# BEST PRACTICES: MENTAL HEALTH SERVICE DEVELOPMENT

Mental health is integral to achieving many development priorities. Ignoring this fact will impede the capacity of countries to reduce poverty and achieve better health and development outcomes.

Some best practice examples of service development in primary health care, hospitals, and the community highlighted below:

## INTEGRATING MENTAL HEALTH INTO PRIMARY CARE

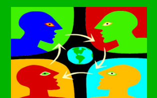
### ➔ Argentina[1]

In the province of Neuquén, Argentina, primary care physicians lead the diagnosis, treatment and rehabilitation of patients with severe mental disorders. Patients receive outpatient treatment in their communities, where they enjoy the support of family, friends, familiar surroundings, and community services. Psychiatrists and other mental health specialists are available to review and advise on complex cases. A community-based rehabilitation centre, the Austral, provides complementary clinical care in close coordination with primary care centres. It also serves as a training site for general medicine residents and practising primary care physicians.

The programme has increased demand for mental health care and allowed people with mental disorders to remain in their communities and socially integrated. The effectiveness of the programme is largely the result of teamwork, in which the primary care physicians lead the therapeutic process, but are supported by other team members such as nurses, psychologists and psychiatrists. Because psychiatrists are used sparingly and institutional care is avoided, costs are lower and access to needed services is enhanced.

[1] Collins PY et al. (1999a) Using local resources in Patagonia: primary care and mental health in Neuquen, Argentina. *International Journal of Mental Health*, 28:3-16; Collins PY et al. (1999b) Using local resources in Patagonia: a model of community-based rehabilitation. *International Journal of Mental Health*, 28:17-24.





## ➔ Belize[2]

In the 1990s, Belize introduced a programme in which psychiatric nurse practitioners were trained and integrated into community-based care. Although operating at district level, these practitioners conduct various primary care activities, including home visits and training of primary care workers. The introduction of psychiatric nurse practitioners in Belize has facilitated numerous improvements:

- admissions to the psychiatric hospital have been reduced
- outpatient services have increased
- community-based mental health prevention and promotion programmes are now in place.

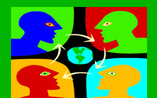
While this approach has not yet resulted in a fully-integrated mental health service, a number of important lessons have been learnt. In countries where there are very few trained mental health specialists, a two stage approach, where primary care practitioner skills are built over time, may be more appropriate than attempting to reach fully integrated mental health care in one stage.

The next phase of the programme will strengthen psychiatric nurse practitioners' direct interactions with primary care practitioners, to increase their awareness and train them to manage mental health issues within their general practices.

## ➔ Brazil[2]

Integrated primary care for mental health in Sobral, Brazil has resulted from a collaborative care approach involving mental health services and family health services. Primary care practitioners conduct physical and mental health assessments for all patients. They treat patients if they are able, or request an assessment from the specialist mental health team, who make regular visits to family health centres. Joint consultations are undertaken between mental health specialists, primary care practitioners, and patients. This model not only ensures good-quality mental health care, but also serves as a training and supervision tool whereby primary care practitioners gain skills that

[2] *Integrating mental health into primary care: a global perspective*. 2008. Geneva, World Health Organization.

enable greater competence and autonomy in managing mental disorders.
Over time, primary care practitioners have become more confident, proficient and independent in managing the mental disorders of their patients. Sobral has been awarded three national prizes for its approach to integrating mental health into primary care.

## ➔ Iran[2]

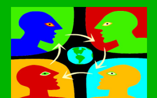
Since the late 1980s, the Islamic Republic of Iran has pursued full integration of mental health into primary care. At village level, community health workers or *behvarzes* have clearly-defined mental health responsibilities, including active case-finding and referral. General practitioners provide mental health care as part of their general health responsibilities and patients therefore receive integrated and holistic services at primary care centres. If problems are complex, general practitioners refer patients to district or provincial health centres, which are supported by mental health specialists. The Islamic Republic of Iran's strong ties between its medical education and health sectors (originating from the Ministry of Health and Medical Education) have facilitated the training of health workers around the country. Further, mental health is regarded as an integral part of primary care, and therefore is treated similarly to other conditions that are included in the primary care package of services. An important feature of the Iranian integration of mental health has been its national scale, especially in rural areas. A significant proportion of the country's population is now covered by accessible, affordable and acceptable mental health care.

## ➔ Uganda[2]

In the Sembabule District of Uganda, primary care workers identify mental health problems, treat patients with uncomplicated common mental disorders or stable chronic mental disorders, manage emergencies, and refer patients who require changes in medication or hospitalization.

These functions were implemented following the inclusion of mental health issues in the Uganda Minimum Health Care package. Specialist outreach services from hospital-level to primary care-level facilitate ongoing mentoring and training of primary care workers. In addition, village health teams, comprising volunteers, have been formed





to help identify, refer and follow up on people with mental disorders.

