pillar to BasicNeeds mental health interventions in both Africa and Asia, and they should be viewed as a formal component of all community mental health treatment. While they unquestionably have an important role to play in promoting mental health and raising awareness of mental illness, their activities extend beyond that perimeter to include basic components of mental health treatment, such as case-finding, referral, follow-up and medication supervision. Moreover, community workers welcome bio-psycho-social models of training and can serve as a complement or alternative to traditional healers for community care.

Although the impetus for task-shifting from health professionals to less formally skilled members of the community is largely resource-driven, community workers should not be seen as a cheap way out. Indeed, community workers are not less skilled workers, they are differently skilled workers.

This point was made forcefully by the *World Health Report 2004* with regards to community workers for HIV and it pertains equally to mental health:

*“Community health workers should not be viewed simply as local helpers who can temporarily take on tasks the formal health care delivery system lacks the resources to perform. They are not primarily a cheap way to deal with human resource constraints.*

*Rather, community health worker programmes can and should be seen as part of a broader strategy to empower communities, enable them to achieve greater control over their health and improve the health of their members.”*

In the long-term, cash rewards must replace in-kind contributions in order for community workers to receive a living wage and be able to maintain their work. These workers are activists whose main role is to mobilise vulnerable members of their community. The benefit of the community worker is that they can mobilise people better than a health worker, not that they can mobilise at lower cost.

In parallel with considerations about expanding the role for community workers in mental health, policy makers, researchers and programme designers should investigate possibilities for involving recovered service users in this function. At BasicNeeds, we think that service users can make a powerful contribution to augmenting the community based workforce, as they have demonstrated in our programmes in Sri Lanka and Tanzania. A community worker programme involving service users and other lay members of the community has the potential for widely scaling up mental health care, truly empowering communities and doing so sustainably.

## 1.3 Mental health within Community Based Rehabilitation

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### **Introduction**

Mental health is an inseparable part of general health and essential for the well-being and functioning of individuals, families and communities.

Mental disorders are a leading cause of disability worldwide and their impact on communities is large, but mental health still has a low priority on the development agenda and for society in general. In all countries that have been studied until now, there is a lack of accurate knowledge about mental health and mental disorders; instead, prejudice, negative attitudes and discrimination prevail. In low income countries, people with psychosocial disabilities<sup>1</sup> have extremely limited access to support and health services. They may live in the community but often are not allowed to participate in community life. The lack of community-based services leaves them excluded and isolated. Community-based rehabilitation (CBR) has the potential to fill in this gap.

### **What is Community Based Rehabilitation (CBR)?**

CBR is a strategy to ensure that more people with disabilities can be reached with good quality and appropriate services so they can take an active part in community life. CBR advocates in practical ways for the inclusion of people with disabilities in all aspects of society.

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<sup>1</sup>In accordance with the CBM Disability and Development Policy we choose the term 'psychosocial disability' when referring to people with chronic mental or neurological illnesses, because this term is based upon the social model of disability that focuses on barriers hindering the full participation of people with disabilities in society.

Comprehensive CBR involves working with people with all forms of impairment and networking with existing services so that they include people with disabilities. Where services do not exist or do not meet the needs of particular groups, CBR programmes provide these.

Sustainability and continuity can be achieved by getting the community to recognise and meet the needs of persons with disabilities in their own communities. This twin-track approach, with its emphasis on developing inclusive communities, not just on the ‘rehabilitation’ of individuals, makes CBR an integral part of community development.

The majority of people with disabilities live in low income countries, where they are particularly vulnerable to poverty and marginalization. Poverty has been shown to increase the risk of disability and conversely, disability increases the risk of poverty. Medical, educational and livelihood services are scarce and often too costly for people with disabilities to access. CBR is a cost-effective strategy that makes use of existing community services, promotes inclusion and thus reaches people with disabilities within their own communities. The new conceptual framework for CBR, developed by an alliance of UN agencies, international NGOs, Disabled People International, academic institutions and some national government representatives, has five major elements – health, education, livelihood, social life and empowerment.

### **Community based rehabilitation and community mental health**

CBR has only recently started taking into account mental health issues and people with psychosocial disabilities who are among the most marginalised people with disabilities. For centuries they have been systematically subjected to dehumanising treatment, discrimination and violation of their basic human rights. Psychosocial disability is perhaps the most misunderstood disability. There are many myths surrounding mental disorders, the most common being: “Mental disorders need treatment by specialists and can therefore not be dealt with by community workers” and “There is no hope for people with mental disorders and nothing can be done for them”

But these ideas are being challenged by a growing body of research evidence that people with different kinds of mental disorders can be successfully treated and integrated at community level.

