
# PHASE 1 COUNTRY REPORT

## A SITUATIONAL ANALYSIS OF THE MENTAL HEALTH SYSTEM IN UGANDA

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# Abbreviations

**CME**: Continuing Medical Education
**DPP**: Director of Public Prosecutions
**HMIS**: Health Management Information System
**HSSP**: Health Sector Strategic Plan
**MHAPP**: Mental Health and Poverty Project
**NMHCP**: National Minimum Health Care Package
**PHC**: Primary Health Care
**PIASCY**: Presidential Initiative on AIDS Strategy for Communication to Youth
**SHSSPP**: Support to Health Sector Strategic Plan Project
**Swap**: Sector Wide Approach
**TASO**: The AIDS Support Organization
**UBOS**: Uganda Bureau of Statistics

# Executive Summary

## Introduction

There is growing recognition that mental health is an important public health and development issue in Uganda. The health system in Uganda currently operates under a decentralized system with Primary Health Care as the basic philosophy and strategy for the national health department. To this end, a Minimum Health Care Package was formulated as the primary focus of the health care delivery system. Mental health is one of the components of the National Minimum Health Care Package, and is supposed to be integrated into Primary Health Care. This was to ensure effective access by all sections of the population to some mental health services. However, there is a paucity of data on the mental health situation in the country. Most specifically, there is very limited information on the burden of mental disorders. Mental health policy development was not informed by any significant research findings, and not much has been done to evaluate its implementation in the country. Overall, mental health is apparently not given the priority it deserves, although it was accredited at the policy development level.

In light of this, a situational analysis of the mental health system in Uganda was conducted. The aim of this study was to examine mental health policy development and implementation in Uganda, in an effort to identify the key barriers to mental health policy development and implementation, the current challenges to mental health service delivery and steps that can be taken to strengthen the mental health system in the country. This study forms part of a broader multi-centre international mental health research consortium in Ghana, South Africa, Uganda and Zambia; the aim of which was to investigate the policy level interventions that are required to break the vicious cycle of poverty and mental ill-health in order to generate lessons for a range of low and middle-income countries.

## Methodology

The fieldwork for the study was conducted between 1st August 2006 and 31st March 2007. The study used both quantitative and qualitative methodologies. Quantitative methods were used to assess the current mental health system and to evaluate the mental health policy and legislation. Qualitative methods were employed to provide an understanding of the mental health situation, processes and underlying issues in mental health policy development and implementation.

Quantitative instruments included:

I. The WHO Mental Health Policy and plan Evaluation Checklist
II. The WHO Mental Health Legislation Evaluation Checklist
III. World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) Version 2.2

Qualitative instruments included:

- Semi-structured interviews conducted at national level.
- Semi-structured interviews and focus group discussions conducted at the district level

**Results**

A number of key issues emerged in this study. These include:

- Lack of public awareness of mental health and mental illnesses.
- Low priority given to mental health at all levels of service delivery.
- Inadequate infrastructure, human resources and financial provision.
- Imbalance of resources between urban/rural mental health services, in favour of the urban areas.
- Limited community mental health care services.
- Inadequate decentralisation and integration of mental health services in the public health system.
- Absence of well developed child and adolescent mental health services.
- Low level of mental health research.
- The importance of the relationship between poverty and mental health.
- The key role of stigma in mental illnesses.
- Low awareness on policy issues by several categories of implementers
- The need to increase participation of mental health care users in policy making
- Limited inter-sectoral collaboration for mental health.
- Limited appreciation for the importance of mental health in several other key sectors, particularly in the education sector.

Mental health was found to be a complex term that is not well understood by majority of the participants. It was viewed as simply the opposite of mental illness; and mental illness was found to be largely viewed from the perspective of odd or queer behavior and eccentric symptoms characteristic of psychotic or manic disorders. It was noted that in the community, mental illness is greatly linked to supernatural causes even when the cause is an obvious physical one. The urban folks however had a more modern scientific understanding of mental illness, attributing it to biological, psychological and social causes.

It was noted that a negative attitude and low interest in mental health still prevail among general health workers, including the PHC doctors although some of them received orientation in mental health during their training.

At macro level, some of the policy makers regarded mental health to be among the priority areas since it is a component of the National Minimum Health Care Package highlighted in the national health policy and the Health Sector Strategic Plan. This was an observation mostly by participants from the ministry of health. However, participants outside the health sector believed that mental health is not a priority area given the low funding levels and inadequate human resources. Prioritization by the ministry of health was viewed to be mostly dependant on whether a particular condition leads to a high mortality rates or not.

The mental health systems in the two study districts differed significantly especially in the area of human resource. While both districts were created around the same time out of some larger existing districts, the mental health system in the rural district was noted to be still in its infancy, with only one recently recruited mental health nurse for the whole district. On the other hand, mental health services in the urban district were found to be relatively well established, with at least a mental health nurse at each health centre in line with the recommendations of the staffing norms developed by the Ministry of Health.

Most participants felt that there is a strong interdependency relationship between poverty and mental illness. While many believed that poverty is among the major causes of mental ill-health, others viewed the link as mostly an associational one and identified a number of other mediating factors for the link between poverty and mental illness. The participants identified a need for concerted inter-sectoral approaches, as a way to break the link. They emphasized the need for capacity building, community empowerment mental health education and improved service delivery to break the link between poverty and mental illness.

Most participants were found to have limited knowledge on policy related issues, and many could hardly comment on this subject. Policy making in government ministries was however reported to have improved a lot following the creation of policy analysis units. It was noted that policies are mostly demand driven and emerge following certain pressing problems in society or identification of weaknesses that need to be addressed.
Most participants believed that effective policy implementation across various sectors is still a challenge, something that was attributed to a generally weak culture of policy implementation and decline in the rule of law. Commitment by the political leadership was reported to play a significant role in effective implementation of policies.

The mental health policy and mental health law were found to be known only by a few participants, specifically those within the health sector. The draft mental policy was not informed by any specific needs assessment, and was developed with minimal stakeholder consultation. Most participants described the current draft mental health policy as a good working document that needed to be finalized into a legitimate policy document.
Dissemination of the draft policy document was reported to have been inadequate, and this was believed to greatly impact on the knowledge about the policy requirements and the implementation.
The participants emphasized the need for involvement of the users in mental health policy development, as well as influential people in all mental health initiatives.

The mental health Act was found to be outdated, as was last revised in 1964. The Act was reported not to be in line with the current draft mental health policy and contemporary issues in mental health care. Thus, it emerged that implementation of the current mental health treatment Act is cumbersome, and that the mental health workers have opted to do what is deemed right for the welfare of the patients though clearly not supported by the law.

**Discussion and Conclusion**

It was noted that mental health services are not yet well organized and integrated into Primary Health Care, as it is assumed under the current decentralized health care system.
Although believed to be prioritized at macro level as a component of the National Minimum Health Care Package, it was noted that mental health is still largely believed to be a low priority area at lower levels mainly because mental illness does not directly lead to a high mortality rate. The relationship between poverty and mental ill-health was noted to be a major one that calls for a concerted multisectoral approach. The widespread stigma and the prevalent negative cultural explanatory model of mental illness were noted to affect the health-seeking behaviour; and therefore need to be addressed urgently for improved access to modern mental health services. The low appreciation of the existence of the draft mental health policy and ignorance about the mental health legislation that were expressed even among the health workers reflected a need for wider dissemination of such important documents continuously.

**Recommendations**

A number of steps have to be taken so as to improve the mental health system. These among others include the following:

1) Finalization of the mental health policy and development of the Mental Health Strategic plan.
2) Review of mental health legislation to bring it up to date with current International Standards.
3) Strengthening the recruitment of mental health staff to fill the existing gaps.
4) Improvement of interaction and training in mental health issues for primary health care workers.
5) Investing more in mental health research.
6) Strengthening community based mental health services by training Primary Health Workers to promote integration.
7) Directing more efforts towards mental health promotion and prevention initiatives.
8) Putting in place a primary health care training program on mental health, spread in all regions in the country.
9) Putting more emphasis on child and adolescent mental health services.

# 1. INTRODUCTION

## 1.1 Introduction

There is growing recognition that mental health is an important public health and development issue in Uganda. Mental health has been recognized to be not only a clinical problem but also a serious public health problem in the country and has therefore been included as one of the components of the National Minimum Health Care Package (HSSP I, 2000; HSSP II, 2005). Globally, despite wide recognition of the importance of national mental health Policies, WHO (2001) reveals that 40.5% of countries have no mental health Policy and that 30.3% have no mental health programmes.

According to the World Health Organization, it was estimated that in 2001 mental disorders contributed 12% of the global burden of disease and it is predicted that this will rise to 15% by the year 2020. It is further estimated that 1 in 4 people suffer from a diagnosable mental disorder during the course of their lifetime (WHO, 2004). Although there is no clear data available on the prevalence of mental health problems in Uganda, it is estimated that 35% of Ugandans suffer from some form of mental disorder, of which 15% require treatment (Basangwa, 2004; as cited by Ssanyu, 2007). Although statistics on mental illness in Uganda are very scanty, anecdotal research evidence suggests an increase in the incidence of mental disorders. According to UBOS (2006), an estimated 7% of the households in the country had disabled members, of which 58% had at least one person with a mental disorder. This implies that about 4% of the households had at least one member with a mental disability.

There is also emerging evidence from developing countries that mental ill-health is strongly associated with poverty and many aspects of social deprivation. The interaction of poverty and mental ill-health has been described as a "vicious cycle" in which the conditions of poverty lead to high levels of stress, social exclusion, reduced access to social capital, malnutrition, obstetric risks, increased risk of violence, and thus to increased prevalence and worse outcomes for mental disorders (Patel, 2001). On the other hand, mental ill-health leads to increased health expenditure, reduced productivity, job loss, and social drift into poverty.

Over the last decade, the government of Uganda has made attempts to formulate a mental health policy after realizing that mental health related problems are on the increase in the country. In addition, a number of strategies have been put in place to strengthen mental health services in the country. Notable among these are:

- Decentralization of mental health services
- Integration of mental health into general health care up to the community level
- Training of staff at all levels (pre-service and in-service training)
- Involvement of other players such as Civil Society Organizations, Traditional healers, and other relevant sectors.

## 1.2 Organization of the National Health System

The objective of the National Health Policy is to establish a decentralized health system ensuring harmony between the Ministry of Health headquarters and the districts, with a component of public private partnership. The above is to be achieved by the establishment of "a network of functional, efficient and sustainable health infrastructure for effective health care delivery closer to the people" (HSSP II, 2005). In pursuit of this objective, government has laid strategies to:

- Develop mechanisms to ensure equity in access to basic services for the most life-threatening health problems, particularly to avert pregnancy and birth-related deaths and the childhood killer diseases.
- Build and strengthen the capacity of health facilities to improve health service provision.
- Strengthen and rationally expand the national health infrastructure through a medium term health facility development plan
- Establish an appropriate and efficiently functioning referral system".

At the national level, there are two National Referral Hospitals (two other hospitals are in the process of being converted to national referral hospitals as well). Below the National Referral Hospitals are Regional Referral Hospitals which are expected to serve a population of 2,000,000 people each. District Health Services are organized hierarchically with a general hospital at the apex, below which are health centres at various levels; i.e.

**District Health Services** (District level- 500,000 population)

**Health Sub-District**

| | |
|---|---|
| Referral Facility | General Hospital (District level - 500,000 population) |
| or Health Centre IV | (County level - 100,000 population) |
| Health Centre III | (Sub-country level - 20,000 population) |
| Health Centre II | (Parish Level – 5,000 population) |
| Health Centre I | (Village Health Team - 1,000 population) |

**Fig. 1. The National Health system**

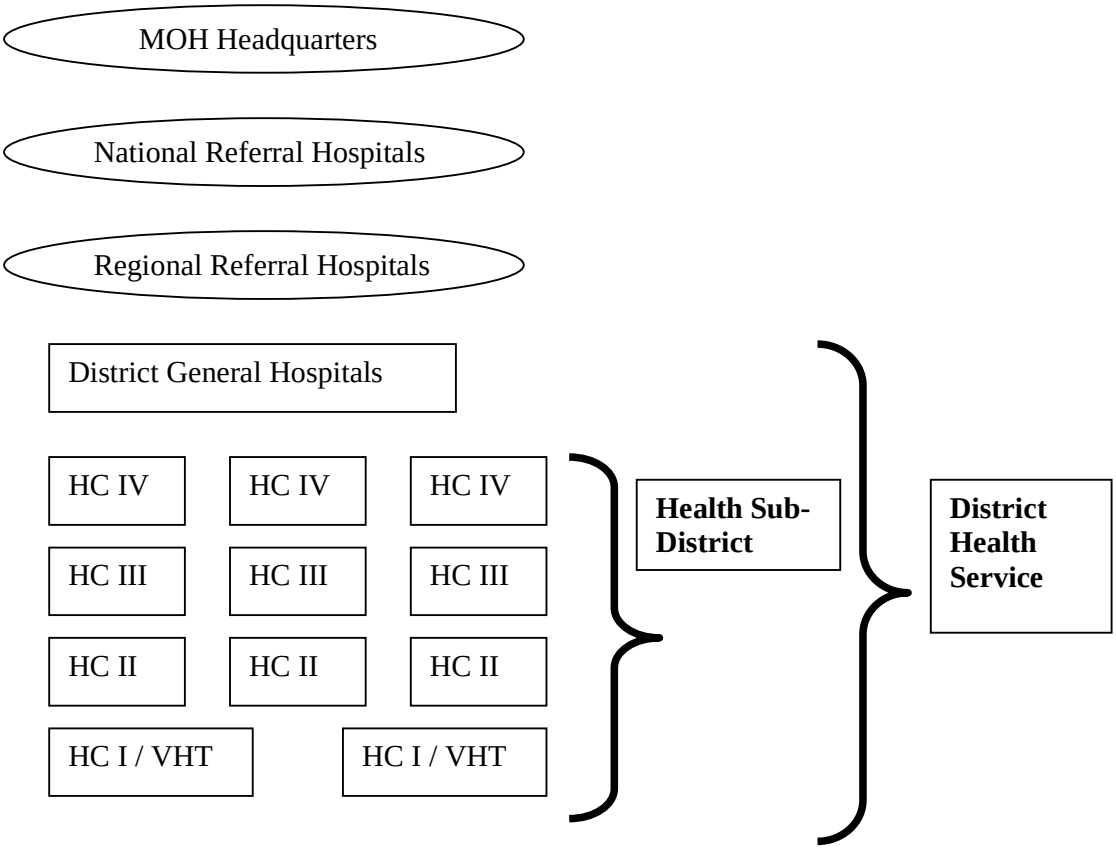
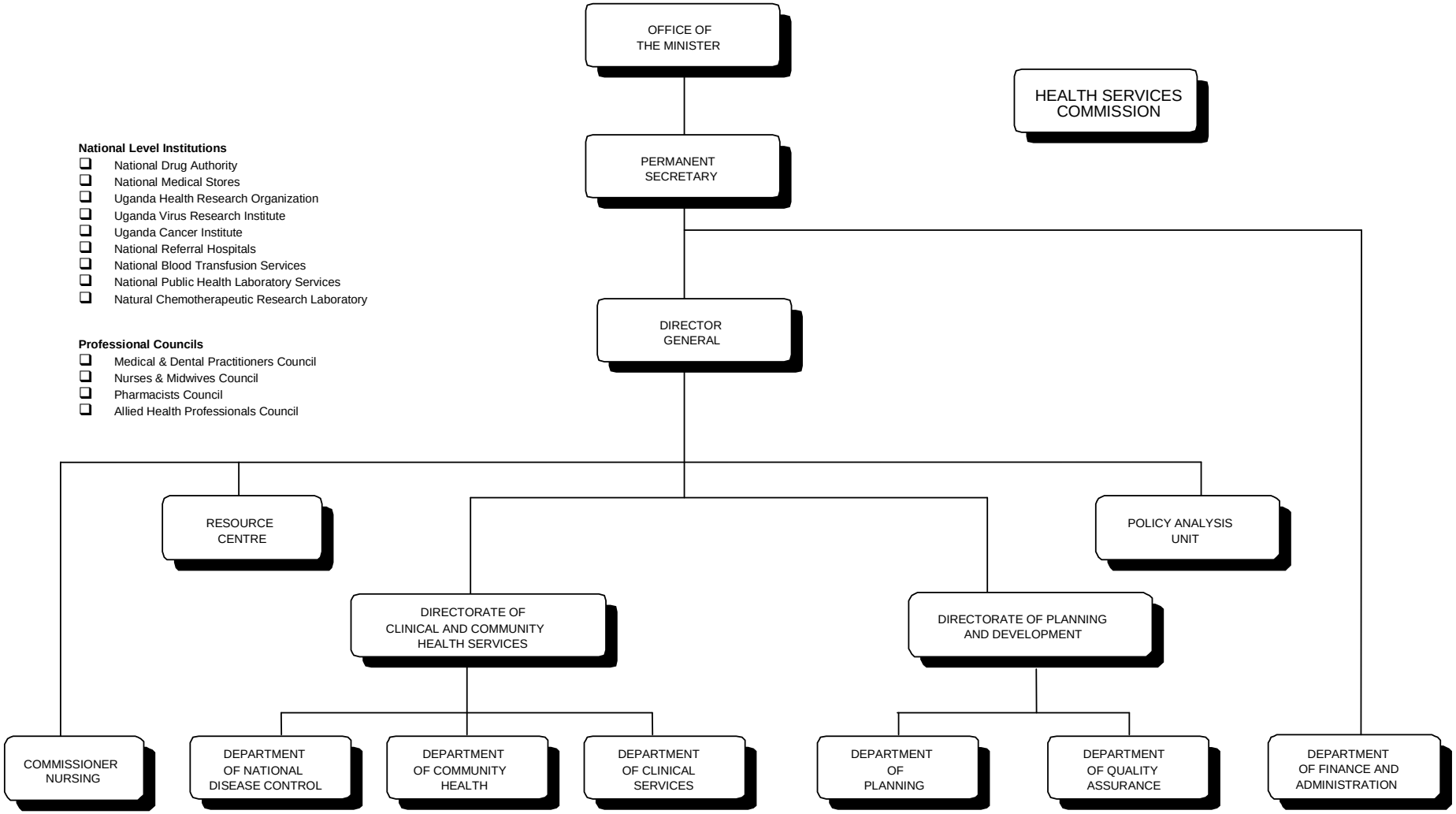


**Fig. 2. Organogram of the Ministry of Health**



## 1.3 Study Objectives

The aims of this research were:

- To understand the general situation regarding mental health in the country.
- To describe and understand the broad context in which mental health policy development takes place in Uganda.
- To describe and analyze the development of mental health policies and mental health law.
- To assess the wider policy-making practices in the public sector.
- To assess the appropriateness of the mental health policies and mental health law, including the involvement of stakeholders and their influence on the formulation of mental health policies and mental health law.
- To assess the current practices of implementing mental health policies and law at national and regional level.
- To assess the implementation of the mental health policy and law at district level.

This research was conducted in the context of a wider international study of mental health policy development and implementation in 4 African countries: Ghana, South Africa, Uganda and Zambia. The study, titled the Mental Health and Poverty Project (MHAPP), set out to investigate the policy level interventions that are required to break the vicious cycle of poverty and mental ill-health, in order to generate lessons for a range of low and middle-income countries. This report presents the findings of the first phase of the study: a situational analysis of the mental health system, and mental health policy development and implementation in the country. The findings of this first phase will be used to inform a set of interventions, to be developed in partnership with the mental health division of the ministry of health. The interventions to be conducted in the second phase will specifically address particular barriers to the successful development and implementation of mental health policy in the country. These interventions will be documented and later evaluated, so as to generate lessons that may be of value for future work in this country, and that could be applicable to other low and middle-income countries.

# 2. METHODOLOGY

## 2.1 Introduction

The study made use of both quantitative and qualitative methodologies. Quantitative methods were employed to assess the mental health system as well as evaluating the mental health policy and mental health legislation. Qualitative methods were employed to provide an understanding of the mental health situation, the processes, underlying issues and interactions between key stakeholders in mental health policy development and implementation.
Quantitative instruments included:

I. The WHO Mental Health Policy and plan Evaluation Checklist
II. The WHO Mental Health Legislation Evaluation Checklist
III. World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) Version 2.2

Qualitative instruments included Semi-structured interviews and focus group discussions conducted at both national and district levels. Findings were triangulated where possible, using two or more sources of data or research methods.
The fieldwork for the study was conducted between August 2006 and March 2007. Analysis and writing up was conducted between April and October 2007.

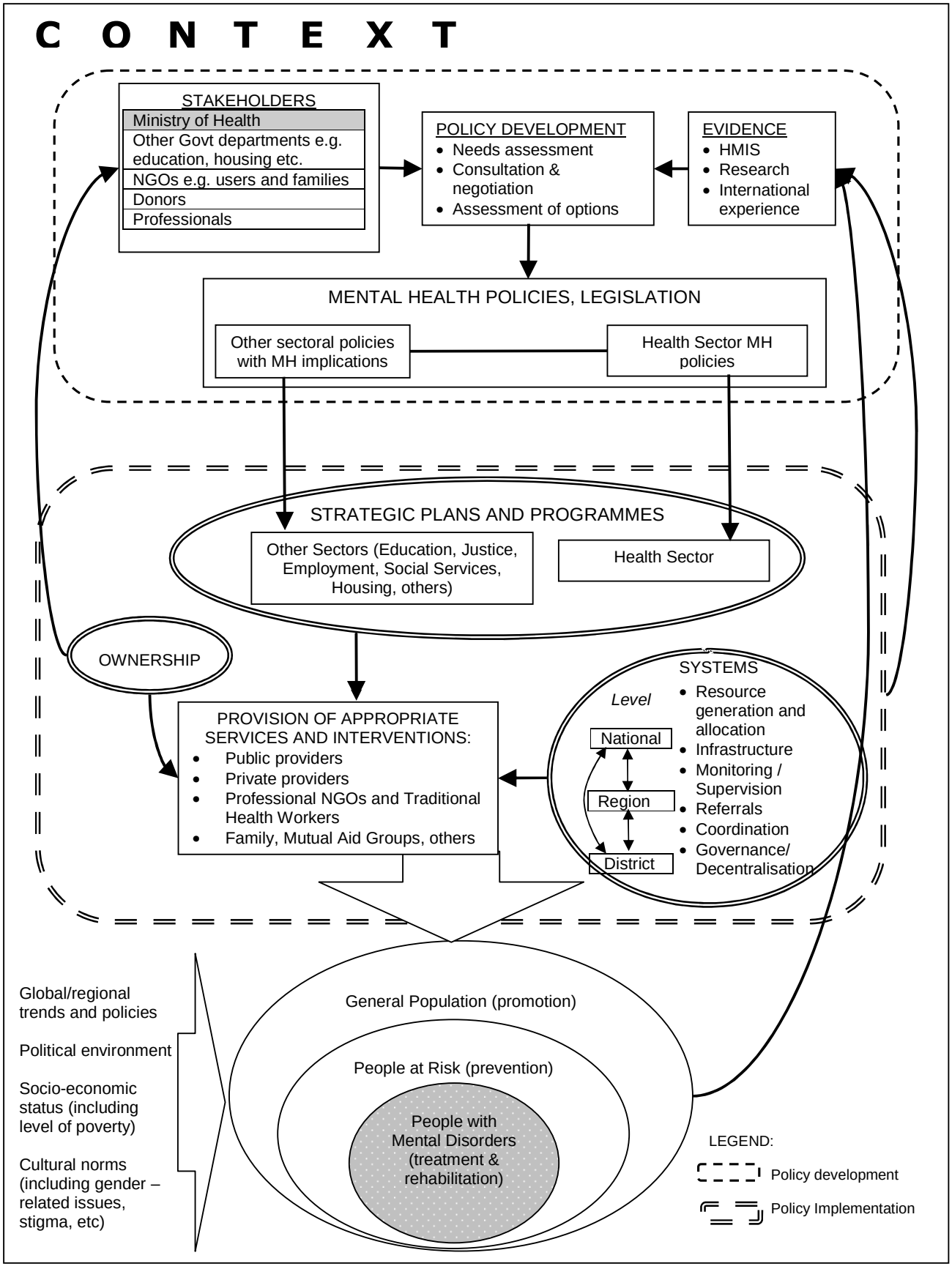
In developing the methodology for this study, a conceptual framework for understanding mental health policy development and implementation (Figure 3) was formulated by the research team (Flisher et al., 2007). This framework guided our analysis of mental health policy development and implementation in Uganda, the data sources that were explored and the stakeholders that were chosen as participants.

In the development of policy, it is critical to align the policy with the mental health needs, context and particular health system of the country. Mental health policy would imply an organised set of values, principles, objectives and areas for action to improve the mental health of a population (WHO, 2005a). The likelihood of the policy being appropriate and feasible depends on the processes by which it is developed and in particular, the extent to which key stakeholders are included within this process (Walt & Gilson, 1994). It also depends on the degree to which the policy is evidence-based.

In the implementation of policy, the existence of an appropriate policy may be a necessary condition for improved services, but may not be sufficient. Three barriers to the effective implementation of policies are commonly experienced. Firstly, the policy itself may be too general and not easily turned into a strategic plan. Secondly, the appropriate health system may not be in place to support the policy. The third key constraint can be a lack of support for, or at worst, resistance to the policy and plan at the implementation level. Such a lack of ownership may be experienced from a number of groups including professional groups, health service managers, service users or the wider community, partly due to the stigma often associated with mental illness.

Mental health is the product of a number of determinants, which may have their origins beyond the formally designated health sector. There is thus a need for a multi-sectoral approach to both policy development and implementation. The Ministry of Health needs to take the lead in this, developing appropriate tools and relationships for working with district health systems and with non-governmental and private providers.

**Figure 3**: **Framework for Mental Health Policy-Making (Flisher et al., 2007)**



## 2.2 WHO Mental Health Policy and Legislation Evaluation Checklists

The WHO Checklist for evaluation of Mental Health Policy and Plans and the WHO Checklist for Evaluation of the Mental Health Legislation are designed to assess the content and the process of developing mental health policy and plans, and the mental health legislation according to a number of criteria (See Appendix 3 & 4).

### 2.2.1 WHO Mental Health Policy and Plan Evaluation Checklist

A stakeholders' workshop was organized for evaluation of the mental health policy using the WHO mental health policy evaluation checklist. A total of 36 participants from various sectors took part in the exercise. The participants were earlier provided with the draft mental health policy document, which they went through prior to the evaluation exercise. Some of these participants had taken part in the development of this draft policy.
These participants were mostly from:

- Ministry of Health Policy Analysis Unit.
- Makerere University Medical School
- Mental health workers from national and regional hospitals
- Mental health user groups and associations
- NGOs working in mental health
- Representatives from other government sectors and line ministries.
- The MHAPP research team

During the exercise, the participants were divided into 3 subgroups. One subgroup looked at the policy process issues, the second subgroup looked at the policy content issues, while the third one looked at human rights issues.

### 2.2.2 WHO Mental Health Legislation Evaluation Checklist

Evaluation of the mental health legislation was done by a sub-committee comprising of:

- the Ugandan research team
- a consultant psychiatrist
- a state attorney

The sub-committee earlier internalized the mental health legislation before the evaluation exercise. An expert solicitor at the Uganda Law Society later reviewed the mental health legislation independently and made a contribution towards the exercise.