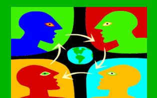
Mental health treatment in primary care, compared with the previous institutional care model, has improved access, produced better outcomes, and minimized disruption to people's lives.

### ➔ South Africa[3]

In Cape Town, South Africa, the Perinatal Mental Health Project prevents and treats psychological distress around pregnancy by partnering with public service obstetric care to provide integrated and holistic mental health support. Since 2002, more than six thousand pregnant women have been screened, and approximately one thousand have received on-site counseling and/or psychiatric care. The service presents no additional costs to the women themselves.

[3] Mental health and development: targeting people with mental health conditions as a vulnerable group, 2010. Geneva, World Health Organization





## MENTAL HEALTH SERVICES AT GENERAL HOSPITALS

### ➔ Ethiopia[4]

Stakeholders working at the tertiary level have collaboratively developed a programme of mental health care at the secondary level by training psychiatric nurses. Twenty-seven regional hospitals and one health centre have opened psychiatric units, each operated by two psychiatric nurses.

### ➔ Nepal[5]

Secondary-level psychiatric units are located in district hospitals. The facilities at the secondary level include smaller psychiatric wards in the military hospital and two regional hospitals, and a small community mental health programme at three other regional hospitals. The mental health care units outside the capital do not include services for long-stay inpatients (Tausig & Subedi, 1997).

### ➔ Tanzania[6]

Community mental health care teams have been established in secondary-level clinics in the capital city but there are no such teams in rural areas. In both rural and urban areas, secondary-level facilities are located in psychiatric units in district general hospitals (Kilonzo & Simmons, 1998).

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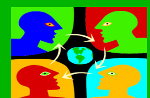
[4] Alem A et al. (1999) How are mental disorders seen and where is help sought in a rural Ethiopian community? *Acta Psychiatrica Scandinavica*, 100:40-7.

[5] Tausig M, Subedi S (1997) The modern mental health system in Nepal: organizational persistence in the absence of legitimating myths. *Social Science and Medicine*, 45:441-7.

[6] Kilonzo GP, Simmons N (1998) Development of mental health services in Tanzania: a reappraisal for the future. *Social Science and Medicine*, 47:419-28.

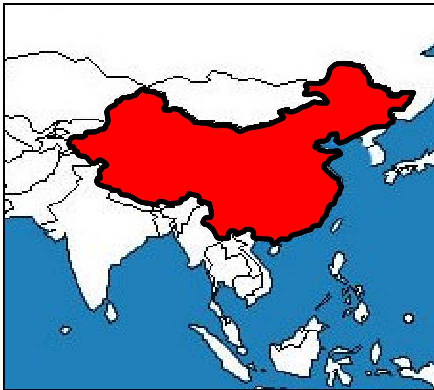




## COMMUNITY SERVICES

### ➔ China[7]

The city of Shanghai is the largest in China, with a population of nearly 16 million in 2000.The metropolis is largely urban, composed of 12 urban districts and nine rural countries. Districts are administratively subdivided into 132 "streets", and further subdivided into 2,783 "lanes", while the rural countries are divided into 230 townships and subdivided into 3,461 villages (Zhang et al., 1994). Organizing mental health services at the municipal, district, and community level, the so-called "Shanghai Model" is currently the most widely-respected model of community-based rehabilitation in China. Locating psychiatric clinics in the primary care facilities of each district allowed treatment to be administrated on an out-patient basis, reserving psychiatric beds at the central hospital for more acute and severe cases.



Today, hospital-based services at Shanghai's municipal and district levels are exceptional, compared to the average Chinese city. However, the sheer number of psychiatric patients makes it clear that reliance only on hospital treatment would hardly meet the mental health needs of Shanghai, much less other cities in China with fewer institutional resources and trained health professionals. Efforts to move beyond in-patient services led to the development of a large community mental health network to provide follow-up and rehabilitation in the community, without which the hospitals would become overcrowded with chronic or relapsed patients. Community follow-up occurs at primary-levels hospitals and includes out-patient services, medical monitoring, and home visit if necessary. Rehabilitation is implemented through guardianship networks consisting of groups of trained volunteers (retired workers, family members, community administrators) who supervise individual patients, maintain treatment schedules, and provide family support. One hundred eighty-four work therapy stations, mainly located in urban areas, also provide rehabilitation services, giving 4,628 clients the opportunity to work and to receive an income, in addition to obtaining treatment, education, and psychiatric care /although the breakdown and closing of state industries as well as a rising unemployment make this option more difficult to maintain). Today, this community network provides services to approximately 60,000 individuals, representing nearly 40% of the population of seriously mentally disabled residents (Zhang et al., 1994). All told, approximately 800 psychiatrists and 1,800 other mental health workers provide services to more than 160,000 seriously mentally disabled individuals in the city.