The focus of CBR on finding solutions with available resources in the community and use of non-specialist workers can be of advantage for mental health work compared to a more clinical focus. The CBR principles of community development, gender and culture sensitivity, active participation of people with disabilities and their families, focus on human rights and commitment to inclusion must also refer to people with psychosocial disabilities. With adequately trained staff, volunteer commitment and incorporation of basic values, CBR can and should include people with psychosocial disabilities.

Many CBR programmes focus on work with children and therefore also have a good starting point for taking into account child mental health. This is especially important because child mental health is a widely neglected aspect although there is evidence that the lack of attention to child mental health may lead to mental disorders with lifelong consequences.

Good mental health is also a valuable resource for community development in general because it enables people to realise their full potential and to effectively solve their problems. The close link between CBR and community development requires taking into account the mental health needs of the whole population.

CBR has the potential to promote and protect the human rights of people with psychosocial disabilities, foster their inclusion in families and communities, support their recovery through medical and psychosocial interventions and assist them in leading productive and fruitful lives in livelihood security. CBR also plays an important role in promoting good mental health for all community members and participating in the prevention of mental disorders.

Since the mental health field is wide, a CBR programme alone will not be able to cover all aspects of mental health. By forming alliances with other institutions and organisations, even small interventions carried out together can have an important impact on the lives of individuals.

### **Approaches for including people with psychosocial disabilities in CBR**

In order to be acceptable and effective when working with people with psychosocial disabilities, CBR has to avoid a narrowly defined medical approach that solely relies on treatment with psychotropic drugs.

The following values are essential:

- just as with all people with disabilities, a human-rights based approach is important;
- diversity and the experience of living with problems are seen as positive values;
- people with psychosocial disabilities are treated with respect and dignity;
- people with psychosocial disabilities and their carers participate actively in all phases of treatment and psychosocial rehabilitation;
- CBR encourages the formation of self-help and self-advocacy groups run by service users and their carers;
- CBR takes into account the diverse needs of people with psychosocial disabilities from medical and psychological needs to their needs relating to food, decent housing, education, work, good relationships with their families and the community;
- CBR works closely together with other sectors such as the primary health care system, educational, labour and social welfare system and local governments to facilitate access to a variety of services.

### **Recovery, treatment and psychosocial rehabilitation**

Recovery is a concept explained by users as ‘a journey of personal growth and transformation. It is about moving beyond diagnosis. It is about creating a satisfying life of your choice.’ Recovery is an empowering model for users and those involved with them. It emphasises the person’s strength and ability to live a full and satisfying life, and the importance of sharing experiences with others.

Although some people with psychosocial disabilities may achieve a complete recovery, recovery does not necessarily mean freedom of all symptoms.

It can also mean that people learn to live well with a mental disorder. Recovery views mental health interventions as tools for living well and emphasises the importance of choice.

For many types of mental disorders interventions comprise a combination of medical, psychological and social interventions that take into account the living conditions of the individual and his or her wider community.

The *medical treatment* of mental disorders consists of medication and physical health care for the person with a psychosocial disability.

*Psychological treatment* encompasses education about the condition and treatment options, counselling and individual or group psychotherapy.

*Social interventions* aim to improve the opportunity for people with psychosocial disability to reach their optimal level of independent living and participation in the community, for example through training in daily living activities, social skills, family interventions, work preparation and work support.

### **Practical steps for including people with psychosocial disability into a CBR programme**

Start with a needs assessment and situation analysis. Based upon this information, decide on priority areas for mental health work to begin. Start small. As the field of mental health is broad it is important to prioritise building upon what works best and on addressing emerging needs as experience with mental health work increases. Involve service users and their families in planning, implementation and evaluation.

#### Needs assessment:

- Establish a small mental health team to take over responsibility for designing and implementing mental health work in the CBR programme.
- Review the national mental health policy and legislation. If it does not exist or is out-dated, advocate for the development of a national human rights-based mental health legislation and policy.
- Identify stakeholders and consult with them. The mental health team can make a list of all relevant stakeholders at different levels (community, district, regional, national) depending on the programme's coverage area and start a continuous consultation process.