## 2.3 WHO-AIMS

Quantitative data regarding the mental health system in Uganda was gathered using the World Health Organization's Assessment Instrument for Mental Health Systems (WHO-AIMS) Version 2.2 (WHO, 2005b). The WHO-AIMS tool has been developed to assess key components of a mental health system and thereby provide essential information to strengthen mental health systems. The instrument was developed following the publication of the World Health Report 2001 (WHO, 2001), which focused on mental health, and provided a set of recommendations. These recommendations address essential aspects of mental health system development in resource-poor settings. For each recommendation, items were generated and grouped together in a number of facets (sub-domains). WHO-AIMS 1.1 consisted of 10 domains covering each of the 10 recommendations. In 2004, the pilot instrument was tested in Albania, Barbados, Ecuador, India, Kenya, Latvia, Moldova,

Pakistan, Senegal, Sri Lanka, Tunisia and Viet Nam. The instrument was used in Albania to develop a plan to implement mental health services reform. The main conclusion from the pilot test was that the instrument is highly useful because it is comprehensive and enables one to collect key information that is useful for action. However, the length of the pilot instrument was a barrier to its use. Consequently, the pilot instrument was substantially revised and shortened. WHO-AIMS 2.2 consists of 6 domains (covering the 10 World Health Report 2001 recommendations comprising 28 facets and 156 items). The 6 domains are interdependent, conceptually interlinked, and somewhat overlapping. All the 6 domains need to be assessed to form a relatively complete picture of a mental health system. The domains include:

- Domain 1: Policy and legislative framework
- Domain 2: Mental health services
- Domain 3: Mental health in primary care
- Domain 4: Human resources
- Domain 5: Public education and links with other sectors
- Domain 6: Monitoring and research

The instrument includes the WHO-AIMS Excel Data Entry Programme and a template for a narrative report.

### 2.3.1 Sample and procedure

Shorter questionnaires seeking specific information were generated from the 156 items in the WHO-AIMS document. These questionnaires were developed and distributed to respondents from the following:

- the head, mental health division, Ministry of Health headquarters,
- the head, department of psychiatry, Makerere University Medical School,
- Makerere University Institute of Psychology
- Mental Health professionals and the records office at the National Mental Hospital
- Uganda Nurses and Midwives Council
- Mental Health NGOs and User associations

Data was collected in 2006, based on the calendar year 2005

### 2.3.2 Analysis

The data was entered into the excel data entry programme and analyzed; and then into the template for a narrative report.

## 2.4 Semi-structured interviews and focus group discussions

Qualitative methods included semi-structured interviews (SSIs) and focus group discussions (FGDs). The primary purpose of using these instruments was to develop a deeper understanding of the mental health situation, the processes of mental health policy development and implementation in Uganda, and the interaction between various systems and stakeholders.

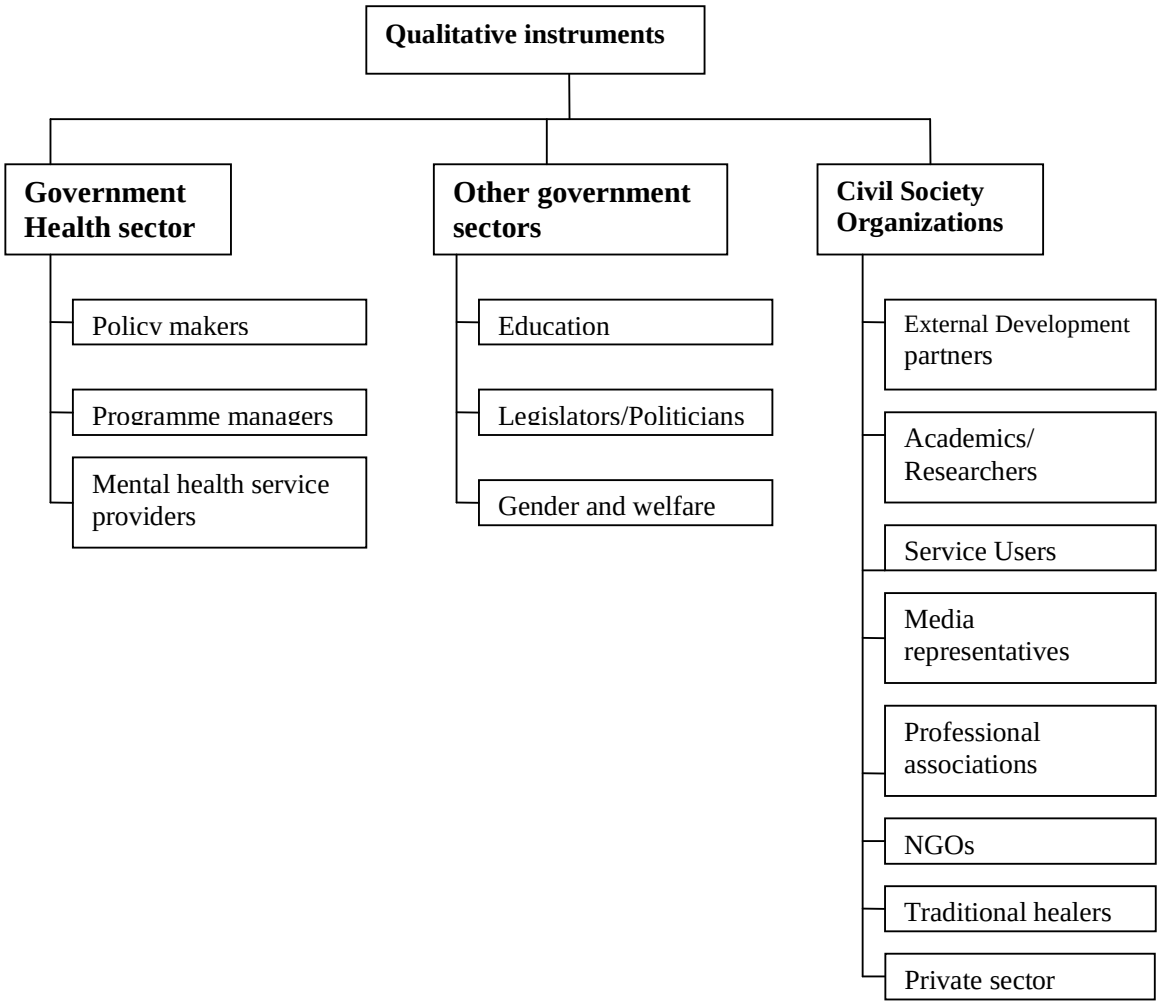
### 2.4.1 Sample and procedure

The sampling of respondents for the semi-structured interviews and focus group discussions was purposive. Respondents were selected mostly because they were known to be resourceful people and had the experience that was particularly relevant to the study. The participants were also selected based on the principle of maximum variation, in order to provide as wide a range of perspectives as possible on mental health policy development and implementation in Uganda.

#### 2.4.1.1 National level

At the national level, a total of 42 stakeholders were interviewed in SSIs. 8 others took part in a focus group discussion.

**Fig. 4 Stakeholders interviewed at macro level**



The semi-structured interviews were tailored according to the specific individual being interviewed. The following generic areas were mostly covered:

1. The general health context in Uganda
2. Key challenges facing the health system
3. Perceptions of mental health
4. Mental health needs and priorities in Uganda
5. Key challenges facing the mental health system
6. The general policy making processes
7. Process of mental health policy development.
8. Role of various stakeholders in mental health policy
9. Content of the current mental health policy and legislation
10. Mental health policy implementation
11. Mental health research

#### 2.4.1.2 District level

At the district level, two (2) districts were chosen as a representative sample for the study. One of the districts is an urban district in the central region and neighbouring the capital city. This urban district has a relatively well-organized health delivery system, and is among the districts rated highly in terms of infrastructure and services delivery. The district has a total area of 2,704 square kilometres. By the 2002 census, its population was 957,280 people. As regards the organization of health services, the district has 19 Government dispensaries (Health centre IIs), 12 health centre IIIs, 5 health centre IVs and 3 hospitals: (1 government hospital, 1 private hospital and 1 missionary hospital). There are also 20 dispensaries, 58 clinics and 15 health centers that are private/NGO health units. The most common ten disease conditions presenting at health units are; Malaria, Respiratory tract infections, Worms, Trauma, Diarrhoea diseases, Anaemia, Malnutrition, Ear diseases, Skin diseases and HIV/AIDS.
There are three main operational areas of the health sector including Administration, Curative and Preventive. The District Director of Health Services (DDHS), now designated as District Health Officer leads the District Health Team (DHT) and heads the District Health Services. Politically, there is a District Health Committee (DHC), an organ responsible for formulation of the District Health Policy and overseeing the implementation of programmes.

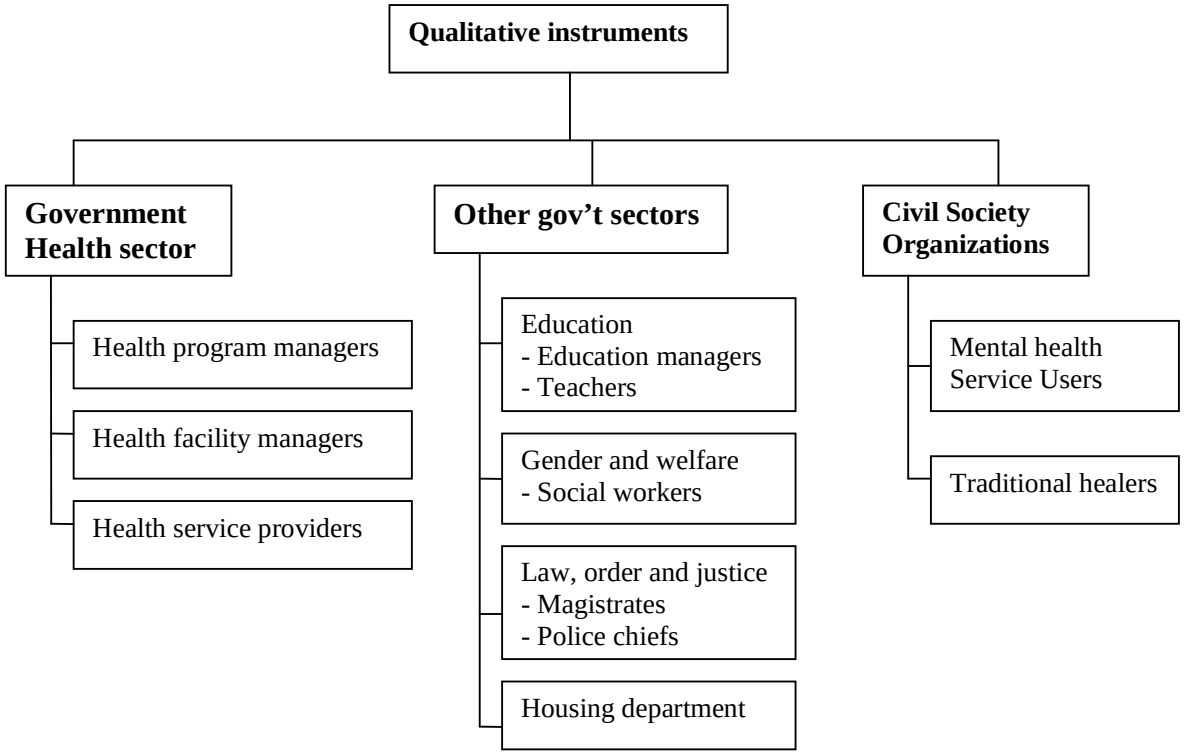
The second district research site was a rural district in the eastern region of Uganda. This district was selected because it is typical of many rural areas in Uganda and is part of the worldwide INDEPTH network and is a Demographic Surveillance Site (DSS) which continuously provides demographic and health information.
The district has a population of over 326,567 people, of which 167,087 are female and 159,480 male (UBOS, 2006). It has a size of 4,672.22 square kilometers with only 23.38% (1,093.56 $km^2$) land, the rest being water. Its health services delivery consists of 16 Government dispensaries (Health center IIs), 3 health centre IIIs at county level, 2 health centre IVs at sub-district level but no hospital. There are 5 private/NGO dispensaries, 2 private clinics and 1 private hospital. The hospital is formerly a leprosy treatment center and currently serves as the general hospital in the district.

In order to improve the health services delivery system and accessibility to health services, the district embarked on an ambitious plan to have a health unit within a 5 kilometer radius

by 2008, equip health units with 80% of essential drugs, ensure that at least 50% of the health units have electricity/solar power, have adequate staffing, and set up female, male and pediatric wards at the HC IVs. The District Health Management Team (DHMT) has plans to ensure that there is increased seeking of medical services and improved access to treatment. Combined effort between government (through the District Director of Health Services (DDHS), NGOs, Private care providers and traditional practitioners is expected to achieve this objective.

The rationale for choosing a rural and an urban district was basically for comparison purposes.
At the district level, a total of 20 semi-structured interviews and 5 focus group discussions were held with various stakeholders.

**Figure 5**. Stakeholders interviewed at the District level




## 2.4.2 Analysis

Interviews were recorded with the permission of respondents and transcribed verbatim. The transcripts were then analysed using NVivo 7 qualitative data analysis software. A framework analysis approach was adopted (Ritchie & Spencer, 1994), in which certain themes were agreed upon by investigators from all four study countries. These themes were based on the objectives of the study (as set out in the introduction). From these objectives, sub-themes were suggested by partners, and reviewed by all partners through an iterative process, until a single framework was agreed upon that could be used by all four study countries. Some specific themes that were not included in the generic cross-country framework also emerged from interviews, and these were added to the coding frame as

issues specific to Uganda. Transcripts were thus coded on the basis of these themes, with additional themes added to the coding framework as determined by the data.

### 2.4.3 Research ethics

Permission to conduct this study was obtained from the National Council for Research, and the Director General of Health Services. Respondents in the semi-structured interviews and focus group discussions gave informed consent to participate in the study. The identities of interviewees have been kept confidential.

# 3. FINDINGS

The findings of the study are presented below under the following thematic areas:

- General context of the health situation
- Mental health situation
- General policy making processes
- Process of mental health policy and law development
- Appropriateness of the mental health policy and law
- Mental health policy implementation at macro level
- Mental health policy implementation at micro level
- Mental health research

These categories are not distinct but rather are for presentational convenience do not produce an exhaustive account of these thematic areas, but rather highlight some of the important issues that have arisen from this research.

## 3.1 GENERAL CONTEXT

### 3.1.1 About Uganda

Uganda is a landlocked country located in East Africa with an approximate geographical area of 236,040 square kilometers, of which about 15.4% is covered by water. As of 2007, the population of Uganda was estimated to be 28.4 million people, having increased from 24.2 million in 2002 at a growth rate of 3.2%. Of these, 48.6% were males and 51.4% females. An estimated 12.3% of the population were living in the urban areas while 87.7% were living in the rural areas (UNFPA, 2007). The percentage of the population living below the poverty line was estimated to be 31% (PEAP, 2005). The prevalence of HIV/AIDS was 6.4% (Ministry of Health, NHSBS 2005).

The proportion of the population under the age of 15 years was 49.3%, and the proportion of the population above the age of 60 years was 4.5%. The life expectancy at birth for males was 50.7 and 52.7 for females, while the literacy rate for men was 76% and 61% for women (UNFPA, 2007).

English is the official language taught in schools, used in courts of law, most Newspapers and radio broadcasts; while Luganda is the most widely used native language. According to the 2002 National Population and Housing Census, the population is predominantly Christian, composed of: Roman Catholics (41.9%), Protestants (35.9%), Muslims (12.1%) and others (10.1%) (UBOS, 2002)

The country is a low-income group country based on World Bank 2005 criteria. The proportion of the health budget to GDP is 3.5. The average per capita income in Uganda is USD 300. The per capita total expenditure on health is USD 36, and the per capita government expenditure on health is USD 8. Government expenditure on health is 10.3% of the total government expenditure. There were 65.3 hospital beds per 100,000 population in public sector and 10.6 general practitioners per 100,000 population. In terms of primary care, there were 350 physician-based primary health care facilities in the country (232 in the public sector and 118 in the private) and 1,443 non-physician based primary health care clinics (1,050 in the public sector and 393 in the private) (HSSP II, 2005)

### 3.1.1 Development priorities

According to the participants interviewed in this study, poverty alleviation, addressing illiteracy and tackling diseases with a high mortality rate were reported to be among the main development priorities in the country. It was noted that poverty eradication is one of the main issues on the development agenda and all policies, plans and programs have to be oriented towards poverty eradication, as per the national policy of Uganda. Some participants however identified community empowerment through capacity building and human resource development; and improvement of social services delivery as the main development priorities where most efforts and resources should ideally be invested. They suggested that improvement of health services delivery would be imperative since a healthier population would result in reduced expenditure due to ill-health and a net increase in production.

### 3.1.2 Influence of international factors

It was reported that programs initiated and supported by bilateral agencies or development partners that are taken to be the authority in those specific areas are readily accepted and taken to be more important since such partners provide the guidelines to be followed. Mental health was specifically reported to have got more recognition after the 2001 World Health Report, which focused on mental health.

> "*…It is the ministry because World Health Organization has recently put stress on mental health; for the last 5 years or even earlier. So now it is on the front page of the strategies of World Health Organization. And so the ministry of health had no choice but to pick up this"* (SSI, senior policy maker, Ministry of Health)

Some of the participants however believed that global health initiatives and policies imposed on countries distort the health systems as they often do not take into consideration the country's existing structures and arrangement.

### 3.1.3 The role of External Development Partners

It was noted that external development partners play a great role in supporting the government to develop and implement its strategies. Their contribution to the Ministry of Health specifically was reported to be immense in terms of financial and technical support. The health sector was reported to be mostly donor funded; with funds channelled through general budget support, earmarked budget support and projects. It was further noted that other than those development agencies supporting the health sector directly, many others support indirectly through their support to the general budget. The funding mechanism is largely by the newly adopted Sector Wide Approach (SWAp), also commonly referred to as basket funding; by which the funders contribute funds towards a general pool and then the sector allocates to specific programmes basing on its priorities. It was however noted that depending on their national government policies, some funders prefer projects and continue to fund and run projects parallel to basket funding.

SWAp vis-à-vis project funding was noted to be a controversial issue by some participants. Projects were reported to bring in constraints such as administrative requirements and the need for extra human resource; yet basket funding can make use of the existing government structures, making it a more favourable option. Some participants on the other hand argued that projects make it easier for funders to monitor their funds and ensure timely realization of visible outputs as compared to basket funding. Aware of the benefits and shortcomings

of each funding mechanism, they noted that the goal should be supporting the common policy and the funding mechanism should be secondary as long as there is transparency.

### 3.1.4 Challenges for the health sector (general)

The participants identified a number of challenges faced by the health sector and the country at large, which among others included the following:

- Underfunding. The fact that the health sector gets a relatively larger share of the national resources compared with other sectors was acknowledged. The funding is however not commensurate to the sector's responsibilities and challenges.
- Mismanagement and misappropriation of resources.
- Poor facilitation, in terms of infrastructure, equipment and staff remuneration. This also serves as a major demotivating factor as regards health service delivery.
- Wage bill ceilings not considerate of the high population growth rate.
- Lack of diversity in terms of personnel.
- Inadequate staffing.
- Disproportionate distribution of personnel between the rural and urban settings.
- A vertical view point of health (health believed to be a responsibility of the Ministry of Health only) and insufficient integration with other sectors.
- Poor planning and prioritization. It was noted that the health system is mostly treatment oriented. Very little goes into health promotion and disease prevention. Most resources go towards treatment of preventable communicable diseases, overlooking the contribution of non-communicable diseases (which are believed to be on the increase) to the disease burden.
- Less autonomy in decision making since the sector is mostly funded by external partners, some of whom often have specific interest areas.
- Interference by political leaders into technocrats' work and politicking in health programs.
- Limited accessibility to quality health facilities especially for the rural populace.
- High population growth rate and high dependency ratio.
- Inequity/disparities in resource allocation and access to services. The gap between the affluent and the poor widening very fast, causing a lot of frustration. As a result, many people become expectant of free high quality services to which they make no contribution.
- Limited community involvement and sense of ownership for health initiatives.
- Low awareness and ignorance about healthier practices in the public.
- Unhealthy cultural beliefs and practices in communities.
- Generally deteriorating quality and delivery of social services in most parts of the country.
- Advent of new diseases and increase in the prevalence of the previously rare health problems in addition to the traditional diseases, yet the sector is constrained financially.
- Selfishness and a tendency of some leaders to put personal interests at the forefront.

Some of the participants believed that the current trend of events has caused apathy and despondency in the population. This was believed to be due to low sensitivity to people's needs by the political leadership at different levels. They expressed scepticism over governments' ability and willingness to make the situation any better.

## 3.2 MENTAL HEALTH SITUATION

### 3.2.1 Perception of Mental Health and Mental Illness

Some of the participants reported "mental health" to be a complicated term that is not well understood. On the other hand, some others, including PHC nurses viewed mental health as the opposite of mental illness or absence of mental illness. By this, they described mental health as a state and not a domain/facet of health. Most of the participants both at district level and national level, including general health workers frequently used the terms "mental health" and "mental illness" interchangeably to mean mental ill-health. Some participants attributed this to the fact that the key word in both terms is "mental", which is largely equated to "madness". Therefore, to many, once the word "mental" is cited in any phrase, it is all perceived to be about illness.

> "*…It is because when you talk of mental…the word "mental" alone, people think it is madness. Before they look at the following word…once you talk of the word mental, they assume it is illness. So, whatever follows…they may not really take it in as they have already heard 'mental'…*"
> (SSI, Senior Nursing Officer, Urban district)

While some teacher participants had a more scientific view of mental health and understood it to be a kind of a continuum with mental wellbeing at one end and mental illness at the other end, others understood mental illness in terms of mental retardation.

In the community, mental illness was reported to be largely viewed from the perspective of odd or queer behavior and eccentric symptoms characteristic of psychotic or manic disorders:

> "*…the perception of the community is that for mental health, it is someone who is fighting and throwing stones and beating everyone…people look at mental health in terms of mania cases*" (SSI, hospital manager, rural district)

> "*…People only know mental health because of the gross diseases like psychosis or people who are manic, forgetting about the simple things like anxiety, alcohol dependency and depression*" (SSI, hospital manager, urban district)

Cultural influence in lay people's perception of mental illness was reported to be very strong and less affected by factors such as education or social class. Mental illness was said to be greatly linked to supernatural causes. Even when it is an obvious physical cause, the "lay man's" explanation will link it to supernatural forces, and/or to witchcraft.

> *"…these illnesses when they come on…um… people treat them at a level…cultural level and normally there are the spiritual healers, the traditional healers,…..…the herbalists. They believe that they do a better job than us, they just have that conception and it's going to take time to get it out of them. If somebody has say schizophrenia, they think it is a spirit of some kind and… it can only be handled by some spiritual healers, not these '**European medicines' as they put it…'the white man's medicine will just accentuate it…it never heals. It just calms it down**. **But the other one…it really attacks it, tackles the real cause'**...."*
> (SSI, District Health manager, rural district)

> *"…there is the traditional cultural view whereby mental illness as many other illnesses are perceived to be coming from the supernatural. Even when the cause is very obviously physical, the explanation goes beyond physical. I will give an example. Someone could be an alcoholic. Everybody knows there are mental illnesses due to alcoholism. But they will say they were bewitched in alcohol"*
> (SSI, Academic and Researcher 1)

Differences in the understanding of mental illness were noted to exist within the rural and the urban context. While the traditional beliefs in witchcraft are still strongly held in the rural communities, the urban folks apparently have a modern scientific understanding of mental illness, attributing it to biological, psychological and social causes. Furthermore it was reported that mental illness among the youths is attributed to substance abuse while that of the middle aged and the elderly is often attributed to witchcraft.
Some of the participants admitted having previously believed that mental illness is incurable, but had gradually dropped the belief on seeing some individuals formerly treated for mental illness live a productive life after recovery. It was however noted that in the communities, belief in treatment and full recovery for the mentally ill is still very low.

### 3.2.2 Interest in Mental Health

It was noted that interest in mental health among most general health workers is still very low, and most of the general health workers who received orientation in mental health never had the interest in mental health, and never developed the interest even after, as they continue to disregard mental health. One PHC doctor affirmed that although they currently spend relatively longer time training in mental health at the medical school than in the past, their interest still remains low and the attitude would take longer to change.

> "*…Yes, we get the orientation in mental health but the attitude doesn't change easily. The time is not enough to change the attitude and develop interest"*
> (SSI, PHC Doctor, Urban district)

> "*…My doctors may not be very much interested in mental services. They will just tell you "**that is a department somewhere**" they always refer those people for there*"
> (SSI, hospital manager, urban district)

This was further illustrated by the fact that some of the PHC doctors approached, declined to take part in the study. Some of participants did not see the rationale of learning about mental health, since to them the field is far from their areas of duty. On the other hand, other participants, especially the teachers expressed an overwhelming desire to know more about mental health and mental illness since they face a lot of challenges when dealing with the students especially the adolescents, the slow learners and those with conduct problems.

Most other participants reported having developed interest in mental health for various reasons, such as their sympathy for the mentally ill people as concerned citizens, the observation that mental illness is increasingly becoming a bigger problem and having had relatives or significant others who developed psychiatric problems. For some of the mental health professionals, it was because they had realized that quite a number of people, including their relatives were battling with problems that were not well understood, and most of them not receiving appropriate help.

Some of the participants, irrespective of their level of education, obligation to the society and the fact that they have relatives with mental illness emphatically expressed their low awareness and disregard for mental health.

> "*…Mental health!!, that is a bad disease I hate. I am not interested; I only sympathize with people who suffer from Mental health*" (SSI, Politician 4)

### 3.2.3 Prioritization of Mental Health

At the national level, mental health was reported to be one of the priorities since it is included and equated to other programs at policy level, and is one of the components of the National Minimum Health Care Package. Furthermore, mental health is given consideration in the Support to Health Sector Strategic Plan Project and has a separate budget line within the ministry of health budget. According to some Ministry of Health officials, prioritization of mental health was largely influenced by the World Health Organization and other international agencies' recommendation. It was noted that a lot of achievements have been realized in mental health service delivery over the past few years, which were attributed to high consideration for mental health by the Ministry of Health and good leadership in mental health.

Despite this affirmative action, the picture seems quite different at implementation level. Most participants especially at micro level strongly believed that mental health is still given low priority, for a number of reasons. Firstly the concern is mostly on diseases with high mortality rates like HIV/AIDS and malaria. Secondly mental health interventions are said to be expensive and not to produce fast, observable and quantifiable outcomes as compared to other conditions and thirdly, that mental health is a concept which is not well understood by many people. The small budgets meant to facilitate mental health activities in some health facilities are often not realized for that purpose. It was reported that in cases of insufficient funding, budgetary re-allocation is based on prioritization and mental health is often among the most affected areas.

> "*…and…I said it is not what…it is not as acutely life threatening that people give it a lot of concern*" (SSI, District health manager, rural district)

> "*…You see in most cases most of these policy makers, I think they are interested in tangible results. But ours… the community based are not easy to see, sometimes it takes long… for example you are dealing a mental case, you are counseling or you are referring somebody…so, they may not see that. So the impact am not very aware with them, but because they don't see that, that is why we also marginalized*" (SSI, Social worker, rural district)

> *"…I also read through the work plan, I found that we are supposed to be catered for with some money. But I asked for the money and asked for the money, not until I realized that I would cause a grudge with my boss*" (FGD, mental health nurse 4)

Furthermore prioritization was reported to be dependent on the burden posed by a condition/disease, as reflected in the Health Management Information System (HMIS) data analysis. Thus, with the very little data collected in mental illness, the disease burden

posed by mental illness is not known. This was largely attributed to the inability of most health workers to identify patients with mental illness due to a lack of adequate knowledge in the field of mental health. The small number of cases reported in the HMIS was also given as an excuse for less consideration of mental health. Poor facilitation for the mental health services was said to be very obvious during the purchase of medical supplies which was reported to be dependent on the number of patients presenting with a particular condition.

> "*…I have told you that not many of these diseases are diagnosed. So, when we are buying we don't really take it as a big priority…we are supposed to buy drugs depending on the data collected. I have told that our clinicians miss out to diagnose the common diseases in people. So, somebody who comes in with anxiety or with depression is diagnosed malaria. And on our returns is malaria. So, when you look at the returns we always buy our drugs depending on what we see; because you can't start saying that I should buy a lot of these drugs when you don't have evidence*" (SSI, hospital manager, urban district)

However other participants especially at primary health level argued that, though few cases are reported in the HMIS, it cannot be a justification for overlooking mental health. They believed that the cases are many in the community, only that health workers lack the skills and knowledge to detect them and that most others do not readily seek help at the health facilities. The health workers believed that low prioritization for mental health starts right at the ministry of health headquarters, spreading down to health facility managers and administrators. They described managers and administrators as being less empathetic to those suffering from mental health problems and hence the meagre resources committed to mental health. Comparing mental illness with HIV/AIDS and malaria, the health workers asserted that resources for other conditions and activities are always readily realized, but not for mental health.