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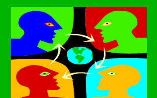
[7] Doris F. Chang, Xu Yifeng, Arthur Kleinman, and Joan Kleinman (2002). *Rehabilitation of Schizophrenia Patients in China. The Shanghai model.* World Mental Health Casebook: Social and Mental Health Programs In Low-Income Countries. Editors Alex Cohen, Arthur Kleinman , Harvard Medical School , Boston, Massachusetts and Benedetto Saraceno, World Health Organization, Geneva, Switzerland. Kluwer Academic / Plenium Publishers, New York2002





## ➔ Sri Lanka[8]

The Sri Lanka programme is built on the principle that all members of the community should be included and that no-one, particularly mentally ill people, should be excluded. It was this principle that resulted in BasicNeeds Sri Lanka developing the BasicNeeds Mental Health and Development Model to work out collaborative interventions on a pilot basis to demonstrate that mentally ill people can participate actively in the process of development.

The pilot project started in February 2003 with thirty four mentally ill people. We now have 1,283 registered mentally ill people in just a small part of the Southern Province. As a result, the mechanism called "Mental Health Care through Community Partnership" was developed, which complements the local government service delivery structure. Crucially perhaps, the most outstanding feature of the partnership are the community volunteers in which community volunteers run a number of very important community based activities including:

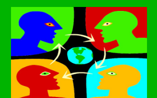
- Monthly mental health camps run in collaboration with a specialist mental health hospital, Angoda and the teaching hospital at Ratnapura outpatient services have increased;
- Outreach clinics by medical officers providing local service in collaboration with general hospitals at places such as Hambantota and Kahawatte;
- Out patient clinics for drug administration in collaboration with primary level hospitals such as the District Hospital of Katuwana.

Piyasena was treated as mentally ill person when BasicNeeds first came into his village. However, now he has joined the volunteer committee which plays an active role in organizing communities in the programme. Equipped with a three wheeler and a loudspeaker, Piyasena is responsible for announcing in the neighbouring villages when we have events such as mental health camps. About 30% of the membership of our volunteer committees are mentally ill people. The balance comprises carers and community members free from mental illness.

The programme has started to get everyone thinking. For example, when BasicNeeds and the Southern Provincial Directorate of Health Services invited five mentally ill persons to share their experiences about mental illness. This was to help the Southern Province Mental Health Forum propose recommendations to the government for the effective replication for the "Mental Health Care through Community Partnership" pilot

[8] *The Basic Needs Review. Community, My Community*, p. 32 to 35; url: http://www.basicneeds.org/download/community_my_community.pdf (last accessed 12 September 2007).





for other parts of Southern Province. Recommendations were also made to the government so that its medical scheme includes A-typical drugs into the essential drug list from January 2005.

Chintha Munasinghe, our Programme Manager, also sees herself as a user of mental health services. She is sitting with a group of mentally ill people and notes:

"I am sitting with my friends here to talk about our personal experiences in mental illness. We feel that this is our duty so as to motivate other mentally ill persons to come forward, talk, discuss and get rid of their pain. We see ourselves as "live" case studies who want to share their experiences so as to educate primary health care officers. This is all part of the training that our Consultant, Dr. Neil Fernando, would like to see happen."

Chintha reflects:

"We still have much to do but I am pleased with "Ape Viththi" - Our News. I was once a journalist and take particular pleasure with this newsletter, which offers an opening to consult mentally ill people and their families for a wider sharing of the model. Stabilized mentally ill people are our main contributors and we also have news from community leaders. Contributions from practitioners are particularly welcome!" chuckles Chintha. Here are some of the milestones that Chintha and her team have achieved:

- Community mental health model of BasicNeeds Sri Lanka recognized nationally and internationally as an effective way of providing service;
- Sri Lanka's largest enterprise development organization, Sarvodaya's Economic Enterprise Development Services (SEEDS) Guarantee Ltd. Is involved in developing an enterprise oriented sustainable livelihoods package for mentally ill people and their families;
- A training programme with project participants to record and analyses family expenditure which is now being used in many households, was developed;
- A participatory home management training programme with 10 families of the mentally ill people experiencing family conflicts, was developed;
- Home gardening systems and horticulture therapy programmes to suit the needs and interests of mentally ill people continues with high participation from mentally ill people. As a result nine discharged mentally ill people labeled as destitute, have reunited with their families and have been employed as gardeners;
- Seventy six members of volunteer committees have taken the responsibility of working with victims of the tsunami disaster in immediately providing emotional support and designing development interventions

Piyasena, who alerts the community about the mental health camp from his tree wheeler comments:

"Even during my schooldays I was scared even to sing a song at a social gathering. It is true that the programme has covered all our medical needs, but more than that, it has helped us to come forward and develop our talents. I was really surprised to find how well I could do the announcing part at the mental health camp. Now I can address even a huge gathering."

Chintha smiles appreciatively and observes:

"The Basic Needs family is proud of mentally ill people in Sri Lanka for taking the lead in sharpening the mental health services in our country -- slowly but surely!"

## Suggested citation:

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