#### Situation analysis:

- Find out which health services and community resources already exist that have the potential for including mental health work. Find out which specialist services exist for referral at regional and national level (secondary and tertiary).
  - Make contact with existing general and mental health services to find out their ways of dealing with mental health issues and interest in community mental health work. Problems of accessibility, acceptance and effectiveness can be identified in consultation with service users and their families.
- Get information about available psychotropic drugs in the country and consult with health services and users about accessibility, acceptance and affordability.

### **Promotion of good mental health and prevention of mental disorders**

Mental ill-health significantly reduces the quality of life of affected persons and their families. An integrated approach to mental health is necessary to change adverse factors that influence mental health such as poverty, violence, neglect and sexual abuse. Mental health promotion requires the involvement of many sectors that have to do with the cultural, socioeconomic and political determinants of mental health. The CBR programme can:

- Promote a climate that respects and protects the basic rights of everybody, including people with psychosocial disabilities.
- Strengthen community networks fostering a sense of social responsibility and discouraging alcohol and substance misuse and community violence.
- Engage different stakeholders to promote mental well-being and increase impact.
- Promotion and prevention are especially effective in childhood when mental, social and physical development is amenable to change.
- Promote preventative measures together with the primary health care system.
- Promote bonding and a secure attachment between mother and child. This reduces the likelihood of child abuse and neglect, of behavioural and emotional disorders in children and of later learning difficulties at school.
- Promote early stimulation of development, positive interactions between parents and children, education of children without violence and prevention of sexual abuse.

- Promote mental health in a school setting to enhance social and emotional competencies of students and prevent substance abuse and violence. A child-to-child approach to foster understanding of mental health and psychosocial disabilities is also useful.

### **Challenge stigma and discrimination in the community**

Discrimination of people with psychosocial disabilities and violations of their basic human rights are often more disabling than the condition itself. To challenge this situation CBR programmes can:

- Provide information and knowledge about mental health and psychosocial disabilities to community leaders and community organisations.
- Explain the difference between intellectual disability, mental disorder and epilepsy. Make clear that there exist interventions that can help people with psychosocial disabilities. Provide accurate data about recovery rates to health care staff.
- Help to overcome fears and prejudice. Avoid labelling and challenge common myths about mental disorders. Make clear that violence is not an inherent characteristic of a person with a psychosocial disability.
- Promote the human rights of people with psychosocial disabilities and challenge discriminatory behaviour when it happens.

### **Support the recovery of people with psychosocial disabilities**

Recovery focuses on the strengths of people with psychosocial disabilities and their capacity to lead productive and satisfying lives.

CBR programmes should:

- Treat people with psychosocial disabilities with dignity and respect and promote a human-rights based approach. Take into account the gender-based mental health needs of women.
- View people's problems in the context of their everyday life, difficult situations and conflicts. Do not treat people as 'cases' or 'disorders'.

- Build a positive relationship with people who have psychosocial disabilities and their carers based upon communication and trust.
- Inform people with mental disorders and their caregivers about the disorder without imposing labels. Inform them about available treatments so that they can make an informed decision about the choice of intervention. Avoid a 'doctor knows best' attitude.
- Shift the focus from the person's deficit to his or her strengths, interests and abilities. Encourage the person with a psychosocial disability to take an active role in recovery.
- Encourage the formation of groups run by service users and/or their carers such as self-help groups and associations for self-advocacy. Promote empowerment of people with psychosocial disabilities and encourage them to provide mutual support.
- Take into account not only the medical and psychological needs of people with psychosocial disabilities but also their needs for food, decent housing, education, work, good relationships with their families and the community.
- Work closely together with other sectors (primary health care, traditional healers, educational, labour and social system, local governments) in order to facilitate access for people with psychosocial disabilities to a variety of services.

### **Provide specific mental health interventions for people with mental disorders**

Mental health interventions usually combine medical, psychological and social interventions. CBR should work together with the PHC system and existing local mental health resources.

#### Ensure access to good medical care:

- Help to integrate medical mental health care into PHC and look for specialist back-up by mental health professionals.
- Train CBR staff and community volunteers to identify people with psychosocial disabilities, establish good relationships with them and their families, identify physical health problems, facilitate access to outreach clinics if appropriate, do

home visits and follow-up treatment. Challenge the myths surrounding mental disorders.

- Secure a reliable supply of essential psychotropic drugs, 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.
- Guarantee the responsible use of psychotropic drugs by good-quality training of health care staff. Inform people with mental disorders and their carers about possible side effects, what to do about them and about the risk of stopping or changing the dose of medication suddenly.

Provide good physical health care to people with psychosocial disabilities through the primary health care system. To achieve that CBR will need to raise awareness providing information to and tackling prejudices of health staff and PHC workers.