> *"…but if these people at the ministry think about it seriously, then that money would be in place. But they don't take it seriously…nobody cares. The cars they drive are very expensive and they can manage to buy the fuel, but buying drugs for the patients is not an issue to them…"* (FGD, PHC nurse 1)

Another nurse in the same group added:

> "*…and whoever comes in just looks at a proposal for AIDS, malaria…among 100, there may be 1 for mental health. So, somebody has to look at what is selling*" (FGD, PHC nurse 5)

Some participants further argued that some leaders tend to be selfish and insensitive to the plight of the mentally ill people, until someone close to them falls sick with the same. Some PHC nurses quoted one health manager who had at one time stated that there are few cases of mental illness in the district, and hence no need for a mental health nurse.
It was further reported that because of the widespread stigma and misconceptions surrounding mental illness, some non-medical administrators at the health facilities do not look at mental health as an area that deserves attention. They tend to believe that purchase of medical supplies for patients with mental illness is wastage of resources.

> *"…because whenever we are buying drugs, again they say but for who? You know! so it becomes a bit of a problem… even now in the administration apart from us who are medical, the other people who are non medical, they look at those people as mad…and…you know so it becomes a bit of big problem"*
> (SSI, hospital manager)

One hospital manager further affirmed that most of the medical personnel to date do not take mental health as an important area because it was not prioritized during their training at the medical school. Increased awareness on mental health was identified as the best solution that would help bring mental health in the limelight. One participant specifically gave an example of visual impairment as an area that had in the past been neglected like mental illness but currently gets significant recognition because of wide awareness raising.

> *"…I will quote an example of this NGO, the sight savers. For them, they are for visual. Before they came, we didn't know that these children were there, but when they came, we have started seeing children with sight problems. So, with mental disorders, it is because nobody is tickling the situation to find out whether those children are there…."*
> (SSI, Senior Education Officer, rural district).

### 3.2.4 Trend in mental health services

Commenting on the trend of mental health services, it was recounted that until recently, mental health services were centralized and services were available only at the National Mental Hospital before the decentralization to lower health facilities.
It was reported that in the public, mental illness was previously seen as an untreatable condition attributable to witchcraft and other related causes. However, with increased sensitization, the public has begun to recognize mental illness as a treatable disease with known scientific causes. Some participants noted that the present achievements as regards mental health care are quite impressive and give more hope for improvement in mental health services. They gave credit to the current leadership in mental health.

### 3.2.5 Mental health services at district level

### 3.2.5.1 Rural district

#### 3.2.5.1.1 History of mental health services in the District

Mental health related services were reported to be generally new in the few health facilities where attempts are currently being made to care for patients with mental illness. At one community health centre, the clinical officer in-charge reported having developed the drive and courage to initiate mental health services at the facility after attending mental health day celebrations and some other workshop where mental health featured on the agenda.

> *"…before, someone could not talk about it, until…one time we had a workshop in Iganga and when also I attended the mental day in Jinja. So the information I gained from Jinja… that was 2003 and again the information I gained from Iganga in the workshop… I came up and…actually I had just been transferred here…I was still new and there was nothing to do with mental health. So, I started that kind of program*" (SSI, Community health centre manager)

#### 3.2.5.1.2 Management Frameworks and Intersectoral Links

It was noted that a district health management committee is non-existent for this district. Instead, there is a District Health Team (DHT) and a social services committee which at times doubles as health services committee. According to the Ministry of Health recommendation for the organization of District Health Services, there is supposed to be a general hospital at the apex, with four other levels of care below. In the case of this district, the designated general hospital is a private missionary hospital. Government owns the health centres at the other levels of care from Health Centre IV, downwards. The reporting system is therefore hierarchical in nature. Health Management Information System is compiled from below, upwards through the Health Centre IVs to the District Health Officer, who then forwards the reports to the Ministry of Health. Such data is used to plan for the services. The health workers reported receiving no support supervision from the regional hospital in the area of mental health.

Intersectoral collaboration in mental health was reported to be lacking in this district. Only a few non-government organizations were said to be in place, mainly concentrating on HIV/AIDS which has been attracting a lot of funding. The district political leadership was reported to be unstable with lots of internal conflicts and administrative problems especially attributable to political squabbles. The participants believed that this grossly affects service delivery and is one of the reasons for areas such as mental health not being at the forefront as yet.

#### 3.2.5.1.3 Mental health plan

It was noted that there is no mental health plan, and no well organized mental health programs running in the district. Mental health was reported to have no budget but to draw from the general PHC budget as an integrated component, but with no predetermined budgetary allocations. While the PHC nurses reported having a minimal role to play in the management of mental health patients, a community health centre manager confessed that for cases of serious mental illness, their role is to sedate and refer. A few mental health drugs were reported to be available once in a while; mostly anti-epileptics. It was however pointed out that no antipsychotic drugs are available in the health facilities. None of the health facilities in the district was reported to have any follow up services for patients.

#### 3.2.5.1.4 Staffing

There was only one newly recruited mental health nurse available for all the health centres in the district. Despite being the only mental health expert in the district, this mental health nurse reported being assigned other duties, as a general health worker. It was noted that at the general hospital, there is no mental health staff, neither is there a vacant position for a mental health professional in the structure, yet to be filled. Staffing at the hospital was reported to be dependent on prioritization, with mental health currently not being one of the priority areas. The hospital manager affirmed that general nurses take precedence and that the available medical officers are in position to attend to patients with mental illness in case they show up.

> *"…we don't have mental health staff in the hospital. Mental health has not been one of the immediate priority areas"* (SSI, hospital manager)

He added:

> *"…but we look at immediate priorities. I can't bring in a psychiatric nurse if don't have the general nurse to take care of general patients"*

The hospital manager was cognizant of the fact that mental health nurses can do general nursing as well, which would perhaps make them be of an advantage as compared to the general nurses. He however assumed that the mental health nurses would prefer doing mental health related work only and hence the reluctance to give them strong consideration. It was reported that health workers at the hospital only attend to the overtly mentally ill patients and that most of the others, especially those with mental illnesses that may present as physical illnesses are missed out. The health manager on the other hand expressed the desire to have more specialists in mental health recruited but reported being limited by the staffing norms.

> *"…..our wish is to have more, resources permitting. The human resource is the most important, then the others can follow. And of course at times by nature of our…by the way the staffing norms…you find that it does not provide for that cadre of staff at many of our health centres".* (SSI, District Health manager)

**3.2.5.1.5 Training needs**

It was noted that with the exception of the midwives (who are the majority in the district), all health workers are believed to have had a component of mental health in their curricula during the training. The health managers however reiterated that very little attention was paid to mental health during their training, and admitted that the period used to be taken as a holiday from serious reading. They never visualized themselves utilizing that knowledge and did not regard managing the mentally ill as their primary role other than identification and referral.

> "*…Year four was a time when people thought it was a bit of time of relaxation. And it was not given that real weight, and you know psychiatry was offered as a by-the-way; not given that emphasis. You know it I is taken as a specialist field. So, for you…it was like you are being taught how to refer…laughing…but when you come out in the field, you realize that it is actually you whom they are referring the patients to*" (SSI, District health manager)

Some of the PHC nurses reported having received no basic training in mental health, and admitted only hearing about the National Mental Referral Hospital. They admitted being ignorant about the location of the National Mental Hospital, and viewed this as a challenge for them to refer patients to a hospital that they only hear about. The mental health nurse on the other hand felt that the training he received was inadequate to enable him handle the challenges of his work and expressed fear of degeneration of the knowledge with time. In view of this, the health workers observed a need for further training and Continuous Medical Education (CME) in mental health.

**3.2.5.1.6 Referral system**

An upward referral system was reported to be in place but not adhered to. Patients apparently seek help where they expect the services. Health workers at the district hospital reported that while a few patients come to the facility through the referral pathway, others often go directly to the higher levels of care. Patients easily identifiable to be having mental illness were reported to be referred to the regional referral hospital right away. With no follow up in the community or a back referral system in place, the primary health nurses admitted losing track of the patients, which makes it difficult to know whether patients ever proceed to the facilities where they are referred. Furthermore, it was reported that many patients often find it hard to seek help at the general hospital since it is a private

facility. When patients are referred to the regional referral hospital, they often opt to go directly to the National Mental Hospital where they hope to get the services. This was also reported to be a common occurrence since the patients somehow get to know that services at the regional referral hospital are inadequate. Others were reported to hold a belief that certain conditions are only treatable by traditional healers.

> "*…So you refer a patient …and you know patients have the information they get from others, they will say 'they are referring you to Iganga, but they will still refer you to Butabika. So, go to Butabika straight away'….why do you waste your time?"* (SSI, District Health manager)

The patients were reported to face constraints of transport with a poor transport system and long distances to the general health facilities where free medical help is available.

**3.2.5.1.7 Support supervision mechanism**

The health workers reported that there is very little support supervision from senior mental health professionals. One clinical officer in charge of a community health centre claimed doing the supervision of the nurses at the facility in mental health. The mental health nurse lamented over the fact that he receives no supervision and has no senior mental health professional to consult.

**3.2.5.1.8 The Police department and mental health**

The police department was reported to have a minimal role in caring for the mentally ill people, especially by delivering them to a mental hospital when called upon. The participant from the police reported having no support mechanisms or guidelines of any nature while dealing with those having mental illness. It was further reported that even in the training curriculum for police officers, mental health does not feature since it is regarded to be outside their jurisdiction.

> "*…Anyway we have never had any training in mental health. We believe everybody is normal until he is taken before the expert*" (SSI, senior police officer).

Police contact with the mentally ill was reported to be during circumstances when the police is called upon to intervene or when such people have committed crimes and have been dragged to police. It was noted that a special police officer (probation officer) is assigned the duty of handling children's issues. However, young offenders were reported to be treated in the same way whether mentally ill or not. The participant from the police reported being less informed about the mental health law. Training in mental health related issues was said to be an option for those police officers in the department of health. Once in the hands of the police, individuals suspected to be mentally ill were reported to be taken to the police surgeon or a medical superintendent in the police force who ascertains whether one is mentally ill and then arranges for transfer of the individual to the mental hospital.

**3.2.5.1.9 Law and justice sector**

The participant from the law and justice sector was rather reluctant to take part in the study because of being less uninformed about mental health. Contact with the mentally ill persons was reported to be mostly for those roaming around in the community and also on occasions when they are brought to court. The latter was reported to happen when such

individuals have been involved in offences. It was further reported that feigning mental illness in the courtroom so as to evade conviction is a common habit for some offenders.

> "*…he pretends he is mad, but the moment they are taken to prison, they come back when they are normal. Somebody comes and shouts, behaves abnormally before court; but 1or 2 days in prison, he comes back behaving just like any other person…"* (SSI, magistrate)

The participant from the judicial sector believed that magistrates as members of the judiciary have no special role to play in caring for the mentally ill other than sending their files to the Director of Public Prosecution (DPP) who then makes an assessment and referral. This participant however had no idea about the kind of assessment done by the DPP and was uncertain on what exactly is done for mentally ill offenders after treatment at the mental hospital.

> *"…the person's file is sent to DPP so that he can be taken to Butabika where they treat the mentally ill…then he can be excused of the crime. Maybe he is kept in the hospital instead of being prosecuted"* (SSI, magistrate)

The juvenile mentally ill-offenders were reported to be handed over either to parents or a remand home if available, in accordance with the children's statute. The participant believed that basic training in mental health related issues in the judicial sector may not be necessary because the nature of training for members of the judiciary strongly emphasizes critical observation and analysis of the situation at the present time, but not relying on preconceived knowledge.

## 3.2.5.2 Urban district

### 3.2.5.2.1 History of mental health services

Mental health was reported to be an area that had been neglected for long but had of late got recognition in this district as one of the priority areas. It was revealed that for quite long, the district neither had a mental health professional nor any staff trained in mental health. It was not until the health manager attended a workshop on mental health that he developed the enthusiasm and managed to convince the colleagues to start giving mental health favourable consideration.

It was further noted that after the same workshop, the health manager realized that a lot of mental health-related data was previously missed out in the HMIS as most cases of mental illness would go unnoticed.

> *"…I was in Masaka for a workshop and she came in and made a presentation there…that time when they were thinking of taking mental health up to the community level…community based mental health. I got touched. I came back and addressed the members, and I think somewhere somehow we started seeing mental health as a priority.* (SSI, District health manager)

He added:

> *"…And again when it came to our HMIS, we noticed that many mental health cases were going unnoticed. Not a lot of data was being captured in the area of mental health"*

The health manager reiterated that mental health subsequently became one of the priority areas in the district, and continues to be a priority area that has been given due consideration especially in the area of capacity building.

#### 3.2.5.2.2 Management frameworks and intersectoral links

The district health system was reported to be working well amidst a number of challenges such as financial constraints. The district is ranked highly in terms of services delivery, including health, as compared to most other districts. This was attributed to a high level of commitment by the personnel and proper utilization of funds.

> "…*We struggle to be on the top by ourselves and when we are there, they think we are getting a lot. But the fact is that for the little we get, we commit it to what it is supposed to do. Maybe that is how we manage to get there*"
> (SSI, District health manager)

Although the district health manager reported that there is a District Health Management Committee, some of the participants expressed uncertainty about its existence. The hospital manager noted that it becomes difficult to set up some of the committees because of limited human resources. No form of multisectoral link was reported to be in place as far as mental health is concerned. It was however reported that the general hospital has some collaboration with the National Referral Mental Hospital, under which a visiting psychiatrist provides some services at the hospital. Furthermore, the hospital manager reported an existing link between mental illness and HIV/AIDS, which prompted them to establish some collaboration between the mental health department and The AIDS Support Organization (TASO). Support groups by TASO were reported to be in place only for those patients having mental illness and HIV/AIDS or mental health problems resulting from HIV/AIDS. Reporting back was said to be done on a monthly basis and to the district health officer, who then reports to the Ministry of Health.

Mental health was reported to have no specific budget, but to be catered for by the general Primary Health Care budget since mental health services are integrated into Primary Health Care. The fraction of the district health budget dedicated to mental health services could not be established due to difficulties in determining the unit cost, but was estimated to be less than 5%.

#### 3.2.5.2.3 The mental health plan

It was noted that there is no district mental health plan in place and mental health is integrated into the General Health Care plan. Limited mental health promotion and prevention programs were reported to be running in the communities. Mental health was reported to be integrated in activities during the outreach programs.

#### 3.2.5.2.4 Staffing

Each health facility at the level of Health Centre IV was reported to have at least a mental health nurse. The district health manager expressed concern over the fact that the recommended staffing norms by the ministry of health make no provision for mental health nurses at the lower levels of care, specifically at Health Centre IIIs and yet a significant number of mental health patients seek help at this level of care. He expressed a need for recruitment of Psychiatric Clinical Officers as well, at least at the district hospital if supported by the staffing norms.

> *"…We don't have mental health nurses at Health Centre IIIs. And I was looking at the structure, I think that is a very big gap. Because they don't cater for that position at Health Centre III and yet these Health Centre IIIs are handling quite a number of these cases"* (SSI, district health manager)

It was further reported that the district designates a mental health focal person specifically to manage mental health issues on rotational basis. Such a person is usually a medical officer in charge of health services in a health sub-district.

**3.2.5.2.5 Training needs**

It was noted that a few of the general nurses had received some orientation in mental health. One PHC nurse reported that rotating through the National Mental Hospital during their training had a significant impact as it gave them some good exposure to mental health problems and their management. She further noted that general health workers who received some orientation in mental health tend to be more receptive and empathetic in the way they handle patients, and endeavour to educate fellow health workers on mental illness. It was however noted that the duration for orientation of the general health workers in mental health is usually inadequate. The PHC nurses reported being unable to effectively handle patients with mental illness even after some orientation in mental health due to the wide scope, but yet insufficient time for the training.

> "…. *It was so hard that you couldn't get things in just one week. Because by the time I went there, I thought by the time I come out, within that one week, I would be able to treat mentally ill patients. But I found that it is not possible. I found that it was such a wide thing that you can't learn it in one week*" (SSI, PHC nurse)

Two health workers from each health sub-district were reported to have received some basic training in mental health, at the National Referral Mental Hospital. The hospital manager reported having discovered that some of the trainees apparently attend such training without any serious motivation and thus never show any improvements in their practice after the training. He proposed that the training should be thorough and well tailored to enable the trainees develop interest in mental health; as well as a change in attitude towards mental illness.

Furthermore, it was reported that some CME sessions have been planned at the hospital, through which the general health workers should have acquired some basic knowledge in identification and management of common mental health problems. The health workers emphasized the need for continuing medical education, especially for the mental health personnel to keep abreast with recent developments in mental health and new drug regimens.

**3.2.5.2.6 Reporting**

As part of the HMIS, reporting by the district health manager was reported to be done to the Ministry of Health headquarters on a monthly basis. Specifically, numerical information on the patients with mental illness seen at various health centres is reported. A great improvement in reporting, in the area of mental health was reported to have been realized following the recruitment of mental health staff and orientation of general health workers in mental health.

*"…when it came to our HMIS, we noticed that many mental health cases were going unnoticed. Not a lot of data was being captured in the area of mental health. So after the recruitment and the orientation of the staff, who happened to talk to other clinicians, the reporting in the area of mental health is improving. Because you could find that for a whole month, they don't report any case of mental illness"*
(SSI, district health manager)

### 3.2.5.2.7 Referral system

A vertical referral system was reported to be in place, though not adhered to, particularly for mental health. The health manager explained that it is a common practice for health workers at different levels of care to refer patients with mental illness mainly to the National Referral Mental hospital. He further reported that while the mental health nurses attempt to manage some of the patients with mental illness and referring the severe cases, people in the community tend to bypass the other levels of care, always rushing straight to the National Referral Mental Hospital. Such problems with the referral system were attributed to the community's belief that mental health services can only be received at the national referral mental hospital.

*"…Because people know that Butabika is the only place where mentally sick people can get treatment. They don't think they can get help from our health centres"*
(SSI, District health manager)

He added:

"*…I can say apparently there may be few or no cases referred with the district system. Somebody could be referred because of another illness but not necessarily mental illness. When it comes to somebody's mind that it is a mental case, they will think of Butabika; not any other place*"

Similarly, a back-referral system was reported to be lacking within the district.

#### 3.2.5.2.8 Support supervision mechanism

Support for health managers handling mental health at the different health centres was reported to be minimal, through an integrated support supervision system. By this, there is a joint arrangement for supervision of health workers in the different specialties. Under this arrangement, the mental health focal person in the district together with a registered mental health nurse are said to participate in the supervision of the mental health nurses. The health manager was noted to be hopeful that the mental health nurses teach and support other general health workers in handling mental health cases through CME sessions although he has not yet taken any deliberate efforts to follow this up. Some mental health nurses reported having taken the initiative to organize for CMEs at their respective facilities but were frustrated by the lack of interest among the general health workers.

"*…You could call for a CME and only 2 people turn up. You call for the CME again and those 2 people don't turn up. Because they lack the interest…"*
(FGD, mental health nurse 1)

#### 3.2.5.2.9 The Police department and mental health

It was reported that the police officers do not receive any orientation in mental health during their training. Contact with the mentally ill persons was reported to be on occasions

when the police is called upon for help. However, the police was reported to pay attention only in cases where the mentally ill are aggressive and a danger in the community due to poor facilitation.

> *"…When you find one in peace or seated somewhere, you bypass and go. But when he is so dangerous to the public, then there is no need to be called. You just intervene there and then"* (SSI, Senior Police Official)

As regards the offenders believed to be mentally ill, the police was reported to acknowledge the fact that these are not criminally responsible, and should not be imprisoned but rather be taken to a mental hospital for care. Mentally ill offenders were thus reported to be taken to a medical doctor or the mental hospital for examination, but not to court. Though a senior officer, the participant from the police admitted being less conversant with the mental health legislation and reported that there are no set guidelines or procedure for the police to follow while handling the mentally ill persons. It was reported that in this district, there are currently no links between the police and the mental health service providers, neither have the police attended any multisectoral forum where mental health is discussed. The police officer visualized no need for training police personnel in mental health issues and believed that any understanding human being would be in position to tell whether one is mentally ill or not basing on observable behaviour.

> "*…I think that one does not require training, because you can see from someone's behaviour…you can easily identify….it doesn't require any training. Because even any person whether educated or not can be able to know that*"
>
> (SSI, Senior Police official)

The participant reiterated that the police's only role as regards caring for the mentally ill persons is picking and delivering them to the mental hospital. The police personnel were reported to receive no training in child and adolescent mental health issues. Children with mental health problems in the hands of the police were reported to be handled just like adults. The participant maintained that poor facilitation of the police department often necessitates individual police officers to facilitate themselves while handling the mentally ill persons, and the burden involved compels most police officers to ignore the mentally ill patients.

#### 3.2.5.2.10 Social workers

Services by the social work department for persons with disability were reported to be mainly in physical disability, not in mental disability. It is presumed that mental health features indirectly while addressing other disabilities. The department's emphasis was reported to be on children, and collaboration is mostly with non-government organizations dealing with children. The community social workers were reported to have minimal training in mental health and to be unable to deal with cases of mental disability. Community participation in sensitization programs and initiatives was reported to be inadequate. People were noted to value the financial benefits that may be involved more than the knowledge.

> *"…You call for a sensitization meeting and people think of how they will benefit from it financially. They ask* ***"will there be allowance?... Will there be lunch?****…"*
> (SSI, Social worker)

Another participant added:

> "…*They asked me for transport refund. They told the doctor* ***'now this gentleman has called us, we have used our transport, how are we benefiting? Just to come and listen to mental illness? How are we benefiting?'***…" (FGD, Mental health nurse 2)

The social workers' department was however reported to be understaffed and less prioritized, often with a realized budget catering for just a fraction of its intended activities. The social workers were reported to be more accessible in the communities, often consulted even in areas beyond their expertise. Community development functions were reported to be overlooked and poorly facilitated because their outputs are not immediate and readily recognized.

#### 3.2.5.2.11 Law and justice sector

The participant from this sector reported getting in contact with mentally ill people as they loiter in the community, but also when they run to courts of law in pursuit of justice, following serious violation of their rights. It was also reported that at times the relatives of the allegedly mentally ill persons attempt to grab or take custody of the latter's property against their will.

> *"…well there are around 2 or 3 cases that have come to me; and these persons…they were like…the relatives had taken away their property. They had been declared insane by those relatives. But when they come to me for help, one says* ***'these relatives are taking away my property; they are saying am mad, but am not mad'****…"* (SSI, magistrate, urban district)

Contact with the mentally ill offenders on the other hand was reported to be on rare occasions, when such people are presented to court to be charged after committing crimes. It was reported that in such cases, magistrates simply take note and refer the cases to a qualified medical doctor for assessment and further referral; in most cases the police surgeon. Offenders proved to be mentally ill were reported to be acquitted on grounds of failure to form intent of the crime.

It was reported that the magistrates do not receive any basic training in mental health, and operate on presumptions as regards mental health matters. Their training entails being cautious and paying great attention to details during court proceedings. Orientation in mental health was however believed to be necessary for members of the law and justice sector. The chain-link program was identified as a suitable avenue for introduction of the mental health to this sector. This is an arrangement for multisectoral collaboration between stakeholders in the law, order and justice sector, involving courts of law, police, prison, lawyers and hospitals.

### 3.2.6 The role of media

It was noted that the media links with the Ministry of Health mostly through its health promotion and education department. The media was reported to be an important stakeholder that links government sectors and service providers to the public through its major role of publicity and education. The participants from the media affirmed that their sector is interested and involved in health but most attention goes to conditions that are prioritized by the Ministry of Health or those that have more events, such as HIV/AIDS and malaria. The media was reported to be less involved in mental health because the users and the public at large tend to be silent and to show less interest in mental health. Interest

was noted to be mostly by individual journalists; at times for personal reasons. Mental health was reported to be an area that is generally not selling for the media. Wider media coverage on mental health issues was reported to be mostly on commemorative occasions. These participants believed that the prevalence and the economic impact of mental health problems are enormous but mental health does not get much attention because mental illness is not dramatic in terms of mortality and physical consequences.

Some of the participants asserted that for mental health to get more publicity and prioritization, the communication strategy has to be revised. They specifically proposed a need to link mental health to issues that are more appealing in the community as a strategy that could help attract more attention. They further proposed a need to involve influential people and such as politicians and celebrities in mental health initiatives since the public tends to pay more attention to them.

> "*…But you need to explain to them why they have to mind. You can present it in an economic argument….For instance…. I don't know how many people know the link between mental health and sexual potence. So, you could use sex as the marketing point. It now begins to create the drama that mental health was lacking before. You can present an economic argument. How much money are we losing as a country because so many people are stressed? I haven't seen anyone trying to market it that way…to make people think "why should I bother about this*" (SSI, Media Representative, 5)

He added:

> "*…It is certainly the biggest epidemic of the next generation. If I look at our life style, we live through a lot of stress because of the modern life style; and all this is impacting on mental health, but no one has really put it on the agenda. No one has convinced the M.Ps that this is the top thing. No one has convinced the president that this is the top thing*"

The participants further affirmed that the current media is highly liberalized and is mostly for profit making. It thus tends to focus on issues that excite the public and attract more sales.

### 3.2.7 The role of private sector

It was noted that private sector appreciated the importance of mental health since it hires human resource, whose mental wellbeing has a direct bearing on performance and production. It was however reported to be less involved in supporting health initiatives since the key areas of HIV/AIDS and malaria are heavily funded by external sources and government.

### 3.2.8 The role of external development partners in mental health

The participants noted that external development partners are beginning to realize the importance of mental health. They believed that although few development partners support mental health programs directly, mental health is partly addressed indirectly in the programs of many other donors. In line with this, all external development partners supporting the Ministry of Health under SWAp partly support mental health in line with the government policy of involving donor partners in priority areas.

The participants further believed that increased donor support and involvement in mental health would require government to take a lead in identifying mental health as a key priority area.

> "*…If government prioritizes, we can support. But if we want to support and they say "No, the other one is a bigger problem, mental illness is small"… what do we do? Your government never presents mental illness as a problem to the development partners...*" (SSI, Representative, ext. development partner 1)

It was noted that some development partners are not involved in direct support for mental health because it is not one of their interest areas or because government has not presented mental health to them as one of the most wanting areas.

> "*…you know mental health…I don't know whether I have ever encountered a specific strategy on the part of the government or ministry of health…it might be ministry of gender and social development that is handling this, and that could be one reason why I am not familiar with it as a government of Uganda priority*" (SSI, Representative, ext. development partner 3)

Furthermore, the development partners were reported to be conscious of the Disability Adjusted Life Years (DALYS) as an aspect in the assessment of the burden of disease, and the contribution of mental illness towards this. They however prefer supporting activities that have more immediate and measurable results, typical of the communicable diseases.

### 3.2.9 The Education sector and mental health

Some of the participants outside the education sector believed that the current style of work in the education system is stressful to the children. It was reported that children in most schools are overworked with academics both at school and home, leaving very little time for relaxation and recreation. Although some of the teachers were in agreement with this, others were opposed to it and believed that it is necessary to keep the learners always occupied. This was based on the belief by some teachers that mental retardation is quite common among the learners and the best way to make such learners productive is by keeping them busy.

> "*…the schools these days overload the kids with work? Simply because they want their schools to perform highly, they pump the kids with a lot of work. You find that a kid in nursery is given homework on a daily basis. There is a time I did homework with my son to the extent that I saw tears rolling down his eyes. Not because I was hash on him,… I was actually trying to be very gentle and supportive. I saw tears rolling and asked him "can we stop here?" he said 'No. If we stop here, the teacher will beat me tomorrow'…*"
> (SSI, Media representative 5)

> "*…It is contributing but not 100%. Because the way I see it, a child with mental retardation problem needs to be given a lot of work which can make him think about that. If these children are given a lot of work, it will compel that person to think…"* (FGD, Primary school teacher 2)

Mental health problems were reported to significantly affect the performance students/pupils, and to result in school drop out due to stigmatization. It was further reported that often many teachers also experience significant mental distress, which compromises their performance and output. One longtime inspector of schools specifically cited hidden mental health problems among students and teachers as one of the underlying factors for strikes in schools.

**Challenges for the education sector**

It was noted that the education sector has not considered mental health seriously. The teachers were reported to have too much work and to hardly find enough time to attend to the mental health needs of the children.

> *"…So, most teachers don't detect that. In fact if the ministry was wise, we would come up with a programme of identifying and training teachers who can detect mental disorders. But currently no, it is not there. They have been trained in visual and hearing…"* (SSI, senior education official 1)

> "*…the code of conduct says a teacher should help a child develop in body, mind, soul, character and personality. But you have been in our school system…the emphasis is academics, and even that one is done wrongly. We think of coaching….pumping a lot of material in the head. You have seen children being beaten because they have not passed exams. We are neglecting the character and personality of the child. That is why you can see many problems around. Those are the areas that lead to bad mental health"* (SSI, senior education official 2)

Emphasis was reported to be mainly on academics because of the current stiff competition among schools, ignoring other areas important for human development. It was noted that there are no specific school-based mental health programs as yet, neither are there any planned arrangements by the Ministry of Health and Ministry of Education for mental health in schools. The current school health program focuses on reproductive health and HIV/AIDS through programs such as the Presidential Initiative on Sex and AIDS Communication to the Youth (PIASCY).

> "*…You know to observe mental health problems among the children, one needs time. You need to sit and observe. And in such a situation where we are looking for first grades, we don't have the time. And the students also don't have the time to rest"* (FGD, secondary school teacher 4)

Another teacher added:

> "*…it is academics. The curriculum is directing us to teach the students and increase the number of first grades. And remember we are competing. If you concentrate on these other programs…straight talk, youth alive…what what, the other one is going to concentrate on academics*" (FGD, secondary school teacher 2)

The policy for the Ministry of Education directs schools to have a male and a female teacher assigned some extra duty of attending to the mental health problems of students/pupils. These teachers mostly act as school counselors and are referred to as senior woman or senior man teacher. Furthermore, it was reported that there are teachers

trained in special needs education, and these are expected to handle learners with disability. These teachers were however reported to be less equipped with skills to handle students/pupils with mental health problems.

> "*…they are teachers. The issue of career guidance and counseling is an assignment given by the head teacher. In most cases, those assigned the responsibility are not trained. So, you find that they are just there…counselors by title. They have little answers in terms of counseling and guidance*" (SSI, senior education official 1*)*

The education officials further reported that emphasis is on career guidance and the mentally handicapped children, and less efforts are directed towards guidance and counseling. They believed that the teachers trained under the Uganda National Institute for Special Needs Education (UNISE) program lack a sound mental health component in their training and have not yet been instrumental in helping children with mental health problems.
The teachers reported that attending to the mental health problems of the students is not mandatory but rather a responsibility they accept at their discretion. The commitment and passion this responsibility entails requires to be reciprocated with improved remuneration.

**Recommendations to the education sector**
Participants believed that prevalence of mental health problems among school going children is on the increase though there is no data to demonstrate this due to the absence of qualified persons to conduct studies to that effect. The following recommendations were made:

- The need to include mental health at least in the primary school curriculum.
- Make a provision for having at least a teacher per school trained to work as a school counselor. These however should be teachers whom the students can confide in.
- Conduct research on the prevalence and burden of mental health problems in schools.
- Revise the curriculum to address issues that are more relevant for human survival, such as culture and life skills for students to benefit in the current competitive world.
- Emphasize training of teachers in child and adolescent mental health issues.

Participants believed that introducing mental health in schools would have a wider multiplier effect in wider publicity and positive attitude change as children would contribute greatly towards the dissemination of information in their communities.

### 3.2.10 Child and adolescent mental health

Child and adolescent mental health was reported to be a largely neglected area at most health facilities. Some of the participants believed that children and adolescents lead a stress-free life and do not experience mental health problems because they are dependants who do not fend for themselves or any others. The majority however noted that children are humans and experience mental health problems just like adults.

Epilepsy, anxiety disorders and mental retardation were reported to be the most common mental health problems seen among the children, believed to be caused by malarial infections. However, substance-related problems, behavioural problems typical of conduct

disorders, emotional problems, domestic troubles resulting from conflicts with parents and relationship problems were reported to be more common among the older adolescents. Children from war-torn areas were specifically reported to be very irritable, often displaying inappropriate behaviours characterized by either hostility or withdrawal. One Secondary school teacher reported having made an observation over time of teenage students with sickle cells anaemia who persistently misbehaved in anticipation of their impending death, only to stabilize and become humble later when the anxiety subsided.

**Causes**

The mental health problems among children were mostly attributed to family breakdown, marital problems and poor parenting characterized by absence of adequate communication between the parents and children. The participants reported that with the current trends in life, there is often a big gap between the parents and their children. The children therefore have limited opportunities for interaction with the elders and minimal guidance on matters pertaining to their conduct; something believed to affect their emotional development. Furthermore, parents were reported to have relinquished most of their responsibilities in nurturing the children to teachers at school, who on the other hand hardly find the time to attend to the non-academic affairs.

> "*…We often tell the parents that they have left this burden on us, but we also have no time for this. So, the parents also have to come back and have time for their children and talk to them. Because a parent comes and tells you* ***'I have given you this child…for me I work in Owino, I come back late in the night, I have no time'****…"*
> (FGD, Secondary school teacher 3)

Breakdown of traditional social values was another factor believed to result in child and adolescents mental health problems. Participants believed that across different cultures, there are important traditional norms and values that used to be upheld strongly. These values were believed to have been protective but have gradually been replaced by foreign cultures due to modernization and globalization. Some elements of the newly adopted cultures are believed to be the origin of moral degeneration and dysfunctional behaviours, making children more prone to mental health problems.

> "*…There is a break down of social values… parents are abandoning their responsibilities. I think there's a problem where they attributed it....is it…child rights. There is a misinterpretation in the community about child rights. They say that government has come out with child rights and they have gripped up our responsibilities. Because they say that you can't talk to the child, the child will report you, you don't have to decide. So now what they have done most of them have abandoned the children…and I think that one also causes a big problem"*
> (SSI, community social worker)

> "*…I think Uganda like many other African countries is facing transition. There was a structure at the village level or country side level considered a traditional one. And it instilled values and it was respected. Then there was some years of conflict…so they lost their sense of tradition and didn't replace with new values. There is now a new structure of community with changes. Look at the North of Uganda…some specific areas, you see children moving with AK 47!!! Of course*

> *there should be modernization of culture but give them some bonds where they can rely"* (SSI, Representative, ext. development partner 1)

The high rate of orphanhood due to HIV/AIDS was reported to be another significant cause of mental health problems among children. Many children assume parental responsibility much earlier, taking care of themselves and the younger siblings (parentification). It is believed that such children often get overwhelmed by the responsibility, which could result in mental breakdown. Some participants further identified defilement as one of the causes of mental health problems among female children and adolescents. In one instance, a devastated young girl was reported to have wondered bitterly whether her father was the real father, having defiled her several times.

> *"…After greeting the uncle, she asked him '**But uncle, is this man really my father? What should I do? At such and such a time, he did this to me. Yesterday when mother went to the garden, he was with me in bed and even caused me a lot of injury'**…"*
> (A defiled young girl, as reported by a teacher)

Defilement of children was reported to be a common phenomenon and a mind-boggling happening that indicates the extent of moral decay in society; and greatly impacts on the mental health of the children. Some participants believed that the mental health of the perpetrators is questionable and this could be an indication of increased deterioration in the mental wellbeing in society.

Mental health problems among children and adolescents were reported to contribute greatly towards poor performance and a high rate of school drop-out. Furthermore, mental health problems in children were reported to go undetected in most cases, continuing through adolescence to adulthood and resulting into serious mental disorders. One mental health practitioner reported coming in contact with a number of University students who had for long harboured distressing feelings that resulted from unpleasant childhood experiences. Incest, defilement and other forms of exploitation of girl children were specifically reported to be on a rise and causing a lot of psychological torture.
Some users who had their first episodes of mental breakdown in their teens specifically noted that childhood onset tends to be more distressing because the individual has dreams and high hopes for the future. They admitted having contemplated or attempted suicide a number of times.

**Challenges**
Management of children and adolescents with mental health problems was noted to be still problematic. Most health workers admitted having insufficient knowledge in child and adolescent mental health issues, and finding the management of children with mental health problems quite a challenging area.

> *"…And sometimes they need a bit of technicalities with which we may not be well versed. So, sometimes we leave those children untouched. We really lack that bit of technicality"* (FGD, mental health nurse 1)

At the mental hospital, it was noted that children with mental health problems are treated from the same wards with adults. Some participants, especially users described this as an unfortunate situation that exposes the mentally ill children to more dangers and impedes

their recovery. Some nurses reported instances of child patients who were sexually abused by adult patients.

> "*…When I was a child, I was 13… imagine I was admitted in a ward where men were...big men....and these were mad men; naked. And yet we were brought up in a way that you don't see the nakedness of an adult. It worsened my situation and actually I had to escape from Butabika hospital*" (SSI, Key informant user 1)

It was further reported that at times children with mental health problems are abandoned at the mental hospital by their parents and relatives. It was noted that while some children with mental health problems are kept behind because the parents don't know where to seek help, others are viewed as a disgrace to their families and deliberately kept behind doors. On the other hand, adolescents were reported to be often hesitant seeking help when confronted with a problem or opening up fully in a bid to attain and maintain autonomy.

**Recommendations as regards child and adolescent mental health**
The participants made the following recommendations as regards child and adolescent mental health:

- Education of parents on the mental health needs of children.
- Teaching parents and potential parents better parenting styles.
- A need to have mental health workers in the schools; specifically school counselors.
- Incorporate and emphasize children's mental health in the teacher training programs
- A need to put in place more social programs for children in their communities.
- A need to involve children in making decisions that directly affect them, instead of imposing ideas and decisions on children without their knowledge and involvement.

## 3.2.11 Socio-economic and Cultural factors

### 3.2.11.1 Poverty and mental health

A strong relationship was said to exist between poverty and mental ill-health. Some of the participants re-affirmed this relationship as one of the key findings in some earlier studies.

> "*…That is one of the things I hadn't told you. What we found out in our baseline survey is that people feel they have become mentally ill because of poverty. They are poor, they are restless, always worried, they don't sleep, they do abc….*" (SSI, mental health professional, NGO)

Poverty was reported to be an important cause of distress that might result in significant mental health problems. Some participants specifically described poverty as a catalyst or a cause for problems such as suicide, depressive disorders and anxiety disorders; as well as leading to relapses in the mentally sick people. While the majority of the participants regarded poverty as one of the major causes of mental health problems, a few participants with a medical background believed that the link is mainly an associational one, but not causal. Many participants referred to unemployment as an aspect of poverty that is leads to frustration and is a high risk factor for mental breakdown. It was further noted that many unemployed people, especially the uneducated ones attempt to cope with their frustrations and social problems by resorting to alcohol and other illicit drugs, thus making them more susceptible to mental health problems.

The participants cited a number of factors linking poverty and mental ill-health. These include:

- The widespread negative attitude towards mental health makes it hard for persons with mental illness to access reasonable employment or credit/micro-finance services.
- The poor usually find it hard to access proper medical care; and when they do, they cannot afford efficacious drugs which are usually expensive, thus they often do not complete the dosage; something that may lead to frequent relapses or exacerbate the illness.
- Delayed help-seeking and self-medication due to financial constraints, which often lead to worsening of the condition are more common among the poor.
- The financial implications of having to travel long distances to access mental health care, given the imbalance in distribution of mental health professionals often deters help seeking.
- Some patients with mental illness at times become destructive, causing significant loses to their families.
- Persons with mental illness often have impaired judgement. They are less likely to be constructive and developmental, and are mostly unproductive.
- Parents with mental illness are less likely to take care of their children well in terms of nutrition and educational support. On the other hand, children with mental illness are unable to progress and achieve in academics leading to reduced opportunities for gainful employment in adulthood and hence a vicious cycle of poverty.
- The chronicity and recurrent nature of many of the mental illnesses make demand for medical supplies outweigh the supply. This is further complicated by the fact that mental health units are often under-resourced, leading to frequent stock-outs. As a result, users at times have to buy drugs which are however reported to be rare on open market and expensive. This drains their little savings, thus sinking them deeper into poverty.
- It was further noted that many patients tend to seek dual treatment; traditional healing and western medical care, making management quite expensive. Some traditional healers tend to be very exploitative extorting a lot of money and property from their clients impoverishing them further.
- Due to poverty, some people at times get lured into performing horrible rituals and inhuman practices so as to obtain wealth. The consequences of such acts are at times traumatizing and may impact negatively on the mental health of the victims and the perpetrators as well.

In the rural district specifically, some of the participants from the education sector viewed the link in terms of nourishment for children. Teachers narrated that children from poor families are often subjected to poor feeding as nearly all the food crops have to be sold to earn money leading to malnutrition. Malnutrition at critical stages of development was believed to impact on brain development and hence mental retardation and or other mental health related problems.

The users too believed in existence of a strong link between poverty and mental ill health. They noted that in addition to the patients being unproductive during the time they are hospitalized or on treatment; their carers also spend the time that would have been spent on productive work nursing the sick relatives. This subsequently lowers their productivity

resulting in significant economic decline within the family. One user specifically described the recurrent nature of her mental illness as a very inconveniencing experience. She explained that her relapses are often associated with higher expenses and little or no productive work, subsequently resulting into financial regression.

> "*…when I relapse, I have to use all the money and go back to zero. So, I have to begin afresh whenever I recover*" (SSI, mental health service user)

Although most participants viewed a unidirectional relationship; that is poverty leading to mental health problems, others believed that the relationship can be two-way. It was reported to be absolutely hard for individuals with mental illness to progress in terms of career development and other achievements. They become unproductive thus sinking into poverty; which in turn causes more distress, and hence they revolve within a negative vicious cycle of poverty and mental ill-health.

A few of the participants however argued that although stress and mental health problems are a reality among the poor, some poor people lead a simple life, free of worries; and are comfortable with the little they have. They further reported that the employed and wealthy on the other hand often lead an equally stressful life as a result of the demands at work or as they struggle to protect and maintain their wealth amidst many other life problems. They noted that mental health problems affect the affluent people as well, and believed that the burden of mental ill-health is more in the developed countries where most people are well off financially. They maintained that mental health problems are mostly among the very poor and the very rich members of the society.

**Breaking the link**

Mental-ill health and poverty were reported to be problems not limited to the health sector alone but to cut across all sectors. Therefore, interventions to break the link between mental ill-health and poverty have to be by a concerted multisectoral approach. The participants identified a need for capacity building and empowerment of the public to increase primary production. They emphasized the need for community empowerment through health education, mental health promotion, and early detection of people with mental illness and improvement of access to mental health services. They strongly believed that to break the link between poverty and mental ill-health, raising the public's awareness on mental health related issues would be necessary and complementary to capacity building and income generating activities.

Furthermore, some of the participants, especially the mental health service users observed that interventions to break the link between poverty and mental ill-health would be more efficient if they addressed poverty at the household level. They emphasized a need for empowerment towards improved livelihood so as to improve the quality of life and reduce the chances of relapse among people with mental illness. They further stressed the need for more support groups for people with mental illness.

Those participants who strongly regarded poverty as a major cause of mental ill-health considered money as a potential protective factor against mental health problems. They thus expressed hope in the long awaited government's proposed poverty eradication initiative "Bonna baggagawale" (prosperity-for-all). However, some participants were not in support of the idea of "prosperity for all" and argued that giving out money is not service delivery and its impact is usually minimal. They believed that the initiative is less likely to

help in poverty eradication and emphasis should be to put in place structures and other facilities for mental health care. Consequently it was recommended that government should establish a living wage to protect citizens from exploitation, and should devise means of supporting the citizens living in abject poverty to meet their basic needs.

A few of the participants however believed that eliminating poverty and breaking the link between poverty and mental ill-health would be virtually hard. They viewed poverty as a trans-generational ideological problem or belief that is deeply embedded in people's minds, rendering them chronically lazy and dependent irrespective of the available solutions.

### 3.2.11.2 Mental health and gender

Gender roles, male dominance and female submissiveness are the key factors that some participants believed to have an impact on the individuals' mental wellbeing. Women were believed to be more vulnerable to mental distress because they tend to be submissive and to have less autonomy over a number of issues. Other participants attributed the males' mental distress to patriarchy whereby men virtually shoulder all responsibility of caring for families; something that was observed to be very stressful to men.

> "*…while for instance a typical working Ugandan woman will come back home in the evening without food, a Ugandan man has to borrow to come back home with something. There are bills like electricity, water, rent....all these are met by men*" (SSI, Key informant, User association)

Furthermore, in the community, mental illness among the males and the females was reported to be mostly attributed to substance abuse and witchcraft respectively.

Some of the participants stated that certain forms of mental illness are more common among individuals of a particular sex; for example psychotic illness was said to be more common among the males, while depression is more in the females. Other participants however believed that the observed gender difference is simply because females tend to seek help more readily than the males. The users reported that society has a tendency to discriminate against the male persons with mental illness and to treat the female patients with sympathy.

### 3.2.11.3 Mental health and stigma

It was noted that mental illness continues to be highly stigmatized both within the elite and the uneducated realms. It was noted that in the community, mental illness is regarded as a unique illness that is traditionally stigmatized. Some participants cited examples of traditional practices such as a tendency by parents to strongly discourage their children from marrying within families with a history of mental illness. It was noted that the general health workers too play a role in propagating stigma against the mentally ill. They were reported to often label patients, use an insulting language, to be disrespectful and to deny mentally ill patients appropriate care; which are clear reflections of stigma.

> *"…even the staffs up to now they feel that these patients should not be on the medical wards, and the government policy says these patients have to be on the wards*" (SSI, hospital manager, urban district)

Stigmatization against mental illness was also reflected in some of the participants' responses, like the use of a demeaning language when referring to the mental hospital and patients with mental illness generally. One participant was quoted saying:

> "*…because when you visit Butabika during working hours, you think Butabika is a place for normal people. It is cleaner than many of secondary schools…and even many other hospitals. You can think the people there are normal*" (SSI, politician)

**3.2.11.3.1 Causes of stigma**

It was noted that stigma is mostly attributed to the beliefs and misconceptions that are generally attached to mental illness. Mental illness was reported to be mainly due to witchcraft, spiritual causes, or as a result of the sufferer's misdeeds; and believed to be an incurable disease.

> "*…Well the stigma is because people think one gets mental illness because he did something bad, or the family has something bad they did. People don't think that one can get mental illness by a natural cause*" (SSI, Hospital manager)

Some user argued that the way colonial governments handled mental illness at the time was itself promoting stigma. The architectural design of psychiatric wards was like that of prisons, different from other wards and isolated. Furthermore, the language used in the mental health law was reported to be rather dehumanizing. Terms such as "lunatics" and "idiots" used in referring to the mentally ill give an erroneous image of mental illness and thereby propagating stigma. According to some participants, in the community, mental illness is considered to be a permanent health problem for which patients are never cured; as implied in a common saying that "*once psychiatric, always psychiatric*". Stigma was also found to be attributed to the aggressive nature of the illness.

> "*…Even me when I see someone who has ran mad, the first thing I will think is that maybe he is going to beat me up or throw something at me. I will have to run away*" (SSI, participant, private sector)

Some of the users believed that seclusion of patients and keeping in-patients in uniforms strengthen institutionalization. By this, patients were reported to be treated like prisoners, and the relatives imagine that they do not have any role to play as regarding the care of their patients. This was believed to contribute to stigmatization further.

**Effects of stigma**

Stigma was believed to at times trigger off aggression and to influence the recovery process of the patients. The mentally ill persons were reported to continue being stigmatized even when they function well after recovery; something that often lead to relapse.

> "*…Unfortunately, people with mental illness are taken to be those who can not think for themselves; whatever they say they are mad, even if they improve… whatever they give…even if its good, we say they are mad…..there is that ideology that if you are mental, then you don't have any idea*" (SSI, Housing Officer)

Participants noted that in the African setting, mental illness is strongly associated with disgrace and loss of respect in society. The mentally ill patients roaming streets often are treated inhumanly even when they are calm and not troublesome.

Stigma was reported to be extended to the family members of the mentally ill persons as well, which at times makes the family members alienate or even to disown the mentally ill. Users and advocates believed that stigmatization can be more hurting and disabling than the illness itself; and is an obstacle to help seeking:

> "*…the stigma which these people face is the most disabling part. Because once you are labeled that you are mentally sick then you lose your job, you lose your integrity in society, people have negative attitudes towards you; however much you can deliver people don't believe you can. Some parents deny there children they think its bad omen*" (SSI, key informant user)

Users affirmed declining to disclose their mental health status even in situations where it may be absolutely necessary for fear of loosing out on opportunities. One user recounted having lost a job because of his mental illness:

> *"…Now like in public service they have just held that question but long ago it used to be there. '**Have you ever suffered from mental illness**?'....it would be a good question if they are going to help you on job that they will not overburden you. But it was a bad question used negatively because they would never call you for interview however much capability you had. Once you declare that you have ever suffered from mental illness, automatically you would be disqualified*" (SSI, key informant user)

He added:

> *"…the manager asked me why I had not told them yet in the forms, the question asking whether I had history of psychiatric illness was there. I answered '**but if I had declared, you wouldn't have given me the job. But I have served well for the past 3 years, and that is why I was even promoted**'. So, they gave me a forced leave and with time, I lost interest and had to resign*".

Stigma often comes along with violation of their rights and they are denied opportunities they pointed out. Stigma does not spare mental health professionals; the general public is said to have a belief that mental health professionals get into this field either because themselves or their relatives have some mental illness. The general health workers and medical students were on the other hand reported to wonder at colleagues who decide on to specialize in psychiatry.

> *"... I tell you it is believed generally in the medical school….you hear students say **"**if you are a psychiatrist, with time you also become a psychiatric person" So, you can imagine that kind of attitude. And someone wants to live a normal life. So, you can impress upon the medical students to like psychiatry….you must convince them that the doctors…psychiatrists are not psychiatric. But that is the kind of attitude they have. Students at the medical school….you can imagine. They think that these senior psychiatrists are also psychiatric. If you go and interview the students, they will tell you."* (SSI, Policy maker, Ministry of health)

A mental health nurse also shared his experience:

> *"…when you introduce yourself as a psychiatric officer rendering services to the mentally sick, they say 'oh! You are also mentally sick'…"*
> (SSI, mental health nurse, rural district)

It was noted that some of the mental health nurses often prefer not to be identified as mental health nurses at their respective health facilities. At one general hospital, it was reported that some of the mental health nurses could not withstand the stigmatization by the fellow health workers and decided to cross to other sub-specialties such as general nursing or midwifery. Mental health nurses affirmed that stigmatization by fellow health workers is such a serious problem that those who abandoned their profession as mental health nurses do not want to identify with mental health any more and feel offended when addressed as psychiatric nurses.
In the community, the National Mental Hospital was reported to be generally associated with 'madness'. The fact that one has to seek or receive help from this hospital was reported to cause some form of psychological torture or discomfort and is often resented because of the associated stigma. Many people would prefer seeking help from private health facilities; but not from psychiatric units or the mental hospital. Such patients and their carers were further reported to often deny history of mental illness or past hospitalization unless the patient presents with very obvious psychiatric symptoms.

> "*…So, if a person knows that he has that problem, but where he has to go for help is Butabika, it also tortures him mentally. But then he cannot afford treatment of a private place…*" (SSI, Primary school teacher, urban district)

A PHC doctor also made a related comment:

> *"…they prefer not to disclose or share details of their patients. As you take history, you may realize that it is mental illness but when you ask, they deny. They deliberately decide to give confusing history of the problem*"
> (SSI, PHC doctor, urban district)

One mental health nurse specifically described an incident when patients and general nurses had to run away from a fellow health worker who experienced epileptic fits while on duty at the outpatient department. The participants believed that such incidents have served to convey message to other health workers that vulnerability for mental illness does not discriminate, and subsequently contributed towards a positive attitude change.

The users on the other hand reported being aware of the frustrating stigmatization they are exposed to due to mental illness, and reaffirmed that they often deny suffering from mental illness. They further reported being stigmatized even by the close relatives who were expected to be supportive. Some of the users reported nasty experiences of abandonment when their close relatives discovered about their illnesses. One user specifically narrated how he had to face separation with his longtime girlfriend following disclosure of his mental health status. He then vowed to intentionally conceal his illness in future to avoid further rejection.

> *"…next time I get a girl, I will pick these people's advice. I will get her pregnant, I breakdown…If she finds out from some external sources that I am mentally ill, I*

*deny… tell her 'I had just cerebral malaria but it has since gone…those people are spoilers, don't listen to them'…"* (SSI, key informant user 3)

Stigma was reported to affect disclosure of the illness, which results in delayed help-seeking. Some participants reported that many people feel uncomfortable identifying with mentally ill relatives and that some parents hide their mentally ill children for various reasons.

*"…And even us one time we had a child with epilepsy come to register, but when the parent was asked 'any problem?" he said "No, he is normal." After a short time, the child was shaking. The parent said 'Ah! The child is sick, but me I never wanted to tell you because knew you would deny my child"*
(FGD, primary school teacher 4)

The community too was reported to be often resentful to patients with mental illness, preferring to have them out of the community and confined in institutions of care.

**3.2.11.3.3 Fighting stigma**

The participants agreed that knowledge would be the most powerful tool in the fight against stigma and hence a need for massive sensitization in the community. They emphasized the need to involve public and private sector, the mental health service users as well as popular individuals who command respect in society in anti-stigma initiatives. The participants further cited use of both electronic and print media as an efficient strategy for a wider coverage. They asserted that to ensure a wider coverage, educative mental health programs should be ran on local radio stations in local languages; specifically during the evening hours so as to target a wider audience. They maintained that the sensitization would attract more interest in the community and make a bigger impact if it is done in the languages that the lay people in the communities understand best, avoiding complicated terminologies. Some participants argued that in addition to increased awareness, giving mental health high priority would help neutralize the stigma by drawing more attention and interest in the public. The users specifically noted that the mental health law itself should have stronger provisions for fighting stigma.

Some of the participants however believed that fighting stigma has to start with the health workers themselves since the general health workers tend to hold a negative view of mental health, and to extend that stigma even to fellow health workers who specialize in mental health. The recurrent nature of mental illness was reported to be a major challenge in the fight against stigma.

One participant however believed in incarceration of the mentally ill people as an effective way to help lessen the stigma, since the public would be protected.

"*…May be by identifying and referring those people in institutions like Butabika. Because, immediately somebody sees a mad person, he will just think that…"Oh!, trouble, the guy may hit me or what". So, the stigma is too much. You just run away for your dear life. So, by keeping those people in institutions, that can help*"
(SSI, magistrate)

### 3.2.12 Rural Versus Urban

In comparing the rural with urban life, participants believed that mental health problems impact more on the rural population mainly because of poverty and low awareness which are characteristic of rural communities. In addition, stigma against mental illness was reported to be more common in the rural areas compared to the urban areas because of the rural lifestyle which tends to be superstitious in nature.

### 3.2.13 Integration of mental health into primary health care

At district level, mental health was reported to be integrated into Primary Health Care as a policy recommendation. It was further noted that mental health does not have a specific budget at district level and it draws from Primary Health Care funds as an integrated component. Some of the mental health nurses however expressed concern over what is said to be integration of mental health into PHC. They believed that integration of mental health into Primary Health Care has not yet been fully realized, and decentralization of mental health services is still weak.