#### Ensure access to psychological interventions

Psychological interventions can be very helpful in improving thinking, stress management and self-esteem of a person with a psychosocial disability although verbalising may not always be culturally the most appropriate way for dealing with painful feelings. CBR programmes should:

- Encourage the person with a psychosocial disability to speak for him or herself and listen to what the person says.
- Look for psychologists who are willing to provide interventions or train non-professionals in a culturally appropriate way. If available, group therapies will generally be more appropriate than individual therapy.
- Train CBR and health workers in culturally appropriate techniques such as listening skills, basic counselling skills, relaxation methods and crisis intervention.

- Work together with traditional healers in an atmosphere of respect and sharing of knowledge. Healers are important mental health resources in countries with limited resources. Reduce harmful practices if present.

In low-income countries families are often the most important resources. With the person's consent provide information about mental disorders and how to deal with problems to the family.

Avoid burn-out through sharing care with other family and community members and encourage the formation of family support groups.

- Encourage people with mental disorders who have recovered to share their experiences with other people with psychosocial disabilities.

#### Ensure access to social interventions:

The needs for social interventions are quite similar for people with a variety of disabilities. CBR programmes can:

- Train CBR workers to identify the needs of people with psychosocial disabilities, plan and implement social interventions.
- Promote integration of people with psychosocial disabilities in family activities and improve housing and shelter for people with psychosocial disabilities who do not live with their families.
- Encourage the person with a psychosocial disability to rebuild social relationships and encourage opportunities for socialisation. Support the participation of people with psychosocial disabilities in community activities.
- Include the person with a psychosocial disability in CBR activities such as access to education and literacy programmes if necessary.

#### **Livelihood activities**

Probably the most important step an adult person with psychosocial disability needs to take for recovery is work.

Livelihood activities are the basis for independence and enablement and do not only imply having an income, but also mean improved self-esteem through holding a valued social position, having contact with others and being able to control one's life. CBR programmes can:

- Integrate people with psychosocial disabilities in mainstream community activities for income generation and give them access to CBR resources.
  - Promote job placement through return to previous work, contact small-scale industries and encourage self-employment in micro-enterprises. Provide ongoing support if necessary.
  - Make work place adaptations if necessary, for example provide a quiet working place if lack of concentration and noise sensitivity is a problem.
- Inform employers of their legal obligations towards people with disabilities according to the disability legislation of the country.

### **Training**

During the needs and situation analysis training, needs will have become clear at all levels. Training should be conducted by mental health professionals who are committed to working with the community and will provide support and back-up.

Involve locally available resource persons in training and supervision of mental health work. Working in CBR often requires a change of attitude for mental health professionals, especially learning to work together with non-professionals such as users, families, PHC and CBR workers.

Identify community volunteers interested in mental health work who are ideally elected and supported by their community.

Organize training events together with the public health system at several levels: for community volunteers and CBR workers, for nurses and physicians in primary health care and if necessary also for psychiatric nurses and mental health professionals.

Focus training on those who are ready to pass on their knowledge to others. If traditional healers are willing, training workshops may also be offered to them.

Train CBR workers in mental health issues; how to identify signs and symptoms of the most common mental disorders, how to support people with mental disorders and when to refer. Incorporate local understanding of mental health and mental disorders into training. Foster empathy and teamwork.

### **Focus on empowerment, advocacy and networking**

Empowerment, advocacy and networking are important for all people with disabilities. CBR programmes can:

- Recognise the personal knowledge of people with psychosocial disabilities and their families; promote the formation of user groups and self-advocacy and offer support if asked for. Foster links between people with psychosocial disabilities and people with other disabilities. Respect the protagonist role of users and families in the fight against human rights abuses.
- Advocate for the development of accessible and acceptable community mental health services that provide assistance to people with psychosocial disabilities.
- Engage in inter-sectoral and multidisciplinary collaboration because the needs of people with mental disorders are multiple and cut across service sectors.
- Revise the existing mental health legislation of your country if necessary. Build alliances with users, families, human rights agencies and others to advocate for human-rights based, non-discriminatory mental health legislation and policies.
- Advocate for people with psychosocial disabilities to be included in national disability and anti-discrimination legislation.
- Promote international conventions that include people with psychosocial disabilities such as the Convention on the Rights of Persons with Disabilities.
- Work with the media to change the discriminatory image of people with psychosocial disabilities.
- Advocate for a higher value in society placed on mental health and well-being in general.