> "*…you find that what we call integration is not there. You find a psychiatric nurse seeing…. you are sent into a general hospital and you are buried into the other side. Because outside there, other medical personnel don't recognize mental illness as…I don't know but they just take it so lightly. And you find that at the end of the day, the management is distorted. Patients leave the general outpatient unit with mental illness not detected…because other medical personnel don't want to identify with the psychiatric conditions, and us who are there are buried in the general side."* (FGD, mental health nurse 2)

Mental health nurses reported working mostly as general nurses at their respective health centres and being unable to attend to the mental health needs of patients due to understaffing. They maintained that patients with mental health problems could easily be identified but because of the heavy work load, attention is paid only to their physical problems without probing for the underlying factors; except for conditions with obvious psychiatric symptoms.

> *"…The moment you enter a clinical room, you look at the patients waiting and you are already worried of "when will I finish?"….laughing… you have 200 patients waiting, whom you are supposed to attend to, each of them individually…maybe there might be 3 practitioners around. So, you are already stressed even before starting the work. You will not want to spend a lot of time with one person. You will come in and call them "Next…headache, what what what… 'Malaria'…go to the window"…"next". With the exception of the epileptics who will come with fits. But they will not elicit other symptomatology. Not because they cannot identify, but because of the workload…"* (FGD, mental health nurse 5)

Another mental health nurse added:

> *"…So, doctor told me 'you have been posted here as a psychiatric nurse but unfortunately you are going to work as a general nurse'. He even went to the point of giving me to head the O.P.D because of the few staff we have. So, if you look at the number of patients we get per day and the staff we have, we actually don't have enough time to look into mental health. Instead we have only time to look into general problems"* (FGD, mental health nurse 6)

These nurses contended that integration of mental health into Primary Health Care would entail having the general health workers able to identify patients with mental health problems and deal with them accordingly. However, this is not the case for most of the health facilities. One district health manager claimed having mental health integrated into Primary Health Care even though one could hardly identify any mental health aspect in the district health programs. He argued that mental health somehow features indirectly in the general health care activities.

> *"…if you look through my work plan here, you will not easily tease a bit of mental health; but it is integrated within. I mean we have the health sector strategic plan of which we are looking at how we really spell out which direction we should be taking for mental health. So, that is basically it. We have it in plan, but implementation may be rather different"* (SSI, district health manager)

He went on to say:

> *"…indirect…integrated within the network of treatment and care that we have, which may not be particularly targeting that but we are treating a person holistically"*

Furthermore, even those health workers who admitted having no orientation in mental health and having no mental health workers at their respective health centres claimed that mental health services are available at the health facilities integrated within general health care.

**3.2.14 Causes of mental illness**

The participants identified a number of factors believed to cause mental illness. The most identified causes were poverty, social problems, witchcraft and environmental factors. Poverty was reported to cause a lot of stress and frustration which interact with a number of other factors resulting in mental ill-health. The role of genetic predisposition was identified by only a few participants with a medical background.

> "…*One of the biggest causes of this situation is poverty. We are seeing a situation where young people, energetic, able to work do not have the opportunity to work. What do they do in the end, they resort to alcohol, they resort to drugs, these out rightly break them down. Because one person may be depressed as a result of unemployment. This depression coupled with poverty leads to mental illness*"
> (SSI, Politician)

It was noted that in the community, mental illness is mostly attributed to curses, disgruntled spirits and witchcraft, especially in cases of severe mental illnesses.

> *"…For most people, with mental illness, they think of the neighbour. Either it is a land conflict, or someone has bewitched him or this and that…that is the main perception of the community. Either a neighbour has bewitched them or an aunt who died is angry with them…things of that nature"*
> (SSI, Hospital manager rural district)

"*…Sometimes there are relatives who come here requesting that we want our patients because this patient has a bad spirit which is following him…so we want to perform rituals… traditional…you know the cultural rituals…*"
(SSI, mental health nurse)

"*…like here, Africans…you are in the village, you are fighting for a piece of land, then your neighbour bewitches you and you begin running around. You will just be mad until you die; because nobody will take care of you"*

(SSI, Magistrate, rural district)

Although most health workers neither accepted nor denied a belief in witchcraft and spiritual causes of mental illness, some expressed their recognition of spirits and witchcraft as potential causes of mental illnesses. They affirmed that patients in the community decide to go to health centres or traditional healers depending on the cause, and that some get cured by traditional healers.

Some of the users admitted having no idea about the possible causes of their mental illness and had never taken trouble to inquire. They reiterated that in the community, mental health problems among the males and the females are mostly associated with substance abuse and witchcraft respectively. One user specifically affirmed that her mental illness was caused by spirits, and that she visits the mental hospital only to get medicine for relief from symptoms. Disappointments in life were reported to cause significant distress. Some participants reported that quite a number of brilliant young people fresh from universities and colleges, often with high expectations and responsibilities are hit by disappointments and frustrations on failing to obtain employment.

"*…I remember a friend of mine who was completely…you know …damaged brain wise; when they read the will and said "that's not my son". All of us knew that was the father. But the man really got deranged you know… till he went out, I don't know whether he recovered because at least the facilities are out. But at the age when the man was a doctor and working you can imagine! A medical doctor!! But that only sentence in the will broke him down*" (SSI, Politician 4)

Some participants identified immorality and loss of compassion as problems increasingly becoming common across different sectors, often resulting in disregard for those in need, and are believed to lead mental health problems. Other social factors identified to be linked to mental ill-health were illiteracy and a rural lifestyle characterized by superstition and vicious cycle of poverty. Growing up and living in an intellectually non-stimulating environment was also believed to impact on the mental wellbeing of those in rural areas. Furthermore, prolonged political conflicts, a stressful environment, physical illnesses, the intricate bio-chemical processes, marital problems, domestic violence and HIV/AIDS were identified as possible causes of mental health problems.

**3.2.15 The burden and prevalence of mental illness**

The participants generally believed there is an upward trend in the prevalence of mental illness. This was partly based on the increasing numbers of the mentally ill persons seen roaming in the streets. The mushrooming evangelical churches and the high number of people getting saved was viewed by some participants to be an indicator of a high prevalence of social stressors in the population, many of which may lead to mental illness.

> "*…The problem is with the policy makers we are trying to assume that the thing is not there. We just theoretically think … 'ah…, it's not a big problem; that one is not a problem' but actually it's a problem. It's a real problem now in the country and if you visit most of the sectors….for example you go to defence. It's because we don't give it the attention it is supposed to deserve. We are only giving attention to these other diseases which are maybe wiped at a faster rate and they have got the money punctuated for them. And that's why they have attracted most of the people. But madness is there…and very many people don't want to expose or to show public that they have mad people*"
> (SSI, Politician 4)

In the rural district, the prevalence of mental illness was generally believed to be low. This was noted to be the case because most health workers do understand mental illness to refer to the severe mental disorders, which were reported to be fewer.

> "*…everything is mixed up with general primary health care and people will never say that there are psychiatric cases until they get people who are fighting"*
> (SSI, hospital manager, rural district)

The presupposed low prevalence of mental illness was also partly attributed to the pattern in the help-seeking behaviour in the community. It was reported that most patients never seek help at the available health facilities but instead go to traditional healers, where there is no documentation. Some of the health workers believed that mental ill-health presents a significant burden in society but often disguises under other physical conditions such as HIV/AIDS, contributing to mortality directly and indirectly.

> "*…Me, I would not argue so much but according to my own understanding of health, mental illness and mental health is the cause of many other diseases that are not classified. When they say it doesn't kill, they are not serious. Now where do they put suicide? It kills indirectly. It is mental health that is causing this HIV in our children. Because if somebody's mental health is positive, she may not go for some of these activities. Mental health is killing indirectly. I don't know whether they want to see it as malaria. They are saying AIDS is the killer diseases, but I don't know whether they know the roots of that AIDS….*"
>
> (FGD, PHC Nurse 2, rural district)

Depression and epilepsy were reported to be the most common conditions in the community.

### 3.2.16 Impact of mental illness

Mental illness was reported to pose a significant burden to the health sector, though not currently well appreciated due to the limited awareness. Mental illness with onset in the youthful age was reported to lead to morbidity and impairment, rendering the sufferers unproductive, thereby posing a burden to the society. The users who reported teenage onset of their mental illness, while in school lamented that mental illness had greatly disorganized their lives. Some appeared very sad as they described the agony of living with mental illness and admitted having contemplated or attempted suicide. The dialogue below with a key informant user illustrates the point:

R - *"… as for me, I survive because of faith; because even the bible says 'the righteous shall live by faith' I don't know where the next meal will come from but somehow it just comes"*

*I- Sure!!! I really feel for you. I understand how you must be feeling especially when you compare yourself with the O.Bs who are doing well. Actually that is the time when some people may contemplate suicide…*

*R - I have tried suicide 3 times. The first time, I took 10 diazepam tablets…but God has always been on my side. When I try suicide, there are very few tablets at my disposal*"

Another mental health service user recounted:

> *"…me I have had a problem of school fees because my family has set me aside as a useless character. They have the potential…but I have to go shopping for sponsors. They think it would be wastage of resources to continue paying for my education"* (SSI, mental health service user)

The users viewed a combination of poverty and stigma as a significant cause of distress and impairment, hindering recovery. The impact of mental illness was viewed to be heavier on adult users who have families and dependants. They further believed that mental ill-health is linked to HIV/AIDS, suicide and homicide; all of which claim lives. Some participants believed that the root cause of HIV/AIDS infection in some individuals is traceable and linked to unhealthy lifestyles attributable to mental ill-health.
Mental illness was further reported to deprive the nation of the potentially productive people who would contribute enormously to national development, thereby impeding development.

### 3.2.17 Coping with mental illness

Users were of the view that having a very supportive family and significant others is very important for one to cope with the mental illness. In addition, they reported using various coping mechanisms to help them deal with the agony and discomforting feelings associated with their mental illnesses. These included:

- Positive thinking
- Strong involvement in religion and belief that what happens in their lives is in accordance with God's plans.
- Conviction that many highly respected people are silently battling with mental illness.
- Avoiding thinking about the illness, and a tendency to think for the day and mind less about the future.

One user who admitted going off the medication after being prayed for by some religious leader and relapsed shortly after differed in her opinion as regards religious healing. She believed that prayers do not cure but only promote a positive attitude towards life and build hope in an individual.

> *"…I think what religion helps is that it gives you a positive attitude towards life. So, instead of worrying about your problems, you assume….you believe God is going to do something about them. So, you start having a positive attitude towards life"* (SSI, Key informant user)

### 3.2.18 Help-seeking behaviour

It was noted that in the community, help-seeking behaviour is mostly dependent on the individual/community's awareness and perception of mental illness, the socio-economic status of the patient and/or carers as well as the severity of the disorder. Most participants (especially in the rural district) reported that for patients with mental illness, seeking help at health facilities right away is a rare practice, except in some cases where the condition is acute or in situations where carers know of some other individuals who received treatment from a health facility for the similar condition and healed. It was noted that accessibility to health facilities also influences the help-seeking behaviour. High transport costs and other financial implications were reported to frustrate the patients and their carers, making them resort to the readily available traditional healers within their communities. Conditions characterized by frequent relapses were reported to be the ones more suitable for treatment by traditional healers, while the seemingly less severe ones are often overlooked.

In the rural district, a relatively small number of patients with mental illness were reported to seek help at the health facilities. It was reported that most patients bypass the local health facilities and go directly to the higher levels of care such as the regional referral hospital and National Referral Mental Hospital where they expect better services. It was further reported that patients and carers are aware that mental health staff are not available in the health facilities and hence their reluctance to seek help locally. The fact that most patients with mental illness initially seek help from traditional healers was undisputed. The participants affirmed that most patients and carers consider going to a health facility as a last resort when no improvement is being realized or when the condition is getting worse.

> *"…They associate it to witchcraft. If somebody begins talking about dead people, seeing insects, they will right away say that one is bewitched. The first point is always a traditional healer*" (SSI, Hospital manager, rural district)

> "*…before they come to hospital, they have to try native medicine. They all think they are bewitched. No body ever thinks of going to hospital first…"*
> (FGD, PHC nurse 3)

It was further noted that some people are often not sure of the availability of mental health services and their effectiveness. Thus, they just go to health facilities as a trial only and shortly go back to traditional healers unless some fast improvement has been realized.

> "*…the moment a patient stays for a few days without improving, they will immediately say '**ebyekka', because I quarreled with so and so. The hospital will not manage'. They run away"* (FGD, PHC Nurse 4, rural district)

The belief in traditional healing was noted to be so strong, in that even when traditional healers realize they will not be of help and send patients to health facilities, the patients do not go but instead try other traditional healers before finally accepting the health facility as a better alternative. Seeking help from traditional healers as the first option was reported to apply to other illnesses as well; though very much emphasized with mental illness. Community's confidence in herbal medicine and traditional healers for mental illness was overemphasized. It also emerged that patients are often uncomfortable with long queues at the health facilities and being pinpointed at, while at the health facility in a rather belittling manner. These were reported to keep away some of the patients.

"*…they call him 'mulalu' (he is mad). That is a negative attitude towards the patients. So, when one is called like that, he can not come back*"
(SSI, Mental health nurse)

Some of the participants also reported that it is becoming a common practice for many frustrated people to run to churches for consolation and prayers or in the pretext of getting saved, when they are overwhelmed by problems in life. Some users affirmed seeking help from religious leaders and terminating treatment with hope that prayers would bring about permanent recovery. The participants reported that the public is not yet aware of the availability of mental health services in other health facilities other than the National Mental Hospital. Demand for services in the rural areas was reported to be very low due to lack of awareness and the belief system.

**3.2.19 Management of mental health problems**

Mental health nurses reported being overwhelmed with work because of understaffing at their respective facilities. They reported that at times they are required to perform duties of dispensers and clinicians on top of their nursing roles. This state of affairs was said to compromise their efficiency in attending to the mental health needs of patients.

"*…I found myself working like a clinical officer…you clerk the patients, sometimes you can identify a case but because the queue is so long….you are the dispenser, you are the one in injection room, you find that giving time to probe for signs of mental illness is difficult"* (FGD, Mental health nurse 2)

The nurses further reported addressing presenting symptoms of mental illness without seriously probing for the possible causes. This was believed to be a major challenge in mental health care.

*"… there are some bits of the practice which may be technical that we are not able to provide. For example we are providing treatment…after diagnosis, we are giving the treatment. But in most cases we are not handling the etiological part of it. You are giving the drugs to treat…you are removing the symptomatology but what brought the symptomatology, you are not removing*" (FGD, mental health nurse 2)

Traditional healing was reported to be mostly by performing the rituals and appeasing the spirits, often with prompt recovery. It was further reported that it is within the belief system of many users and their carers that modern medicine is only important for relief from symptoms for patients with mental illness, and that the actual cure is usually through traditional remedies, which are believed to be capable of attacking the actual cause of the problem.

Some health workers however reported a tendency of traditional healers visiting psychiatric facilities to get knowledge on psychotropic medications and dosages, and later purchase and administer the same medications as herbal concoctions.

"*…as they teach us that whether treated or not the symptoms go, they will go to the witchdoctors, they give them herbs and most of these witchdoctors add chlorpromazine in the herbs. So the patient improves"* (FGD, Mental Nurse 1).

*"…One of the traditional healers used to come to the ward rounds some years back. He could come and sit on the ward round, he listens, he knows which people you are giving chlorpromazine, which ones you give haldol, how many milligrams…..…*

*then he goes to pharmacies and buys, he mixes in his herbs; so, the manic will settle and he continues eating the money "* (FGD, Mental Nurse 4)

The users reported experiencing some distressing side-effects of the drugs especially at the beginning of a particular course of treatment, which may lead to inconsistence or non-compliance resulting in frequent relapses.
The participants identified a number of challenges in the management of mental health problems, which included the following:

- That mental health is so medicalized and efforts are mostly on symptom relief. Little is done to address the causative factors even in cases where the possible cause could be traceable.
- Psychological care for patients with mental health problems is still a neglected area that needs to be emphasized.
- A very high ratio of patients to health workers making it difficult to fully attend to the patients' problems.
- Many people regard the mental hospital a dumping place for persons with mental illness and abandon their relatives there.
- A tendency for carers and relatives to interrupt the treatment course, taking away patients from hospital against medical advice, and smuggling in herbs for their hospitalized patients. The herbs are believed to antagonize treatment.
- Patients abandoning medication after being prayed for and/or advised by some religious leaders.
- Side effects of the drugs, especially when they have just been started on a particular course of treatment, which leads to inconsistence in the use of the medication or non-compliance; eventually leading to frequent relapses.

The religious and other participants with non-medical background strongly emphasized the need for psychosocial care, particularly with psychological interventions.

**3.2.20 General health workers**
It was noted that while some general health workers did not have any orientation in mental health during their training, many of those who had the opportunity still disregarded psychiatry, taking it to be a specialist field of less relevance to them at the time. They envisaged their role as identification and referral of the mentally sick, with no management role. However they now acknowledge the challenge of acquiring skills in management of the mentally sick, as they have come to realize that a number of patients with mental health problems go unnoticed because of their inadequate knowledge in mental health.

*"…I told you our training spoilt us. It is like the issue is about identifying the person and in many cases we can't even put diagnosis to that patient. We shall just put an umbrella diagnosis 'mental health problem', referred to Jinja hospital…laughing…"* (SSI, District health manager, rural district)

PHC doctors specifically were noted to have limited interest in mental health. This was further illustrated by the fact that some of those approached declined to take part in the study:

*"…My doctors may not be very much interested in mental services. They will just tell you* ***'that is a department somewhere'****…they always refer those people there"* (SSI, hospital manager)

They take their role to be only identification and referral of patients. However some of the primary health workers attributed the general practitioners' low interest in mental health to the amount of time required to carry out a psychiatric assessment. Furthermore one PHC doctor made an observation that most general nurses do not have the motivation to practice mental health and continue to mismanage patients with mental illness although they attend training sessions in mental health.

> *"…they go there for the sake. They keep avoiding mental health patients. Others think sedating is the only management they can do. They keep sedating the patients every time…you ask the nurse 'how have you managed the patient?' She tells you 'I have sedated him'… You hear her tell others '****those ones don't disturb me, I just sedate them'****…"* (SSI, PHC doctor, urban district)

It was further noted that most of the general health workers are unable to identify patients with mental health problems at the outpatient department, and therefore many patients go unidentified and unattended to.

> *"…the majority of the general practitioners cannot detect a patient with mental illness. They cannot. And it is because of this reason that you may be in a facility and they tell you that '****we have never seen anyone with mental illness here. The only mental patients we see are on the streets, are moving naked****…' because for them they have that belief that anyone who is mentally ill is undressing, moving naked… they are not able to identify the other areas"* (FGD, mental health nurse 5)

Another mental health nurse added:

> *"…So I was concerned. I went and asked doctor "Doctor, ever since I came here, there is nothing I have ever heard of as a day for mental health clinic and yet there are days for other clinics. Then he told me '****you know, me I have never seen any mental patient here'****…"* (FGD, mental health nurse 4)

It was noted that Psychiatry as a profession is not yet well appreciated at the medical school and the medical students' motivation to specialize in psychiatry is quite low. The PHC doctors who have been in service for a relatively longer period attributed this to mental health being a specialty that used not to be given much weight at the medical school as compared to other specialties. On the other hand, those who had just graduated from the medical school affirmed that they mostly learn psychiatry as one of the stipulated courses but the duration and emphasis are not sufficient for one to develop the interest to cause a positive attitude change. Most PHC nurses also reported having received no training in mental health. Findings by WHO-AIMS revealed that out of the medical officers and nurses registered with their respective professional associations by the year 2005, only 0.8% and 4% respectively had specialized in psychiatry.

### 3.2.21 The role of Religious leaders

Religious leaders were also reported to be an important source of help for people with mental health problems in the community as they provide counseling and advice as well as making appropriate referrals.

### 3.2.22 The role of Traditional healers

Traditional healers were reported to be key players in the provision of mental health services and often the first source of help for patients with mental health problems, especially in communities where mental health professionals are not readily available. Most participants believed that nearly all patients with mental illness will at some point in life visit a traditional healer. Besides the reasons of the community belief system and accessibility, traditional healers are said to be preferred because of their hospitality and affordability of their services. Furthermore, their terms of payment were reported to be negotiable unlike modern health practitioners. It was reported that traditional healers greatly outnumber medical health workers.

> *"…we have realized that most people here will first try to help themselves when they get a health problem before going anywhere. When they fail, the majority come to traditional healers. It is well known here that no one gives counseling as good as that given by traditional healers. Because they may even give tea or food if necessary; something that you can't find in Mulago if you just go there, unless you are admitted. And also even our charges are quite user friendly....in most cases it is negotiable...it doesn't necessitate a receipt that if you don't pay you are retained. That is why you find that the biggest percentage of patients (about 65%) go to traditional healers and they are comfortable with that"*
> (SSI, Key informant traditional healer)

> "*…here traditional medicine is taken very seriously and if you come with an intervention to say "stop", you may not succeed very fast. But we may encourage them to go but also inform them about other benefits of going to the health worker. Or we may also help the traditional healers to be able to handle where they are able to and refer. Because over 90% go to the traditional healers*"
> (SSI, Community social worker, rural district)

The traditional healers believed that they play a very important role in providing mental health services, and reported treating the biggest number of patients with mental illness. They stressed the need for government to support them so as to modernize their herbal medicine and their practice in general. It was noted that a collaborative relationship between traditional healers and medical workers for better mental health service delivery has always been agitated for but has not been realized. Traditional healers further believed that medical workers do not appreciate their contribution and are less enthusiastic about this collaboration.

> "*…traditional healers play a very vital role in health here…good enough, even WHO has already recognized them. And we are very happy that WHO realized that we do a very good job*" (SSI, Key informant traditional healer)

The same traditional healer added:

> "*…they could even get at least one educated traditional healer…because we the educated ones are there… and make an arrangement in which he/she also goes to Butabika hospital and dispenses the traditional medicine to patients; so that we can realize the collaborationwe have always agitated for. Because we have always talked of collaboration but we have realized that the medical health workers want*

*this collaboration to be only for their benefit yet we as traditional healers have things in which we are better than them"*

Although a few of the health workers did not recognize traditional healers as mental health service providers having their own treatment modalities, the majority acknowledged that traditional healers have an important role to play because most mental health patients have greater trust and confidence in them.

> *"… Because they believe in traditional healers for everything. By the way, you will find that even somebody with meningitis is first taken to a shrine; and you will find that meningitis also causes mental illness"* (FGD, PHC nurse 5, rural district)

They further asserted that although the efficacy of the traditional healers' herbal regimens and rituals may be debatable, they offer better counseling and give more time to the patients as compared to other health workers. Although some health workers declined to show their position on the efficacy of traditional healers' medicine as counterparts in mental health service delivery, others indirectly expressed their confidence in the traditional healers' practice. They agreed that traditional healers have an important role to play as service providers and should be incorporated in the mental health service delivery system, after being taught healthier practices. They further admitted giving little time to mental health patients and recognized the traditional healers for being more empathetic and better counselors in this regard.

> *"…Actually most of our people do use traditional healers. That is their…I think they should be incorporated. They should be told to assess and do good referral. I don't think they can treat. But I think they can also do good counseling. Actually they can be better counselors than us the health workers. And these people have trust in them. So, they can be incorporated into the system….and actually they can assist in delivering health services"* (SSI, a hospital manager, rural district)

> "*…Because all mental health problems at least they have ever visited traditional healers at any moment and these people are very good at counseling. So, I think they go there because they have time for them, for us we don't have time for these people we always think we are busy"* (SSI, hospital manager, urban district)

The health workers reported that many traditional healers somehow consider them as competitors for patients and tend to keep patients to themselves even when they are not capable of helping them, instead of referring such patients to health facilities. However, some traditional healers were reported to have been sensitized and are now able to refer the difficult ones to health facilities.

## 3.2.23 The Mental Health System (WHO-AIMS)

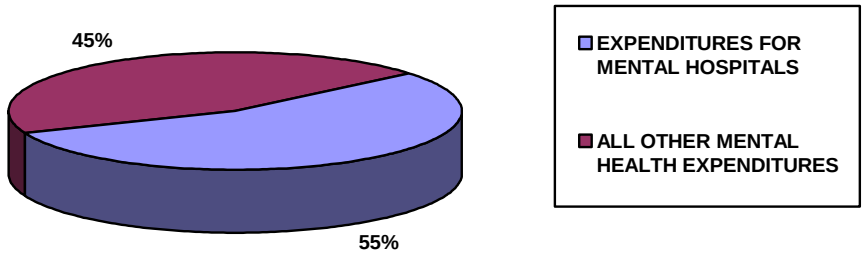
Assessment of the mental health systems (using WHO-AIMS) was done in 2006, and data collected was based on the year 2005. This section of the report therefore bears information on the mental health system as of December 2005.

### 3.2.23.1 Financing of mental health services

About one percent (1%) of health care expenditures by the government health department is specifically directed towards mental health in primary care. However, as part of the

integrated health service delivery, other aspects of mental health are funded within the general health budget as well. Furthermore, under donor support to the government, the health sector's financing is currently supplemented by funding from the African Development Bank (ADB), where nearly 45% of the support goes to mental health. This raises the expenditure on mental health to approximately 4%.
Of all the expenditures spent on mental health, 55% was directed towards the National Mental Hospital. One hundred percent (100%) of the population has free access (at least 80%) to essential psychotropic medicines. This is based on the fact that medication is provided at no cost in all public health facilities. For those that pay out of pocket, 37% of the daily minimum wage is needed to pay for one day antipsychotic medication while 7% of daily wage is needed to pay for one day dose of antidepressant medication. Mental disorders are not covered in the current social insurance schemes, but are listed in the proposed National Health Insurance Scheme.

**GRAPH 1.1 EXPENDITURE TOWARDS MENTAL HEALTH SERVICES**




## 3.2.23.2 Mental Health Services

### 3.2.24.2.1 Organization of mental health services

There is an office for coordination of mental health services at the Ministry of Health headquarters with the candidate at the level of Principal Medical Officer. The main roles for the office are basically policy development, resource mobilisation planning, and coordination, plus monitoring and quality assessment of the mental health services at regional and district levels. Mental health services to communities are organized on the basis of catchment/service areas at Regional and District levels. There is only one mental hospital, which also offers general health services at the outpatient's facility to the population in the neighbourhood within a radius of 10 Kilometres.

### 3.2.23.2.2 Mental health outpatient facilities

There are 28 mixed outpatient mental health facilities available in the country, with no special clinics for children and adolescents only. The number of users per 100,000 general population treated by these facilities could not be established. However, they treated a total of approximately 13,710 new users a year. Of all the new users treated, 40% were female and 16% children and adolescents.

The users treated in outpatient facilities were of mood disorders and epilepsy mainly [reliable data on the diagnoses per disorder was not available]. The average number of contacts per user could not be established. Fifty four percent (54%) of the outpatient facilities provide follow-up care in the community and conduct outreach clinics whenever they have funds but these are not regular. Only a few of the users (1-20%) had received one or more psychosocial interventions in the past year. Fifty seven percent (57%) of the mental health outpatient facilities had at last one psychotropic drug of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytics, and antiepileptic medicines) available in the facility or a near-by pharmacy all year round.

**3.2.24.2.3 Day treatment facilities**

There is only one day treatment facility available in the country. This facility treated 0.64 users per 100,000 general population. Of all users treated in day treatment facilities, 49% were females and 36% are children or adolescents only. The average number of days users spent in day treatment facility is not known. There are no day treatment facilities for children and adolescents only.

**3.2.23.2.4 Community-based psychiatric inpatient units**

There are 27 community-based psychiatric in patient units available in the country with a total of 1.4 beds per 100,000 population (The facilities considered here are the psychiatric units in all hospitals other than the National Mental Hospital). Fifteen percent (15%) of these beds in community-based inpatient units are reserved for children and adolescents. Aggregated information on admissions to these units and diagnoses was not available. One to twenty percent (1-20%) of patients in community-based psychiatric inpatient units received one or more psychosocial interventions in the previous year. Thirty seven percent (37%) of community-based psychiatric inpatient units had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility.

**3.2.23.2.5 Community residential facilities**

There are no community residential facilities available in the country.

**3.2.23.2.6 Mental hospitals**

There is one Mental Hospital available in the country with a total of 1.83 beds per 100,000 population. The Hospital has mental health outpatient facilities. The number of beds has increased by 11% in the last 5 years. No beds in mental hospitals were reserved specifically for children and adolescents. Of all the patients treated in the mental hospital, 41% were females and 16% children and adolescents. No reliable data on diagnostic groups was available. However, the patients admitted to the mental hospital were noted to be of two main diagnostic groups: mood disorders (33%) and epilepsy (17%), based on the number of contacts.

The hospital has an occupancy rate of 100%. The average number of days spent in the mental hospital is could not be established. However, almost all patients spend less than a year in the hospital except for some few mentally-ill offenders. [However, the tendency of patients to escape from hospital is still common; and this makes it hard to determine the accurate number of days patients spend in the mental hospital]. The number of patients physically restrained or secluded could not be established. 21-50% of the patients in mental hospitals had received one or more psychosocial interventions in the previous year. The

mental hospital had at least one psychotropic medicine of each therapeutic category (antipsychotic, antidepressant, mood stabilizer, anxiolytic and antiepileptic medicines) available in the facility all year long.

**3.2.23.2.7 Forensic and other residential facilities**

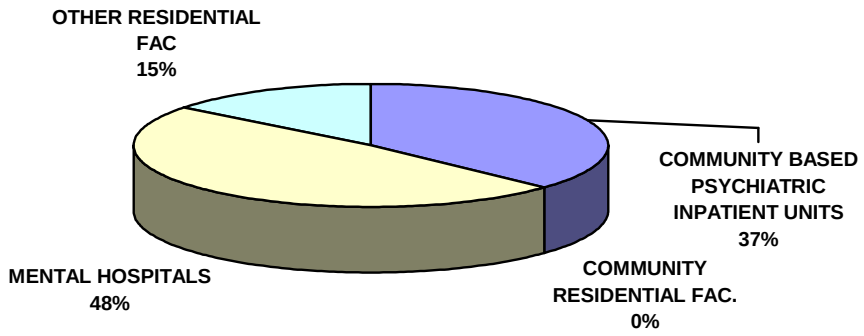
In addition to beds in mental health facilities, there were also 0.42 beds per 100,000 general population for persons with mental disorders in forensic inpatient units (a bed capacity of 116). All these beds are within the mental hospital. However, only about 10% of the beds in this unit are occupied by the mentally-ill offenders. This category is of long-stay patients, with some who had spent more than 5 years in the unit.

There were 7 other non-public residential facilities, 4 of these for children and adolescents with mental retardation while 3 are for people with alcohol and substance use problems. There were a total of 120 beds for youths aged 17 years and below with mental retardation and 30 beds for people with substance abuse problems.

**3.2.23.2.8 Human rights and equity**

Most admissions to community-based inpatient psychiatric units admissions were voluntary. The proportion of involuntary admissions to the mental hospital could not be teased out of the records. The patients who were restrained or secluded at least once within the previous year in community-based psychiatric inpatient units, as well as in mental hospitals could not be ascertained as there was insufficient recording at the time. Sixty two (62.4%) percent of the psychiatric beds in the country were located in or near the largest city. Such a distribution limits access for rural users. On average, there is a substantial difference between government-administered and private for-profit mental health care facilities in terms of the average number of minutes of an outpatient consultation with a psychiatrist and average number of beds per nurse in the facility. Inequity of access to mental health services for other minority users (e.g., linguistic, ethnic, religious minorities) is not an issue in the country.

**GRAPH 2.1 - BEDS IN MENTAL HEALTH FACILITIES AND OTHER RESIDENTIAL FACILITIES**




**Note**: The biggest challenge in determining the number of users treated per facility, diagnoses and other information was that for the few facilities where information was

available, the information was based on the number of attendances and not specific patients.

The percentage of users for children and/or adolescents varied substantially from facility to facility. The proportion of children users was highest in the day treatment facility and lowest in mental hospital. Psychotropic drugs are mostly widely available in mental hospital, followed by outpatient mental health facilities, and then inpatient units.

## 3.2.23.3 Mental Health in Primary Health Care

#### 3.2.23.3.1 Training in mental health care for primary care staff

About ten percent (10%) of the training for medical doctors was devoted to mental health, in comparison to 3% for General Nurses. The percentage for non-doctor/non-nurse primary health care workers is unknown. In terms of refresher training, the proportion of primary health care staff with at least two days of refresher training in mental health could not be established.

#### 3.2.23.3.2 Mental health in primary health care

Both physician based primary health care (PHC) and non-physician based PHC clinics are present in the country. For physician-based primary health care clinics, a few (1-20%) had assessment and treatment protocols for key mental health conditions available, just like the non-physician-based primary health care clinics. The majority (51-80%) of physician-based primary health care doctors and the non-physician based primary health care clinics made at least one referral per month to a mental health professional on average. Only a few of the PHC doctors had interacted with a mental health professional at least once in the previous year. A few of physician-based PHC facilities have had interaction with a complimentary/alternative/traditional practitioner, in comparison to none (0%) of the non-physician-based PHC clinics, and a few (1-20%) of the mental health facilities.

#### 3.2.23.3.3 Prescription in primary health care

While doctors, clinical officers and nurses are allowed to prescribe and/or to continue prescription of psychotropic medicines with restrictions, other Primary Health Care workers are not allowed to prescribe psychotropic medications. For example clinical officers and nurses in Primary Health Care are usually not allowed to initiate a prescription but can continue a prescription or they can initiate a prescription in emergencies. In contrast, psychiatrists, medical officers and psychiatric clinical officers are allowed to prescribe psychotropic medications without restrictions. As regards the availability of psychotropic medications, only some of the physician based PHC clinics (21-50%) had at least one psychotropic medicine of each therapeutic category (anti-depressant, anti-psychotic, mood stabilizer, anxiolytic and anti-epileptic) present in comparison to a few (1-20%) of the non-physician based PHC clinics.

## 3.2.23.4 Human Resources

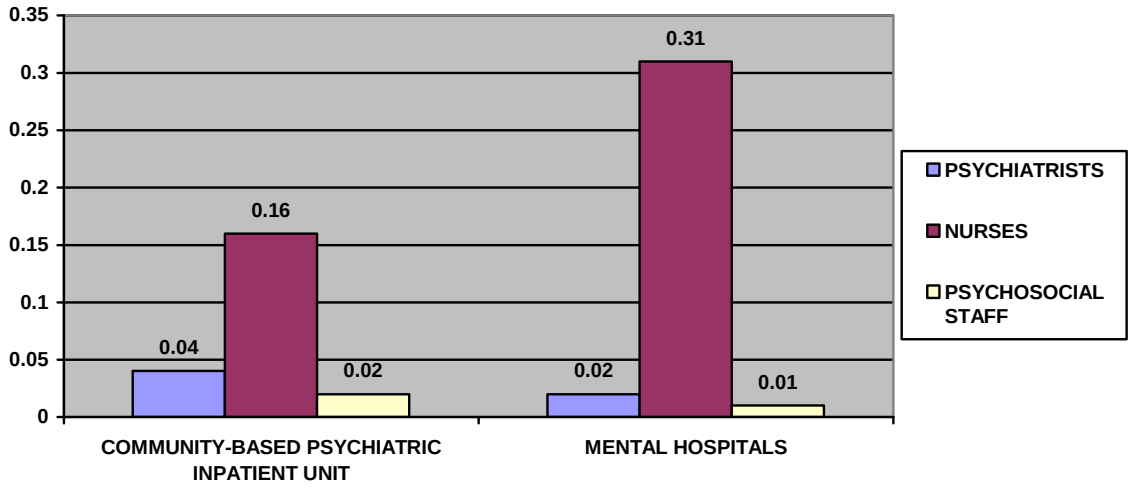
#### 3.2.24.4.1 Number of human resources in mental health care

The total number of human resources working in mental health facilities or private practice per 100,000 population was 1.13, with each category as follows: 0.08 psychiatrists; 0.04 other medical doctors; 0.78 nurses; 0.01 psychologists; 0.01 social workers; 0.01 occupational therapists; and 0.2 psychiatric clinical officers; other health care workers

(auxiliary staff, non-doctor PHC workers, health assistants etc) exclusive. Five Percent (5%) of the psychiatrists worked for only government administered facilities, 5% for only NGOs/for profit mental health facilities/private practice; while 90% worked for both sectors. Accurate data on distribution of the other professionals was not readily available. All the professionals worked for both in and outpatient facilities. Fourteen (14) psychiatrists worked in community based psychiatric inpatient units and 8 in the mental hospital. The 8 other medical doctors mentioned, who are non-mental health specialists all worked in the mental hospital. Sixty two (62) nurses worked in community based psychiatric inpatient units, while 153 work in the mental hospital. Three (3) of the psychosocial staff worked in the community based psychiatric inpatient facilities and the other 3 in the mental hospital.
Only 0.8% of the medical doctors and 4% of the nurses were specialists in psychiatry.
As for human resources in mental health facilities, there were 0.04 psychiatrists per bed in community based psychiatric inpatient units in comparison to 0.02 psychiatrists per bed in mental hospitals. There were 0.16 nurses per bed in community based psychiatric inpatient units as compared to 0.31 nurses per bed in the mental hospital. Accurate data for other mental health staff was not readily available.

The distribution of human resources between the urban and rural areas was disproportionate. The density of psychiatrists in or around the largest city was 11 times greater than the density of psychiatrists in the entire country. The density of nurses was 13.4 times greater in the largest city than the entire country.

**GRAPH 4.1 - AVERAGE NUMBER OF STAFF PER BED**




### 3.2.23.4.2 Training professionals in mental health

The number of professionals who had graduated the previous year in academic and educational institutions was as follows: 162 general medical doctors, 4 psychiatrists, 13 psychologists with at least 1 year training in mental health care, 10 occupational therapists with at least 1 year training in mental health care. The number of general nurses and that of social workers with at least 1 year training in mental health care could not be established.

However, there were 1,491 nurses who registered with the nurses and midwives council that year. None of the psychiatrists emigrated to other countries within 5 years of completion of their training. The accurate number of mental health care staff with at least 2 days of refresher training in the rational use of drugs, psychosocial interventions and child and adolescent issues was not readily available.

#### 3.2.23.4.3 Consumer and family associations

There are 2225 users/consumers who are members of user associations. However the numbers of families who are members of family associations was unknown. Government does not provide financial support to user associations for mental health initiatives. Consumer associations have been involved in formulation and implementation of the mental health policy and plan to some extent; but not the legislation. Only 4 of the NGOs were involved. A few mental health facilities interact with consumer/user associations.

### 3.2.23.5 Public education and links with other sectors

#### 3.2.23.5.1 Public education and awareness campaigns on mental health

The Principal Medical Officer in charge of mental health at the Ministry of Health oversees public education and awareness campaigns on mental health and mental disorders. Government agencies, NGOs, professional associations and international agencies have promoted public education and awareness campaigns in the last 5 years. The campaigns have targeted the following groups: the general population, children, adolescents, women, and trauma survivors. In addition, there have been public education and awareness campaigns targeting professional groups including: Health care providers (conventional, modern, allopathic, complementary/alternative/traditional sector, Teachers, Social services staff and Leaders and politicians and other professional groups linked to the health sector.

#### 3.2.23.5.2 Legislative and financial provisions for persons with mental disorders

There are no legislative provisions to provide support for users in the following areas:

I. A legal obligation for employers to hire a certain percentage of employees that are mentally disabled.
II. Provisions concerning protection from discrimination at work (dismissal, lower wages etc) solely on account of mental disorder.
III. Legislative or financial provision concerning priority in state housing and in subsidized housing schemes for people with severe mental disorder.
IV. Financial provision concerning protection from discrimination in allocation of housing for people with severe mental disorder.

#### 3.2.23.5.3 Links with other sectors

There are formal collaborations between the government department responsible for mental health and the departments/agencies responsible for primary health care/community health, HIV/AIDS, reproductive health, child and adolescent health, substance abuse, child protection and education. As regards support for child and adolescent mental health, information on the proportion of primary and secondary schools that have either a part-time or full time mental health professionals was not available as well. The number of primary and secondary schools with school based activities to promote mental health and prevent mental disorders is unknown. The percentage of prisoners with psychosis was greater than 15% while that with mental retardation was unknown. Only a few (1-20%) of the police officers, judges and lawyers had accessed training in mental health in the past 5 years. There was no mental health facility where users had access to programs that provide

outside employment and there were no patients reported to have received social welfare benefits for their mental disability.

### 3.2.23.6 Monitoring and evaluation of services

There was a formally defined list of specific data items that ought to be collected by all mental health facilities. The extent of data collection is variable among the mental health facilities, though many of the facilities are not collecting the expected data. Of the data that the mental hospital collected and compiled, only data on number of beds was reliable. Both mental hospital and community based psychiatric inpatient units collect and compile data though there were gaps. Mental heath data is published by the government health department in an annual performance report. All the mental health facilities report and transmit data to the government health department; lower facilities doing this through their supervising levels.

## 3.2.24 Challenges to mental health care delivery

The participants identified a number of challenges believed to impede effective delivery of mental health services. It was noted that the public generally holds a negative view of mental health, with very little appreciation of mental health as an aspect of health; mainly regarding it to be synonymous with mental ill-health.

> "*...Recently I wrote to some of the organizations here requesting for funds to organize the mental health week, and most of them were perturbed. There is one who said "you want a kilalu week!!"…. "a mad week*!!"…
> (SSI, mental health practitioner, NGO).

Participants noted that due to poor appreciation of the determinants of health, mental ill-health is less recognized as a major contributor to the burden of disease in the country. Furthermore, there is currently no clear understanding on the extent of the burden of mental illness in the country because few epidemiological studies have been conducted. Planners tend to rely on estimates and assumptions.

Other challenges among others included the following:

**Systemic**

- Inadequate and skewed pattern of distribution of mental health staff.
- Poor facilitation of health facilities.
- Wage bill ceilings not considering the high population growth rate.
- Inconsistence of regular in-service training in mental health
- Low prioritization for mental health
- Misconceptions about mental illness and a generally wide spread negative attitude towards mental health
- Emphasis on the curative aspects, with limited efforts in health promotion and disease prevention.

**Administrative challenges**

- Low awareness and appreciation for mental health in the community
- Inadequate knowledge and training for most health workers
- Frequent stock-outs of medical supplies in public health facilities and yet psychotropic medicine is very expensive on open market.

- Poor case detection and mismanagement of the mentally ill by most general health workers.
- Minimal follow-up of the patients in their communities.
- Emphasis on symptom management, with less efforts to address the likely causative factors
- Lack of efficient support supervision, specifically in the rural setting.
- Tendency to stick to the ancient forms of therapy and difficulty in accessing modern and more efficient drugs.
- Many non-medical administrators of health facilities show low appreciation for mental health services and disregard for mentally ill patients; and think buying them drugs is wastage of resources.
- Decentralization of mental health services and integration of mental health into primary health care are still a challenge.
- Low interest and community participation in health initiatives. The community tends to focus on the financial gains and/or implications.
- Carers' tendency to abandon patients with mental illness
- Congestion and longer delays at public health facilities cause much inconvenience.
- Community awareness on the availability mental health services is still limited.
- Negative attitude towards mental illness is mostly attributed to culture, and yet culture is very hard to alter.
- Users expressed dissatisfaction with the therapeutic relationship with medical personnel, which they described as often brief and not inclusive. They reported that unlike in the private facilities, medical staff in the public hospitals usually give patients very little time for consultation, do not adequately educate them about their conditions and rarely seek look into the patients' social life or welfare and other problems that might affect their wellbeing.

Some participants however acknowledged the effort that has been taken so far to educate the public on mental health related issues in the media but believed that the impact of this is very minimal, citing a poor reading culture of Ugandans and the fact that Newspapers' coverage is mostly limited to Kampala, targeting the educated. They maintained that use of print media is less effective in terms of coverage and interaction.

> "*…And you have talked of reading news papers, some of us there is a way we read news papers. We look at the front page, look at the headlines, then go to sports…laughing… you may say in Kampala people read news papers; but how many read these papers to the depth? Some look for cartoons, and then fill the puzzle, finished. Some only look for jobs…laughing… Am telling you 'front page, any politics, FDC issues, PRA issues, what has Museveni said then go to sports right away…'how did Arsenal perform?'….So, the article by Dr. Kigozi may not be seen"* (SSI, senior education officer)

### 3.2.25 Recommendations and areas of action

The participants identified a number of areas that need to be improved, and made a number of recommendations. These included the following:

- Need for an active mental health education and promotion program for the general public.
- Need for urgent recruitment of mental health staff to fill the existing gaps.

- Mental health should cease to be solely a ministry of health problem but be spread across other departments especially that of education and the community development.
- Allocate more resources for mental health at all levels of care.
- Ensure a continuous supply of free psychotropic medication at the health facilities.
- The need to strengthen the decentralization of mental health services and integration of mental health into primary health care.
- The need for emphasis on community based mental health services.
- Equip community health workers with mental health knowledge and skills.
- Emphasis should be on primary preventive measures rather than curative interventions.
- Provide all cadres for mental health, including psychosocial mental health staff.
- Regularly review the staff numbers to match the ever increasing number of patients.
- Introduce mental health in school curricula.
- Introduce school-based mental health programmes.
- Introduce mental health in all training institutions for general health workers, with in-service training in mental health for qualified staff as well.
- Need to strengthen child and adolescent mental health services.
- Involving political leaders and other influential people in advocacy and awareness campaigns.
- Develop strategies for capacity building and community empowerment geared towards creating a working culture and increasing production so as to fight poverty.
- Hold mental health events more often at national, district and rural levels.
- Improve the dissemination of mental health-related information through sensitization workshops, brochures, flyers, radios, T.Vs etc.
- Equal consideration should be given to milder mental health problems before they develop into severe conditions.
- Ensure early identification of cases of mental illness and timely appropriate referral.
- Need to develop a better communication strategy in mental health to target a wider audience by through strategies such as involving influential people like celebrities and linking mental health to issues known to be more appealing.
- Put in place a mechanism for addressing the mental health needs of the service providers.
- Mental health services users should be involved in planning for mental health services and policy development.
- Mental health workers should be spread in all public and private health facilities for increased access.
- Create a conducive environment for mental health nurses to practice as mental health nurses.
- Strengthen inter-sectoral collaboration on mental health issues.
- Government should put in place some form of financial support for the mentally ill, at subsistence level since most of them can’t maintain gainful employment.
- Promote alternative medications such as herbal regimens, which have less side effects.
- Invest more in mental health services, especially rehabilitative and psychosocial services for the conflict and post-conflict areas.
- Lobby organizations supporting health programmes to incorporate mental health in their programmes and/or make use of mental health workers.
- More hours should be allocated to psychiatry and mental health subjects for medical students.

- The political leaders in various government sectors should respect the technical staff and refrain from interfering with their work.
- Recognize the role of traditional healers as mental health service providers.
- Long stay patients need to be well prepared for discharge and re-integration in the community
- Need to give mental health services in prisons more emphasis.

### 3.2.27 The future

The participants generally projected an increase in the incidence and prevalence of mental health problems. They affirmed that given the current trend of events, life challenges and the high competition for resources, more frustrations with mental health problems should be expected in future. They specifically predicted a higher rate of suicide in future. They believed that mental health would become a very crucial area in future since modernization comes along with many challenges in life and anticipated increased awareness and utilization of mental health services. They however believed that this would depend on the emphasis given to the mental health policy and the overall consideration for mental health services.

> "…*the changing world is putting very many challenges to us where by simple mental health diseases are going to develop in all professions, where by mental health has to come in to really work in many of these things. So, mental health will become one of the departments that will really be very crucial*…"
> (SSI, hospital manager)

Some participants believed that the current political leadership has to do more in order to tackle the concerns of the population. They envisaged mental health problems posing a bigger burden to the health sector in future, perhaps greater than the one currently posed by HIV/AIDS currently.

> "…*Unless the leaders of this country start tackling real issues concerning the population; particularly poverty, we are going to see a continued increase in the numbers of people who will break down. There is the issue of drugs. Young people frustrated because they are not employed, and many of those employed but not having enough to maintain themselves are breaking down"* (SSI, Politician 2)

> *"…I think the most important thing is to get the issue on the agenda, get the people who allocate the budget to understand that this is the biggest epidemic of the next century. It could actually become worse than AIDS…and we need the experts to tell that*" (SSI, Media representative 5)

## 3.3 GENERAL POLICY MAKING PROCESSES

Most participants both at district level and national level were less conversant with policy related issues, and many could not comment on the subject at all.
It was reported that policy making was previously carried out by a few individuals in the top management of a particular sector developing a policy based on what they believed to be the major concerns at the time, with limited involvement of most stakeholders. In the process, various inappropriate policies were developed. However, following the creation of policy analysis units in government ministries, policy development has improved alot.

### 3.3.1 Policy development

The few participants who commented on policy issues had different opinions about the ideal policy making process in respect of the current approach. Although they recognized the bottom-up approach as the most appropriate one for policy development, many expressed uncertainties with regard to how policy development should start and the levels at which policies have to be approved. The ideal policy making process was reported to be one that starts with a situational analysis, followed by identification of the needs and problems that have to be addressed and then setting out the strategies to address them. It was however reported that many policies often do not go through the proper procedure, largely due to limited resources availed for the exercise. Some participants believed that the creation of policy analysis units has not yet brought about significant changes in the policy development process and maintained that many policies are still developed by a few individuals within particular sectors, with very limited consultation.

> "*…So many times, it is that the sectors sit down, with very little consultation with the stakeholders to come up with policy documents, which are then circulated to the different agencies and other sectors to give their comments. Now, with the poor reading culture and an outstretched civil service, many times the comments may not come, or if they come they are not detailed enough. The situational analysis is usually not extensive, it is limited to possibly review of documents, a few key informants interviews for national level teams. There is not usually enough money to go down to all the levels, to the community to gather the kind of data needed for a thorough policy development*" (SSI, a Programme Manager, Ministry of Health)

It was reported that the main sector policy has to be forwarded to the cabinet and parliament for approval, while departmental policies are approved by the top management committee. Departmental policies address department specific issues and have to be in line with the overall policy of the sector. Furthermore, some participants believed that approval of policies should be by the parliament, by which process the policies become laws.

### 3.3.2 Policy initiation

Policy initiation was reported to be by three main avenues. Firstly policies could be demand driven. Thus policies emerge following pressing problems that arise in society and have to be addressed urgently. Secondly, policies could emerge in an effort to address some weaknesses identified either in performance reports or following some assessment exercises. Thirdly, policies could be initiated by political leaders and top officials in sectors. This could be as a result of some commitment by the political leadership, effort to fulfil pledges in their manifestos or undertakings deemed necessary for the sector by the political leadership. Policies initiated by the political leadership were reported to be the most valued ones in terms of resource allocation and implementation.

### 3.3.3 Stakeholders

Service providers, service users, funding agencies and participants from sectors with policies relevant to the one under development were believed to be the key stakeholders for any policy development. Involvement of service users was specifically said to be crucial for any policy development process since they are more knowledgeable about their needs and subsequently the feasibility and practicability of the policy decisions about to be made. The participants emphasized the need to present policy documents to the development

partners supporting a particular sector for their comments as stakeholders since they fund the sector's activities.

### 3.3.4 Policy implementation

The participants noted that stakeholder involvement in the policy formulation process greatly impacts on the implementation. Some participants reported that the responsible departments and offices often show much concern with policy development, but almost none with the implementation. They identified a need for the responsible departments to value and invest equally in policy implementation as well, and to draw implementation guidelines for policies generated.

> *"…The bad thing is that they have generated so many policies. Everything is policy, policy, but implementation of these policies is not there. People concentrate so much on developing the policies but they leave implementation to whom it may concern. They spend so many hours, days, money in developing the policies. They should put the same commitment in implementation. When you develop the policy, develop the implementation guidelines as well. So, there is a big gap there. The policies have been developed; but operationalization of the policies is so limited"* (SSI, a health manager at district level)

The participants strongly believed that wide stakeholder involvement in policy development is necessary as it impacts on the value attached to the resultant policies and is a determinant for their keen involvement in the policy implementation. They further identified involvement of the service users as a very important strategy for effective mental health policy development.

> *"…if you have developed a policy from up there and you think it is good for me, and I have not contributed, then you should come down and assist me to implement. Because if I don't have a stake in the development of the policy, and you want me to have a stake in implementation, I may not value it the way you value it. That means you valued the formulation but you don't value the implementation. So, I think the stakeholders should be involved at all levels of policy; formulation, implementation, evaluation"* (SSI, a health manager at district level)

### 3.3.5 Challenges to policy development and implementation

Participants cited a number of challenges to policy formulation which included the following:

- Policies are often formulated based on assumptions, which creates a discrepancy between the policy contents and the reality on ground. This greatly undermines the implementation of such policies.
- The policy making process in many sectors is still a top-bottom approach, with priorities being set by government.
- Top management in some sectors tends to be less interested in policies, committing fewer resources towards policy development.
- Wide stakeholder involvement makes the process very lengthy and expensive. This forces most departments to opt for short cuts.
- Some policies are not well developed and do not match the available resources, making their implementation rather difficult.

- A common tendency to set inappropriate priorities.
- Lack of adequate infrastructure and training.
- Inadequate dissemination and low public awareness about policies.
- A tendency for people to be conservative and reluctant to adopt new policies that come with changes.

### 3.3.6 Recommendations

The participants strongly emphasized a need for policies informed by research, and wide consultation of all stakeholders. They further stressed a need for monitoring of policy implementation and regular evaluation of policies to ascertain whether policies are realistic and whether the intended goals are achievable; and to inform the policy reform exercise whenever deemed necessary. Furthermore, the participants emphasized the need for timely dissemination of policy documents and seriousness with the implementation of the set out policies.

## 3.4 PROCESS OF MENTAL HEALTH POLICY AND LAW DEVELOPMENT

### 3.4.1 Mental Health Policy development

Most participants outside the health sector were ignorant about mental health policy development and could not discuss the subject, other than making a few recommendations for consideration during the policy review process. While some of the participants admitted being aware of the existence of the mental health policy with no knowledge of its details, others who claimed to be knowledgeable about the policy confused it with the mental health law. The draft mental health policy was reported to have been developed with limited stakeholder involvement.

The participants reiterated that users should be involved in mental health policy development since they are more knowledgeable about their needs and priorities, and not just being represented by non-users. Citing a now worldwide slogan in the disability movement "NOTHING ABOUT ME WITHOUT ME", the users stressed that without their involvement, the resulting policies would not be objective.

> "*…they have to consent, they've a right to self-determination. Without their involvement, they would disown the policy and Act, considering them to be for the professionals who developed them*" (SSI, key informant user)

Although participants agreed that ideally it would be essential for users to participate in the policy formulation, some were skeptical about this possibility in view of the big numbers of the users, and proposed that the practical way would be to have selected representative samples.

> "*…they can participate...especially those ones who have recovered. Because they know their needs better*" (SSI, PHC nurse, urban district)

> *"… I mean the thing is that we go to school to be able to internalize issues for others. So really…they have people who are technically equipped, I think they should be able to plan for others. But it would be very good if they are inclusive, but I don't think it would be very possible" (*SSI, hospital manager, rural district*)*

The participants identified a number of key stakeholders whose involvement in the mental health policy development is necessary. These included the mental health professionals, service providers and the users, traditional healers, religious leaders, development partners and academic institutions. Involvement of mental health service users in the development of the mental health policy was believed to be an important determinant for their keen involvement in the policy implementation. More-so, most participants shared a belief that "disability does not mean inability" and maintained that the people with mental illness can be productive if supported.

#### 3.4.1.1 The process

The participants believed that the mental health policy development process should ideally start with a thorough needs assessment, after which a technical team should draft the policy document and then present it to all stakeholders through a consultation process to check for its appropriateness. After consensus, the policy should later be presented to development partners for their comments as well through the Health Policy Advisory Committee, and finally to the sector's top management committee.

#### 3.4.1.2 Use of information in mental health policy development

Although no specific needs assessment was done to inform the current mental health policy, it was noted that many policies and plans specifically in the ministry of health are based on routine surveillance data collected annually. Some participants however believed that the health information and reporting system is still inadequate especially at district level; and that mental health data is scarce. It was reported that decisions are often made based on empirical evidence with no well documented reports. The participants emphasized that research findings should inform policies accordingly, and maintained that policies and plans should mostly be based on local data although regional and international data could be helpful as well.

#### 3.4.1.3 Challenges in mental health policy development

It was noted that stakeholder involvement was not wide enough for the current mental health policy. Some sectors were not represented at all, while others were reportedly represented by individuals who were not the most suitable participants. Some participants however believed that direct user involvement was less important since they were deemed unable to contribute meaningfully as stakeholders.

The traditional healers reported being unaware of the current mental health policy and had not been consulted in its development. They however believed that as complimentary mental health service providers, they are key stakeholders who ought to have been involved in policy development.

#### 3.4.1.4 Recommendations for mental health policy development

The following recommendations were made towards the mental health policy development process:

- To strengthen evidence-based practice, academic institutions should be involved in mental health policy development since they have the potential to do research to inform policy.
- User involvement is very essential in policy development and should not be overlooked.
- Users should be involved in mental health initiatives. Responsible users can be very informative of what goes on in the world of users and can be influential since fellow users are more likely to trust them as role models with real experience.

- The mental health law and policy should address the fact that society is resentful of people with mental illness.
- All levels of health workers have to be consulted in the process.

### 3.4.2 Mental Health Law development

The participants were generally less conversant with the development of the mental health law and very few commented on this subject. It was however noted that there exists an out-dated mental health law and arrangements for its amendment are underway.

## 3.5 APPROPRIATENESS OF THE MENTAL HEALTH POLICY AND LAW

### 3.5.1 Appropriateness of the mental health law

The mental health law was reported to be important, especially for protection of the patients' rights and the mental health service providers from possible unnecessary accusations. It was noted that the mental health law in Uganda is an old Act which was last revised in 1964. This law was noted to be out-dated and not in line with contemporary issues in mental health care. Most participants admitted having no idea about the mental health legislation and could hardly comment on the subject. Only the mental health professionals and a few other participants with a medical background were aware of the mental health law.

It was noted that one of the most significant flaws of this law is its failure to make a distinction between involuntary and voluntary care. It almost focuses entirely on issues to do with detention of the mentally ill. As a consequence therefore, the law fails to adequately promote and protect the rights of people with mental disabilities both within the health care context and in the community. Furthermore, the law was noted to use a derogatory language that promotes stigmatization of the mentally ill. Some participants argued that the act is a Mental Health Treatment Act even by the title and hence not relevant today.

Only a few legislative issues as per the WHO checklist for evaluation of mental health laws were noted to be addressed in this mental health law. These included police responsibility, determination of mental disorder, emergency situations and involuntary admission. According to most of the values and principles therein, the current mental health law was noted not to be in consonance with the mental health policy, making its implementation rather cumbersome. The law promotes custodial care and is less vigilant on the rights of the mentally ill. The law was further described as a prejudiced one, and hostile to persons with mental illness; mainly focussing on protecting the community from people with mental illness.
The participants noted that amendment of the mental health law has stalled because the need for a new law is not well appreciated.

**Areas of action in the Mental Health Law**

The participants made the following recommendations as regards the new mental health law:

- The need for a completely new law, in line with the mental health policy and the current trends in mental health care. The law should emphasize the observation of

the rights of persons with mental illness in line with international human rights standards afforded to all human beings.

- Key players in the implementation of the mental health law such as the police, magistrates and mental health professionals should be trained in the mental health law.
- Care in the least restrictive environment should be emphasised. Where possible people should be provided with care close to their communities (eg. community based services)
- The law should promote supported decision making for patients with mental illness.
- The law should come out strong against stigmatization of the mentally ill.
- Sexual exploitation of the mentally ill patients, especially the females should be addressed.
- In order to care for persons with mental illness and help them get absorbed in the labour market, the law should persuade employers to have a certain percentage of their employees who are persons with mental illness, as is the case in some other countries.
- Issues related to incapacity and incompetence as well as guardianship should be addressed.
- The focus of the new law should go beyond the regulation of involuntary admission and treatment, to cover issues related to voluntary care, access and quality of care.
- The law should contain provisions regulating living and treatment conditions in psychiatric hospitals.
- The law should establish mechanisms to monitor conditions in mental health facilities and oversee cases of involuntary admission and treatment
- The law should regulate practices of traditional healers to prevent human rights violations and promote appropriate treatment and care.
- Dissemination of the mental health Act should be emphasized.

### 3.5.2 Appropriateness of the mental health policy

It was noted that policies are very important as they help guide on where to put resources so as to maximize the benefits from the limited resources available. The participants believed that the appropriateness of the policy should be measured basing on how far it improves the welfare of the primary beneficiaries; and in the case of the mental health policy, the mentally persons and their families. They noted that a number of principles in the draft mental health policy are for the welfare of the users (e.g principle 1.6.8 on consumer support) and therefore this policy could be rated fairly. Some participants however were of the view that policies developed without wide stakeholder involvement mostly reflect the needs of the policy makers but not the targeted primary beneficiaries and are therefore inappropriate. This was believed to be true of the current draft mental health policy, which has remained in draft form since the year 2000; and for which stakeholder involvement was reported to have been limited. Development of the current draft mental health policy was reported to have been by some mental health professionals and consumer groups. The following components were noted to be addressed in this draft mental health policy:

- Developing community mental health services
- Decentralization of mental health services.
- Integration of mental health services into Primary Health Care.
- Human resources
- Involvement of users and families
- Advocacy and promotion

- Human rights protection of users
- Equity of access to mental health services across different groups
- A monitoring system

The following were believed to be weaknesses with the current mental health policy that need to be addressed:

- There was no situational analysis and needs assessment done to inform the policy.
- Stakeholder involvement in the policy development was limited.
- A number of values and principles pertinent to medium mental health care are not addressed.
- The policy does not address the relationship between mental illness and poverty.
- The policy is not clear on financing for mental health activities and quality improvement.
- The areas of action are stated as mere intentions; and not in a committal manner.
- Emphasis is on the medical/pharmacological approach, overlooking the role of other mental health service providers such as psychologists and social workers.
- The policy does not make a provision for welfare benefits for people with mental illness.
- Government does not commit itself to supporting civil society organizations in promoting mental health services.
- Research and policy evaluation are not addressed.
- Child and adolescent mental health issues are not strongly addressed.
- The policy does not strongly address issues of conflict and mental health

Decentralization of mental health services was highly commended as one of the strengths of the current mental health policy.

**Integration with other policies**

It was noted that mental health is somehow addressed in the overall health policy as an integrated component of Primary Health Care. A few participants also believed that some of the policies in other departments within the health sector are considerate of mental health.

Some participants however believed that policies in other relevant sectors such as education, labour, gender and social development do not embrace mental health.

**3.5.2.1 Areas to be addressed in the new Mental Health policy**

The following were suggested as areas to be addressed when revising the mental health policy:

- Highlight the issue of economic empowerment for persons with mental illness to become productive and self-sustaining.
- Emphasize vocational education and training for persons with mental illness as it is intellectually less demanding and less straining but enables one become productive.
- Streamline mechanisms for putting in place community based mental health services, emphasizing mental health education, promotion and disease prevention activities in the community.
- Emphasize school-based mental health services.
- Emphasize rehabilitation and occupational therapy for patients.
- Clarify and emphasize the issue of mental health counselling.
- Strongly address child and adolescent mental health issues.

- The policy should result from a thorough needs assessment, wider stakeholder consultations, and be based on the expressed mental health needs of the Ugandan population.

Overall, the current draft mental health policy was found not to be in conformity with international standards, but a good working document to guide mental health service provision in the country in absence of an approved mental health policy.

#### 3.5.2.2 Other policies impacting on mental health

The participants cited policies in the following sectors as some of those policies outside the health sector that impact on mental health:

- The education sector.
- Finance department.
- Gender and social welfare
- Transport sector
- Law, justice and order system
- Land policy
- Public service – labour laws.

Most participants were not conversant with all government policies, particularly those with a direct bearing on people's mental health. They described some common unwritten practices that are discriminative against persons with mental illness. They cited examples of people having to lose jobs the moment they are declared mentally ill, failure to get a job and access to credit microfinance on account of current or previous mental disorder.

It was however noted that some of the participants who commented on the mental health policy were actually unfamiliar with the policy document. One participant who had earlier commended the mental health policy and the policy making process in general later admitted being less conversant with the policy.

> "…*You see, I don't know what is there. You should first have given me the opportunity to look at the policy and see the loopholes. Now it becomes difficult for me to tell you that 'this is lacking, this is like this'*…"
> (SSI, a policy maker, ministry of health)

## 3.6 MENTAL HEALTH POLICY AND LAW IMPLEMENTATION AT MACRO LEVEL

### 3.6.1 Implementation of the mental health law

It was noted that the mental health law is out-dated and not seriously implemented. The mental health practitioners were reported to do what is deemed right in caring for the mentally ill, but their practice is not supported by the law. Some participants cited the ever increasing number of persons with mental illness roaming streets as one example to indicate that the mental health law is not currently well implemented. It was reported that in the past, the mental health law and the recommendations therein were observed. For example magistrates could visit the mental hospital to review the patients and the reports made as was required in the Mental Health Treatment Act. However, the Act has been overtaken by events and its implementation has become cumbersome, with regard to the current modern approach to mental health care. It was however noted that arrangements

for the amendment of the law are underway and the outline of the proposed new mental health bill has been sent to the cabinet.

Low awareness about the mental health Act was reported to be a major reason for its poor implementation. Even those expected to know about the mental health law were found to be ignorant about it. It was noted that only some of the participants from the law, order and justice sector knew about the existence of the mental health law. One participant (a mental health practitioner in the community) further reported having made an observation through his interaction with the police that most police personnel are unaware of the mental health law and its contents.

> "*…as I said, I thought earlier on that the police knew all about the urgency order. As I was talking to them, I realized that they knew nothing*"
> (SSI, Mental health practitioner, NGO)

Some participants believed that the legislature tends to be keener on issues that mostly suit their political interests, and therefore anticipated procrastination in the amendment of the mental health law given the low appreciation and priority for mental health. Furthermore, some participants were sceptical whether the new mental health law would be fully observed and implemented as used to be the case, given the present day decline in rule of law. They emphasized the need for wide consultation in the development of the law and wide dissemination of the new mental health law for successful implementation.

**User rights**

It was noted that there is no national or regional human rights review body for assessing the human rights protection of users in mental health services. Neither the mental hospital nor the community based in-patient psychiatric units in other general hospitals receive any review/inspection of human rights protection of patients. Similarly, the mental hospital and community based inpatient psychiatric units do not have specific training, meeting or any other type of working sessions on human rights protection of patients. Some of the health workers however have had some general training on human rights issues among the mentally sick as part of their overall training. Violation of the rights of the mentally ill persons was reported to be a fairly common practice. Some participants reported that in some communities, it is somehow acceptable to treat the mentally ill inhumanly because they are not respected as useful citizens. The participants maintained that people with mental illness too have rights that need to be protected**.**

> "*...even in society…the way society looks at them, it is like they don't mind about them. And even when assaulted, you may not see anyone reporting to police that a mad man has been assaulted there. And if this mad man committed an offence, even court may not take the case serious"* (SSI, magistrate, urban district)

They further noted that government policies and actions may suggest equal treatment and opportunities for all but this is not the case in practice, especially as regards the mentally ill people. They gave examples of occasions where the law enforcers themselves have violated the rights of mentally ill offenders. The participants emphasized that people with mental illness should receive equal respect, treatment and access to opportunities just like others, as this would contribute enormously in the fight against stigma. They however believed that this would have to start with clear guidelines as part of the government policy.

### 3.6.2 Implementation of the mental health policy

It was noted that although the current mental health policy is still in draft form, it is officially recognized and the mental health activities are in line with this draft policy. The draft was further described as a good working document to guide mental health activities that has to be finalized into a legitimate policy document. Some participants however foresaw inadequate implementation of the mental health policy even after its finalization due to a culture of weak implementation of various laws and policies in the country.

> "*…there are so many other policies in Uganda…the problem with them is implementation. There are so many laws here which are just redundant. So we need to find strategies…why don't people implement them? There are policies, there are laws, but they are not being implemented*"
> (SSI, Policy maker, ministry of education)

Translation of the policy into strategic plans was reported to be a challenge, though a very important step to guide the implementation process. It was noted that somehow the mental health policy gets translated into annual plans and budgets but the main challenge is the small ring-fenced budget, which hinders the implementation of some of the activities due to inadequate funding. While some of the participants expressed satisfaction with the implementation of the current draft mental health policy, others believed that it is not well implemented. Inadequate implementation was partly attributed to the fact that the policy is still a draft and not widely disseminated.

The participants cited the following challenges to effective mental health policy implementation:

- Low prioritization of mental health
- Inadequate resources, both human and financial.
- A negative attitude and low appreciation of mental health.
- Inadequate supervision, monitoring and evaluation.
- The stakeholders left out during the policy development process can not be active players in its implementation.
- Lack of empathy for those suffering, especially the mentally ill members in society.
- Difficulty in coordinating all the concerned sectors, since the mental health policy has multisectoral facets.
- Low awareness following the limited dissemination of the mental health policy.

### 3.6.3 Areas of action for policy implementation

The following suggestions were made as regards mental health policy implementation:

- Translate the policy into strategic plans
- The mental health policy should be subjected to evaluations and modifications periodically.
- There is need for an independent body such as academic and research institutions to conduct the monitoring and evaluation of the implementation of the policy and law.
- In view of the limited resources, use should be made of the existing community resources and structures in policy implementation.
- Civil society involvement in mental health should be boosted.
- The mental health division should emphasize collaborative linkage with traditional healers.
- Need for wider publicity of the mental health policy.

## 3.7 MENTAL HEALTH POLICY IMPLEMENTATION AT MICRO LEVEL

The few participants at the district level who commented on the mental health policy issues expressed their ignorance about the policy and believed that the policy was not being implemented properly at the district level. It was noted that disregard for mental health is at times deliberate and is based on prejudiced beliefs and preconceived assumptions. Some health managers admitted knowing about the mental health policy and having received copies of the policy document but never having taken time to read the document. They seemed not to have taken the policy seriously because they believed there was poor stakeholder involvement in its development.

> "*…I received a copy…but I have not read through. Because you find that policies within this country are generated from above. So, I don't know how much other stakeholders contributed in generating that policy"*
> (SSI, a health manager, urban district)

Some of the participants attributed poor policy implementation at district level to inadequate flow of resources following the decentralization process. They argued that service delivery and responsibility were decentralized but budgeting and resource allocation were not equitably passed on to the district.

## 3.8 MENTAL HEALTH RESEARCH

As regards research, almost all psychiatrists, psychologists and social workers; and a few of the nurses (1-20%) had been involved in mental health research. Findings according to the WHO-AIMS instrument indicated that only about 2 – 4% of all the health publications in Uganda during the previous 5 years were on mental health. The research had focused on some areas including epidemiological studies in community samples, epidemiological studies in clinical samples, non-epidemiological clinical/questionnaires assessments of mental disorders, services research and psychosocial/psychotherapeutic interventions.

It was noted that the ministry of health recognizes the importance of research to provide evidence-based practice although it is not well funded. Some senior official in the Ministry of Health pointed out that the Ministry had planned to allocate 10% of its budget to research but this has not been realized due to inadequate funding. Research was reported to be very important for improved service delivery and for evidence-based decision making. Most participants argued that research findings quantifying the burden of mental illness would inform advocacy strategies and serve as a basis for increased investment in mental health.

It was reported that most research in the field of mental health is currently based on individual interests, opportunities for a particular project and through consultancies. Furthermore, much of the funding for mental health research was reported to be by international agencies, which fund research based on their agenda. Mental health research linked to HIV/AIDS was reported to have attracted more funding recently because of the high priority given to HIV/AIDS in the country and elsewhere in the world.

### 3.8.1 Challenges

The following factors were identified as major challenges for mental health research:

- Low priority for research in general.
- Limited skills in advanced epidemiological research.
- Low funding in most budgets for all service sectors including academic and teaching institutions such as hospitals.
- Even for the little research done, there is very limited dissemination and utilization of the research findings.

The participants suggested the following areas of action in the field of mental health research:

- Local researchers should identify and liaise with international institutions with interest in mental health research.
- The mental health department should set research priorities.
- The health sector should mobilize more resources for operational research and should identify research priorities.
- Promote and facilitate dissemination of research findings as a culture.
- Utilize research findings to inform policy development and strategic planning.

### 3.8.2 Areas for further research

The areas suggested for further research included the following:

1) Establishing the burden of mental illness in the country.
2) The impact of mental illness on the economic development.
3) Investigating the treatment process and the effect/effectiveness of traditional healers' regimens on patients with mental illness.
4) A longitudinal study to establish the causal link between poverty and mental illness.
5) The risk factors in mental illnesses.
6) The link between mental ill-health and HIV/AIDS.
7) The immediate and long-term impact of mental illness on individuals and the nation.

# 4. DISCUSSION

**Introduction**

The results generally reflect some contradictions and discrepancies as regards the general context of health and the mental health situation in Uganda. For example at the macro level, some participants, especially from the Ministry of Health gave a picture that mental health is a priority area. On the other hand, most of those outside the health ministry and at the district level believed that mental health is not yet a priority area. Such discrepancies seem to have arisen due to inadequacies in the dissemination of information on the side of policy makers and possibly because some individuals lack the initiative to seek information and/or do not know where to access such information. Similarly, some participants seem to have spoken on a number of issues out of ignorance, making false assertions and comments.

## 4.1. General Context

The results clearly revealed that health, poverty alleviation and fighting illiteracy are known to be key developmental priorities in Uganda. Some of the participants however appeared to identify what they believed should be the development priorities and not what are known to be the current development priorities. This implies that either they are less informed about the current development priorities or they notice a discrepancy between the development priorities as stated by the government and the reality in practice. Many participants believed that government has not yet invested enough towards the realization of its development priorities as well as the Millennium Development Goals. It should however be noted that despite the comprehensive health policy which emphasizes a wide range of disorders including mental disorders, emphasis is still geared towards fighting those diseases with high mortality rates. There appears to be an underestimation of the contribution of non-communicable diseases such as mental illness towards the disease burden despite the projected increase, and to provide fewer resources. By 2001, mental disorders contributed to 12% of the global burden of disease. According to the 2006 Global Burden of Disease study, mental disorders contributed to 13.5% in 2006 and this is projected to rise to 15% by 2020 (WHO, 2006; WHO, 2001). Illiteracy and ill-health were noted to significantly contribute towards poverty, and it is thus in order to direct more efforts towards the literacy rates and health in the poverty eradication campaign. However, although the need for better health is recognized and believed to contribute towards poverty alleviation, mental health is not given the weight it deserves. This raises a concern as to whether government appreciates the relationship between poverty and mental health.

Community capacity building, human resources development as well as improvement of social services delivery systems are other key factors that were stressed and need to be placed on the development agenda for Uganda.

It was noted that although the external development partners play a major role in deciding the priorities of various sectors under the sector wide approaches, the Ministry of Health is ultimately responsible for the priorities. It was quite evident from the results that financing of mental health services is greatly donor driven, both through SWAp and with project funding. This is in agreement with WHO-AIMS findings that as per 2005, the budget for mental health was at 4% of the total Ministry of Health budget because of external funding by the African Development Bank (ADB), compared to the usual 1% through the regular budget mode of funding. However, it is worthy noting that participants especially from the

Ministry of Health and development partners differed in their views as regards the two funding mechanisms by donors. Some were in favour of SWAp, while others preferred the project approach as stated earlier. Despite the disagreement, they all believed in transparency as a key factor for proper utilization of such funds. It was striking to note that the influence of international factors such as the donor partners significantly determines how high or low priorities are set for particular programmes. Indeed that is how mental health in Uganda attracted both local and international funding. The World Health Organization (WHO) was noted to have had very significant influence in having mental health to be rated high so as to be part of the Minimum Health Care Package. While for a long time mental health had not been in the limelight, it is evident that the world health report of 2001 raised the profile of mental health significantly.

A number of key challenges within the health sector were identified by participants and these would certainly adversely affect Mental Health which is already a disadvantaged programme.

## 4.2 Mental Health Situation

The results revealed divergent views of mental health, reflecting a low knowledge base and appreciation for mental health. The negative views on mental health and the related stigma were however expected given the wide spread misconceptions surrounding mental illness. It was clear that the negative attitude and view of mental health is because most people do not appreciate mental health as a domain of health and instead perceive it in terms of illnesses. One senior nursing officer explained that the word "mental" is mostly related to madness, and that once it appears anywhere, one automatically thinks of mental illness, hence the faulty layman's perception of mental health. The terms "mental health" and "mental illness" were used synonymously, and the consistence and persistence with which this happened was surprising. All this expressed low awareness on mental health even among the health workers, which could be an explanation for the low interest in the field by many people, including policy makers. It is quite unlikely for one to pick interest in an area or field that he/she does not understand clearly.

Furthermore, it was clear from the responses that the faulty perception of mental health and mental illness remains a major challenge, contributing to the high preference of traditional healers by the public. A gradual change in the public's perception of mental health has been realized due to improved service delivery and sensitization. This was acknowledged by many of the participants as resulting from the government's effort and the current leadership in mental health. It is clear that mental health services are now decentralised and the policy makes provisions for service delivery up to the lowest health facility. However, most participants felt that effective mental health service delivery is not yet realized under the decentralized system which calls for more investment in mental health by the government through the Ministry of Health.

The participants varied in their views as regards prioritization of mental health in the country. At the macro level some participants, especially those from the Ministry of Health headquarters emphasized that mental health is prioritized because it is among the components of the Minimum Health Care Package. Further evidence for the high priority was noted as the increased resource mobilization for the programme within the two big projects through the Support to Health Sector Strategic Plan Projects (SHSSPP I and SHSSPP II). On the other hand, most participants at micro level were opposed to this. In

their analysis, the majority (especially at primary health level) were of the view that mental health is not yet a priority area. Some of the reasons for this were that:

- Priority is currently given to diseases with high a mortality rate.
- Funds meant for mental health activities are diverted to what are regarded priority areas.
- Inadequate staffing for mental health.
- The few that are available are very often assigned different duties.
- Lack of interest and stigmatization by the general health workers.

Non-prioritization of mental health is greatly attributed to a poor HMIS in which minimal information is captured on mental illness. The available information in some of the medical records often does not represent the true picture, giving the managers and planners an impression that mental illness is not a big threat. It was noted that factors such as lack of skills to detect the less severe mental health problems, lack of concern by the policy makers, and managers/administrators of health facilities being less compassionate for the mentally ill contribute towards the low priority for mental health. It should also be noted that the wide spread stigma and misconceptions attached to mental illness contribute to the low prioritization.

Although some participants believed that mental health is not a priority area, it should be noted that mental health is a component of the National Minimum Health Care Package and there have been some significant developments of late aimed at improving the mental health services. However, many participants seemed unaware of such developments. Much of the information on mental health and such recent developments are in Newspapers as well as policy and plan documents, which are accessed and read by only a few people. A number of such documents (on SHSSPP I and II) indicate the rehabilitation of mental health services and many other achievements. This was partly attributed to a poor reading culture among many Ugandans, which was cited by a number of participants as a major challenge, and was found to be true of some health managers. Such health managers expressed their ignorance about the current staffing norms; which were widely disseminated in the Health service commission guidelines (2005). Secondly, effective dissemination of information is still a challenge. This was evident given the fact that the draft mental health policy has been in place since the year 2000 and yet the majority of the participants had never heard about it. Thirdly, inadequate funding, with bureaucracy involved in the process probably explain the inadequate staffing. Although the staffing norms stipulate the number of mental health workers expected at district level, often the wage bill ceiling may not allow the district to recruit the required staff.

Furthermore, it should be noted that low prioritization and inadequate funding for mental health is a reality for most low and middle-income countries. According to the WHO (2001), almost a third of the countries worldwide do not have a specific budget for mental health, and one fifth of those spend less than 1% on mental health.

**Mental health services at District level**

**Rural district**

Mental Health services were noted to be offered in a few of the health facilities ever since they were established in 2003. However the findings indicate that mental health services are among those services that are still highly marginalized in this district because of the belief that mental illness is not an emergency or may not result in death. One health manager was quoted saying:

> "*…and as I said, it is not what…it is not acutely life threatening that people give it a lot of concern*".

This was an unfortunate statement as it came from a top health manager portraying ignorance and a wrong attitude. The finding also shows that it is the commitment and concern that motivates health workers to consider mental health problems rather than the level of training. Some PHC nurses could appreciate the burden caused by mental disorders and yet the doctors and health managers at times were of the view that mental illness was not a major concern.

Such findings would imply that many of the persons who present with mental health problems at these health facilities are undetected or mismanaged. The health facility staffs are supposed to handle basic mental disorders, recording this vital data in the HMIS forms. However, very often this is not done because of the limited skills to diagnose the problem in addition to the faulty design of the forms which only allows for limited diagnostic categories to be captured.

> "*…he says they are not so many cases, because he is not on the ground. If he was on the ground seeing these patients from morning to evening, he would realize that something needs to be done*" (SSI, Mental health nurse).

It was noted that this District had no specific plan for mental health and basically depended upon the national Health Sector Strategic Plan, which the health manager reported to be difficult to implement when it comes to the mental health component. The district plan appeared not to contain any details for mental health programme implementation. The managers however seemed aware of the need to implement the national heath sector strategic plan interventions as spelt out for mental health. He however reported having mental health integrated into general health care, although no substantiation was made about this claim. This implied that mental health was out of the district integrated service programme within the district. This was further evident in the contradictions the managers kept on making. While they claimed that the integration process is ongoing, the contradiction of mental health not being in the district work plan will necessitate future evaluation of programs to ascertain the degree and extent of integration of mental health in the general health services at that level. The fact that most participants could not explain how the integration process is being carried out casts doubt on the extent and effectiveness of the process at this level of service delivery. Furthermore, most nurse participants appeared to have a very low knowledge base, emphasizing the need for massive continuous professional development for all the staff cadres in the field always.

**Training in Mental Health**

Sadly, the majority of the health workers in this district seemed to have had little exposure or training in mental health. Some had trained many years back, before it had become a policy requirement to include a substantial mental health component in the curricula for health workers. Others admitted having trained during a time this policy requirement was in place, but missed the training for flimsy reasons such as lack of transport to the National Mental Hospital. Some of those who had been exposed to mental health during their training reported attrition of the knowledge over time, due to irregular exposure and lack of regular CMEs in the field. Many of the PHC nurses had never even visited any mental health facility and recognized this as a challenge on their part, having to refer patients to places which they do not know and have no idea of how they operate. The situation is complicated further with the absence of regular support supervision visits from the centre

as well as continuous professional development as mentioned above. Furthermore most of the medical officers in the district trained at a time when the curriculum at the medical school had a limited content on psychiatry. Even then the doctors admitted having overlooked the subject, with a belief that it was a specialist field since it was not examined as a University exam in the past.

Although a few general nurses from the rural district had attended training sessions in mental health at the National Mental Hospital, It was however surprising that none of the participants mentioned this; implying that perhaps this training was not taken seriously or did not make a significant impact to them.

With the exception of teachers, the non-health workers felt they had no role to play with the mentally ill and therefore such knowledge appeared irrelevant to them. The police chief believed that such knowledge would only be relevant to those police officers in the medical section of the police. The teachers on the other hand observed that some mental health component is provided in their training because they have to deal with slow learners and the mentally retarded. They however felt that what is covered in their curriculum is insufficient. The participants from the police department and judiciary felt that they had no major role to play as regards mental health, since their training has no content on mental health and they had never been exposed to the contents of the mental health legislation. These findings revealed a major weakness for such an important department which is expected to maintain law and order in the country.

Generally there was understaffing in all medical cadres, with mental health being the worst hit, with only one recently recruited mental health nurse at HCIV in the whole district. This was unfortunate since according to recruitment guidelines for the health professionals in the district and urban authorities (2005), each district is supposed to have at least five mental health workers (Health Service Commission, 2005). The guideline provides for a psychiatric clinical officer and psychiatric nurses at the district hospital, and psychiatric nurses at health centre IVs. Mental health services in the rural district were said to be greatly affected by lack of political will. This inadequate political support manifests in limited resource allocation as well as low priority for the recruitment of human resource for mental health.

Although mental health is expected in each district to be part of the Minimum Health Care Package, it is evident from this study that mental health in the rural district is still underdeveloped; which may be true of many other rural districts in the country. In line with this, in a baseline survey by SHSSPP (2004), it was observed that the development of mental health services in the country has been slow and beset with many problems. Some of the problems among others include high levels of stigma in the community, lack of skills in the management of mental illnesses by earlier trained health workers, paucity of specialists and low priority accorded to mental health in planning and budgetary process.

**Urban district**

For the urban district, the situation was relatively much better though the mental health services had only been recently set up in an organized way. The need to train all district health managers became evident as it was reported that the commencement of mental health services in the district started soon after the district health manager had received some training in Health Management Information System, and had also noted that the state of record keeping was not up to date. The district was reported to have recruited at least

one mental health nurse at every HCIV and also designated a focal person for mental health at the level of a medical officer, responsible for the overall service delivery in a particular health sub-district.

Findings clearly indicate that efforts have been made in this urban district to improve mental health service delivery. They are advocating for recruitment of more mental health personnel, even at lower levels, and programs to retrain their general health workers in mental health. Programs for continuous professional development and short refresher courses have been developed to this effect. However the trainings were said to be rather too short for them to confidently handle mental patients.

The urban district health managers were relatively knowledgeable on the requirements for an efficient Mental Health programme. However, effective integration of mental health into Primary Health Care was noted to have some challenges. The practice of deploying Mental Health workers to other programme was still common reflecting the lack of importance attached to Mental Health. The results further revealed that the referral system is not well adhered to as the community tends to bypass the system and take their patients directly to the National Mental Hospital where they expect better services. This is an indication of inadequate sensitization for the community.

As regards the role and the need of training in mental health for the police, the participant from the urban district differed from his counterpart in the rural district in that the former appreciated the need for the police officers to train in mental health and also believed that the police's role should be to deliver the mentally sick to a mental hospital whenever called upon. Findings also reaffirmed that the police force is not well informed about the mental health law and that poor facilitation affects the timely transfer of patients to hospital. The law, justice and order sector was said to have no major role to play in the management of the mentally-ill, just as it was in the rural district. Although the Mental Treatment Act of 1964 proposes police to play a key role in the admission of the acutely mentally ill patients, the police chiefs interviewed had no knowledge of the law. This reflects a breakdown in previous training of police officers which served to orient them on the mental health law. The lack of knowledge was also found among judicial officers who were paradoxically empowered to decide on people's mental health status. This raises questions on the quality of the current training of law, justice and order of personnel. In case of mentally-ill offenders, the role of the magistrates is simply to take note and refer the cases to a qualified medical doctor for assessment and further referral. This probably explains why their training has no component of mental health. Orientation in mental health was seen as a crucial issue for them.

There were major differences in the level of mental health services between the urban and rural districts. While the urban district was demanding for the scaling up of services, the rural district expressed less need for mental health services. The rural district appeared contented, relegating all mental health services to traditional healers and religious leaders. The findings clearly elucidate the immense investment needed to establish mental health services in rural district. While the good practices in the urban districts indicate that it is possible to decentralise and integrate mental health services. The findings also indicate the need to review both the pre-service and in-service training programmes to give adequate exposure to general health workers to equip them for mental health services.

The findings further indicate a need to strengthen all programmes including prevention, and promotion, support supervision and the referral system even in the urban district as these were still very thin on the ground.

As regards the history of mental health services in the districts, the district health manager of the urban district was instrumental in initiating mental health services. The manager in the rural district on the other hand seemed to have played a lesser role. The manager of the only health centre where there is a mental health nurse in this district reported having initiated mental health services at the facility after attending some mental health function. This further indicates that absence of well developed mental health services in the rural district is mostly attributable to the attitude of the health managers who may not follow the recommended guidelines.

The advocated multidisciplinary approach was found not to be functioning as evidenced by poor knowledge and participation of social workers in mental health services.
The findings further indicated that mental health funds at district level are not ring-fenced and tracking allocation for mental health is very difficult. There is need to ring-fence some funds for mental health services and hold districts not allocating mental health funds accountable.

It is evident that there is a big difference between the rural and the urban districts in terms of mental health services development; in line with the findings by the WHO-AIMS instrument which indicated a major difference in mental health services between the rural and urban settings, in favour of the urban. Some of the participants attributed the current state of affairs and the relatively inefficient mental health system in the rural district to the fact that it is relatively new. The district was created out of a larger existing one, and came in place without planned infrastructure and all institutions needed, including proper staffing structure. They believed that the same is true for most new districts. It should however be noted that the urban district too was new, and was created in the same year as the rural district. This therefore implies that the observed difference in service delivery is attributable to other factors.

**The education sector**
Contradictions were noted about Uganda's education system. Some of the participants, especially those outside the education sector believed that the system is so stressful to the children that even the little time for recreation is compromised for academic excellence. Some teachers however believed it is necessary to keep the learners always occupied for better results. Academic excellence is thus emphasized currently because of the stiff competition among schools, ignoring the other areas quite important for human development. Mental ill-health was said to greatly affect the performance of pupils/students; very often leading to school drop out due to the stigma. Results also clearly indicated that teachers have a big role to play as regards the mental well-being of their pupils/students most especially the senior women/men teachers who are often assigned the role of counselling; yet they are not so efficient in their counselling skills. The participants from the education sector appeared more knowledgeable on mental health problems and their impact on children and adolescents but lamented the lack of services in schools. The finding is positive in that the leaders did not display a negative attitude and could be an excellent resource in rolling out services for children and adolescents.

**Other sectors**
The media seemed prepared and willing to promote mental health, and proposed some marketing strategies for mental health. However, there was no evidence of private sector involvement with mental health as HIV/AIDS agenda had taken over their interests. Explanatory models for the relationship between HIV/AIDS and mental health could be useful for using the same resource to address mental health.

**Child and Adolescent Mental Health**
It was noted that while children and adolescents constitute over 50% of the country's population (UNFPA, 2007), child and adolescent mental health continues to be a largely neglected area, with no well streamlined specialist child and adolescent mental health services in place. It was noted that much of the effort as regards child and adolescent health has been directed towards HIV/AIDS and reproductive health. There are no special mental health services for this category of the population apart from the counseling services for the raped and defiled cases, although they were reported to have significant mental health problems just like adults.
With an estimate of 39% of the world's population being children, 20% of the children and adolescents worldwide are believed to suffer from overt mental health problems or disorders (WHO, 2005c). However, well developed child and adolescent mental health services have been noted to be scarce, especially in the developing countries. In a survey by the WHO, only 34 countries worldwide were found to have some identifiable mental health policies which may have some beneficial impact on children and adolescents.

It was noted that many children with mental disorders are often regarded as a disgrace to their families and left behind unattended to. In line with this, the WHO (2005c) acknowledges that the burden associated with mental disorders in children and adolescents is considerable and made worse by stigma and discrimination.

Mental disorders account for a large proportion of the disease burden in young people in all societies and most disorders begin in early years although they are often detected in later in life (Patel et al, 2007). In absence of a well developed child and adolescent mental health programme therefore, there is a need to integrate child and adolescent mental health interventions with all the existing programmes, including those within and outside the health sector such as education.

## Socio-economic and cultural Factors

**Poverty and mental-ill health**
The findings confirmed a strong relationship between poverty and mental illness. The two are mostly linked in a vicious cycle of exclusion, limited access to services, low productivity, assets depletion and diminished livelihood. People with severe mental illness were reported to be less likely to be constructive or development oriented because of their impaired judgment. The chronic nature of mental illness probably drives the sufferers into poverty as they become unproductive. Even when they are willing to work, the rest of the community may be unwilling to offer them even casual work. Besides draining the family savings, the family members have to spend a lot of time looking after the sick family member, limiting the time invested in livelihood activities. Although at times poverty may not directly cause mental illness it may exacerbate the underlying causative factors. Some people with mental illness were further reported to become destructive, implying strained

relationships with neighbours and a need to spend money on resolution of disputes at local courts; which further encroaches on their meager resources.
It was noted that poverty impacts on help seeking behaviors as patients may not be able to finance themselves to the health facilities especially if they are deep in the villages. This observation is in line with many other studies that have confirmed this link. Fauerstein (1997) argued that the poor often live far from where care is offered and that the poorer the mentally disordered, the greater the burden. Some participants from the rural districts affirmed that some people find it hard to spend their little money to seek medical services before the condition has worsened. The poor are said to value their physical health more than their mental health. Some participants further observed that urban dwellers lead a relatively more stressful life due to the cost of living and other challenges, with minimal social support due to the current change in the style of life. Fauerstein (1997) further notes that social support can be an asset but urbanization undermines the traditional family caring patterns.

However, it must be noted that a few participants, especially those from the academia acknowledged the link but believed that much as stress and mental ill-health are a reality among the poor, they can be found among the rich as well. Their assertions implied that mental health problems are mostly among the very poor and the very rich members of society.

> "…*when you have a population and you look at the mental state of the population according to the social class, the distributions are U. Those who are the poorest have a high rate of mental disorders, and those who are the richest also have a higher rate of mental disorders*" (SSI, Mental Health Professional/Researcher 3)

**Stigma**
It is believed that stigma mostly arises from the cultural explanatory model of mental illness. The levels of stigma exposed by the study were quite shocking. Stigma was found to be extended to those with the disorders, their relatives as well as the mental health professionals. The findings underscore the high investment and effort required to fight the deep rooted stigma which was noted to be even more than anticipated. A study by Basic Needs, Uganda (2005) found that many families do not want to be identified with the mentally ill relatives and that when patient does not show improvement fast, he/she is abandoned. Similarly, various types of beliefs across different cultures were cited, which hold a strong aspect of stigmatization against the mentally ill persons. The belief that mental illness is incurable and mostly caused by bad spirits exacerbates and intensifies the stigma and exclusion.
It was surprising that on service training of some primary care workers had not translated into attitude change and more assessment do establish the cause would be required.

**Help Seeking Behavior**
The results suggest that help-seeking behaviour in the rural district is greatly influenced by the traditional belief system and explanatory model of mental illness in the community. Traditional healers are reported to be the most popular source of help for mental health problems in the community. In this community like many communities in Africa, mental illness is mostly attributed to supernatural powers and the remedy can only be sought from traditional or spiritual healers (Leff, 2006., Okello & Ekblad 2006). This has condemned many mentally ill people to never accessing effective modern treatment and perpetuated the belief that nothing can do for them (SHSSPP, 2004). The services of traditional healers are

said to be readily available since there are many healers in the communities at affordable rates. On the other hand, the western health facilities tend to be located in urban areas far away from the rural areas and usually with inadequate staff levels. This limits access to quality medium care. Lack of information about availability of the mental health services, financial constraints, heavy work load and stigma are also believed to influence help seeking behaviours. Findings were in line with the results of a study by Basic Needs Uganda (2005) in which it was found that over 80% of the patients with mental illness first visit traditional healers, and that patients often use both types of interventions at the same time.

Results from the urban district revealed variations in the factors that influence help-seeking behaviours within the community. This mainly dependents on the belief system, and socio-economic status of the patients and their carers. People in the community were reported to seek help at the health centres mostly for other medical conditions other than mental illness. People with mental illness were reported to seek help either at the national referral mental hospital or try alternatives such as traditional healers and religious leaders. It was also evident that users of the mental health services seek help from multiple sources, with the majority going to traditional healers where they perform rituals to appease the spirits. Lack of awareness of the availability of mental health services and side effects of the drugs were noted to impact negatively on the help-seeking in the health facilities.

**Prevalence of mental illness**

Although most participants believed in an upward trend in the prevalence of mental illness, it was noted that currently there is lack of a reliable mental health information system capable of providing reliable data on the prevalence and of mental illness. It should be noted that scarcity of data on the prevalence and disease burden for mental illness is a major factor for low prioritization. Patel et al, (2005) noted that the true burden is likely to be underestimated because of inadequate appreciation of the connection between mental disorders and other health conditions.

**Integration of Mental Health into Primary Health Care.**

Some health managers claimed having mental health services integrated in general health care even in facilities where there were neither mental health workers nor general health workers who had received training in mental health. Interestingly, such health managers had admitted giving mental health low consideration even during their training, and not having any traceable mental health aspects in their work plans. This would therefore imply that since the policy advocates and emphasizes integration of mental health into Primary Health Care, some health managers assume that mental health services are automatically integrated and are being offered. It is thus unfortunate that the implementers of government policies are not sure of how to proceed with the implementation and hence a need for massive reorientation in the new policy requirements.

The process of integration further seems to be undermined by heavy workload in addition to the general health workers who have no interest in mental health. This suggests a need to strengthen the whole health system by providing adequate human resources, space and other requirements in addition to training of health workers and addressing stigma. Health managers were aware of guidelines for integration of mental health but were not implementing them indicating a need for regular support supervision and technical support in the development of district work plans for effective implementation of all guidelines.

**Management of Mental Health problems.**
One of the major findings was the limited psychosocial and other complementary forms of management thus indicating a strong emphasis on pharmacotherapeutic interventions for the management of mental illnesses. This was reported to be a major weakness of the mental health system, leaving clients with no alternative other than to resort to traditional/spiritual healers. There is thus a need to provide holistic care by developing multidisciplinary teams including clinical psychologists, counsellors and social workers.

In view of the inadequate orientation for the general health workers in mental health and the finding that the existence of a mental health professional had some positive change in the delivery of mental health services, there is a need to ensure that a critical number of mental health professionals are deployed primary care settings to provide the much needed guidance. Indeed regular capacity development for all general health workers would strengthen the mental health service delivery as envisaged in the mental health policy and plan.

**Consumer associations**
The current mental health policy encourages development of consumer associations. There is however a need to promote the development of NGOs for users and carers in addition to the existing ones. The users equally identified a need for more support groups and associations in which they have a bigger decision making role to determine their destiny.

**Human resources**
Findings indicated a poor human resource base which was worse at the Mental Hospitals. A disproportionate distribution of Health workers between rural and urban areas was noted as a major challenge. Despite a population of 30 million people, the country has very few trained mental health professionals. With the exception of the psychiatrists, only a proportion of the other mental health professionals are employed and working in the public mental health service sector. There is therefore a need to review and strengthen the human resource establishment especially at the Hospitals, and to develop appropriate models to ensure access to care in the rural areas including motivating the specialists to conduct outreaches and support supervision to the lower health units. Furthermore, the scaling up of training of middle level mental health professionals such as Psychiatric Clinical Officers is likely to have a positive impact, since they accept to work in rural areas.
However, comparing with the previous level of staffing for mental health (as indicated in the WHO ATLAS report, 2005), it was noted that some improvement has been registered, especially an increment in the number of psychiatrists.

## 4.3 General Policy Making Process
Although the main purpose of the study centred on policy development and implementation, it should be noted that this is the area where little data was generated. Most of the participants, especially at the micro level exhibited limited knowledge on policy issues, and many could hardly comment on the topic. This could be attributed to the fact that the policy was not widely disseminated and the limited implementation strategies for both the mental health policy and legislation. It is therefore necessary that in future, the need for more effective communication and dissemination of policies to various stakeholders should be taken into account.

## 4.4 Process of Mental Health Policy Development

The few participants who commented on the mental health policy identified gaps in consultation and ownership of the policy necessitating a review of the policy with adequate incorporation of stakeholders' views. However, considering some remarks, one wonders whether some participants understood the difference between the mental health policy, plan and law. It was also evident that the choice and the roles of stakeholders were not clear to the participants. Although the consultation during the policy development process may not have been wide enough, it should be noted that not everybody would be involved in the process of developing the policy.

## 4.5 Appropriateness of the Mental Health Policy and Law

Although a number of weaknesses were identified, the draft Mental Health Policy had addressed some of the key issues that need to be taken into consideration for mental health policies. The finalization of the policy would be expected to address the gaps identified by the participants. However some proposals such as the request for welfare benefits for people with mental illness were not relevant to Uganda as they are not applicable given the current socio-economic situation. The participants tended to mix up proposals for the policy with activities to be included in the strategic plan, an area that needed to be clarified. The finalization of the mental health policy should be followed with development of the strategic plan detailing how to implement the policy requirement. This also clarifies some of the confusion between the two documents. Furthermore, some proposals which were suggested for inclusion in the mental health policy could be accommodated in other relevant laws and policies.

The mental health law was noted to be outdated and inappropriate. It was further noted to be "a mental health treatment Act" and not a mental health Act. By this, some participants believed that the current law is about treatment only, and yet mental health is more than just treatment. This was noted to be one of the main weaknesses of the Act. The participants proposed the need for a new mental health law, and their proposals were in agreement with the principles developed for the review of the mental health law. These are expected to address important provisions in the WHO guidelines for the general legal framework expected in the modern mental health practice. Other than treatment and medical aspects, the policy and legislation should address and improve the welfare of the mentally ill persons, especially their socio-economic development.

## 4.6 Mental health policy implementation at macro level

Overall, considering the activities and achievements in mental health so far, the implementation of the mental health policy at macro level could be rated as satisfactory. It should however be noted that some of the participants still believed that mental health policy implementation is still inadequate. It was noted that some external development partners received copies of the draft mental health policy but did not take it seriously. This could also be a further indication of the low priority given to mental health.

> *"…we received a copy. And I can say the ministry of health is well organized about informing us of their programs…but I have to be frank with you, I have not gone into the details of the policy. I don't know…"*
> (SSI, Representative, development partner 3)

Other representatives however reported being unaware of the mental health policy. Although these were from agencies that are currently not involved in direct support of mental health activities, it would still be worthy disseminating the policy to them to be able to contribute in advocacy and lobbying. Mental health cuts across other programmes in some of the activities supported by the development partners, and it is possible that mental health is a substantial component being supported as well. In general, there appeared to be a lot of weaknesses in the implementation of government policies by primary health care managers.

In addition to the consultation in the development of the mental health policy, dissemination should be widely carried out to enable the implementers appreciate their roles. Another reason for failure to implement policy requirements was related to the gross underfunding at primary health care levels, which demotivates health workers. This suggests that policies should be more realistic and developed taking into consideration the availability of resources. Some participants expressed lack of confidence in the system, that even new policies would not be implemented however good they may be. This pessimism as regards general policy implementation should be taken note of as an important threat to mental health policy implementation even in future.

In emphasizing the need for the finalization of the policy, some participants believed that there is currently no mental health policy implemented because the current one is still in draft form.
It was also noted that some participants expected to be conversant with the mental health policy by virtue of their positions frequently contradicted themselves in their responses, reflecting low knowledge on mental health policy issues. Others attempted to comment on mental health policy issues but apparently seemed uninformed about the policy. This could partly be attributed to a number of factors such as inadequate dissemination of the policy document, but could also be the individuals' weakness.

## 4.7 Mental Health Policy implementation at micro level

Although the few participants at district level who were willing to comment on policy issues believed that there is no policy implementation at the district level, it should be noted that there are some form of mental health services offered at most health centres in these districts. This is an indication of the decentralization and integration of mental health into Primary Health Care; which are recommendations in the mental health policy. One major point of concern however is the need to highlight the difference between policies and policy documents. Apparently some people are actively involved in the implementation of policies but never realize this and continue to state their ignorance about such policies because they have not received or read the official policy documents. This illustrates the importance of disseminating the official policy document to various stakeholders and implementers. Although some form of mental health services were found to be in place it was noted that the policy recommendations are not strictly adhered to and mental health policy implementation at district level is still inadequate. As indicated in the findings, it should be noted that the issue of decentralization of responsibility vis-à-vis centralized allocation of resources is a crucial matter as regards effective services delivery, and should be addressed in the policies.

Although it was reported that one reason for failure to implement policies at micro level was decentralisation of service delivery and responsibility without decentralising budgeting and resource allocation, this may not be true. Districts set their own local priorities and

allocate the PHC finds according to those priorities. The Ministry of Health headquarters only provides standards and guidelines. There is therefore a need to educate district managers on the use of ministry of health guidelines.

## 4.8 Mental Health Research

The role of research in better service delivery was observed and undisputed. Although it was reported that the ministry of health recognizes the importance of research, mental health research seems to be a matter of less significance and not yet on the research agenda. It was noted that most mental health research so far has been done independently by academic institutions or non-government organizations; and not commissioned by the ministry of health. The few studies done by the mental health department have been through individual researchers by consultancies; limited in scope and for specific time-bound accomplishments. It was noted that the Ministry of Health had earlier planned to devote 10% of the budget on research but failed to uphold this due to inadequate funding. With financial support for research predetermined in this way, it would be expected that 10% of the realized budget could still be devoted to health research to reflect the commitment. The weaknesses identified in the area of mental research therefore suggest that the Ministry of Health has not yet taken a deliberate move to prioritize research in mental health. It thus becomes a matter of concern and contradictory for the policy makers to stress the need for evidence-based practice without reasonable investment in research.

It should however be noted that some individuals seem to have lost confidence in the importance and rationale for research. In this study, some participants apparently believed that research is often for wastage of people's time and only benefits the individual researchers because the impact of most research activities is never realized in the community. They wondered what the responsible bodies often do with their research findings. The implication for this therefore is that as more resources are invested in health research, significant reciprocal improvements are expected in services delivery.
Overall, the findings indicated very scanty research on mental health and highlighted a need to increase advocacy and investment in mental health research to build the body of evidence for guiding mental health plans.

### 4.9 Limitations of the study

1. The purposive sampling strategy and limited time did not allow for interviewing a wider range of stakeholders, thereby limiting the diversity in the opinions that were solicited.
2. The interview and FGD guides were very lengthy, making it hard to probe for clarification in many relevant areas. This limited the quantity of information that was obtained in some areas.
3. Some of the participants were less conversant with certain areas and frequently contradicted themselves as they attempted to give responses portraying a positive image.
4. Much information couldn't be collected by the WHO-AIMS due to absence of reliable sources.

# 5. CONCLUSION AND RECOMMENDATIONS

## 5.1 Strengths of the Ugandan Mental Health System

The mental health system has the following strengths:

- Existence of a mental health coordination office.
- Reasonable appreciation for mental health research and significant investment among the human resources for mental health research.
- There is a fair balance between the mental hospital and community based psychiatric inpatient units.
- Existence of a Draft mental health policy, though yet to be finalized.
- Existence of some community based mental health services, which can be strengthened.
- Improved curriculum content to enable better exposure to mental health during pre-service training within nursing and clinical officers' training schools.

## 5.2 Weaknesses of the Ugandan Mental Health System

Significant weaknesses within the mental health system that need urgent action include:

- The mental health policy has remained in draft form for quite long.
- The Health Information Management System has a lot of gaps and doesn't effectively capture all relevant data.
- The Mental Health Legislation is an obsolete one which should urgently be revised.
- Regular outreaches and support supervision at health centres is still very low.
- Collaboration between the mental health department and some other government sectors is not adequate
- Interaction of mental health services with family's and consumer's associations is still in its infancy.
- In-service training for primary health care staff is still inadequate.
- Resources and training for psychosocial care are insufficient.
- There is no comprehensive Mental Health Strategic Plan
- Mental health financing is still inadequate
- Regular supply of psychotropic medicines is still a problem.
- Relatively low psychological interventions in the management of mental illnesses, especially at micro and macro levels.

## 5.3 Conclusion

This has been the first major mental health systems study for Uganda, conducted by both quantitative and qualitative methods. The study has revealed very important findings, some of which will require immediate interventions if Ugandans are to access quality mental health services. The assumption that mental health services are reasonably well organized and that the health unit staff at both micro and macro levels know their roles in the integrated health care delivery was proved wrong as only a limited number were noted to appreciate this policy requirement to that effect. The relatively low appreciation of the existence of a national mental health policy and national mental health programme, and ignorance of the mental health legislation calls for urgent action not only to review these documents in a wide consultative form with representatives of all expected stakeholders in

the country but also to disseminate them even in the current status, while awaiting for the review process. The widespread stigma towards mental disorders and the prevalent cultural attitudes towards the causes of mental illness which in turn affect the health-seeking behaviour will have to be tackled as soon as possible for improved access to modern mental health care. The paucity of knowledge on mental health among the general health workers should be a major source of concern for policy makers at the ministry of health headquarters, which calls for urgent rectification through massive and purposeful in-service training.

## 5.4 Recommendations for strengthening Mental Health Systems

Considering the context given by the situations mentioned above, possible areas of action are:

- Finalization of the mental health policy and development of the Mental Health Strategic plan.
- Improvement of interaction and training in mental health issues for primary health care workers.
- Strengthening of community based mental health services by training Primary Health Workers to promote integration
- Strengthening multi sectoral collaboration
- Developing training on mental health and human rights
- Review of mental health legislation to bring it up to date with current International Standards.
- A primary health care training program on mental health, spread in all regions in the country.
- Review and strengthen staffing for mental health

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# 7. APPENDICES

## 7.1 Appendix 1: Informed consent agreement: *Interviewer copy*

Good morning/afternoon. My name is _____from_____. We are conducting interviews with key people, like you, about how mental health policies are developed and implemented in _____ *(country)*. The purpose of this study is to gather information that will help us to understand the factors necessary for the development and effective implementation of appropriate mental health policy. I would like your permission to talk with you today about your ideas and experiences related to mental health policies in this country.

We will use what you tell us to improve our knowledge of mental health policy development and implementation. I would like to tape record our conversation. Everything you say will be kept confidential. Your name will not be used in any reports of our research findings.

It is up to you if you wish to take part in the interview. It is up to you if you wish to answer any or all of my questions. The interview should take no longer than _____ minutes, but can be stopped by you at any point.

Do you have any questions about the purpose of the interview or how the interview will be conducted?

If you agree to participate in this interview, please sign two copies of this form – one for you to keep and one for me to take away with me as a record of your agreement to participate.

**I agree to take part in this interview**

**I agree / do not agree to this interview being tape recorded**
*(Cross out as appropriate)*

Participant's signature_____

Date _____

Interviewer's signature_____

Date _____

If you have any further queries regarding the research or issues discussed during your interview, please contact Dr_____ *(country coordinator)* at _____ *(telephone number).*

## Informed consent agreement: *Participant copy*

Good morning/afternoon. My name is _____from_____. We are conducting interviews with key people, like you, about how mental health policies are developed and implemented in _____ *(country)*. The purpose of this study is to gather information that will help us to understand the factors necessary for the development and effective implementation of appropriate mental health policy. I would like your permission to talk with you today about your ideas and experiences related to mental health policies in this country.

We will use what you tell us to improve our knowledge of mental health policy development and implementation. I would like to tape record our conversation. Everything you say will be kept confidential. Your name will not be used in any reports of our research findings.

It is up to you if you wish to take part in the interview. It is up to you if you wish to answer any or all of my questions. The interview should take no longer than _____ minutes, but can be stopped by you at any point.

Do you have any questions about the purpose of the interview or how the interview will be conducted?

If you agree to participate in this interview, please sign two copies of this form – one for you to keep and one for me to take away with me as a record of your agreement to participate.

**I agree to take part in this interview**

**I agree / do not agree to this interview being tape recorded**
*(Cross out as appropriate)*

Participant's signature_____

Date _____

Interviewer's signature_____

Date _____

If you have any further queries regarding the research or issues discussed during your interview, please contact Dr_____ *(country coordinator)* at _____ *(telephone number)*.

## 7.2 Appendix 2: WHO – Assessment Instrument for Mental health Systems (AIMS)

### Survey Questionnaire

**Guide:** 1- *For questions with multiple choice responses, answer with Yes or No against each alternative.*
*You can also put "Unknown" for an item/question whose answer is not known or "Not applicable" for one that is not applicable according to the country setting.*
*2- All questions are for the previous full calendar (up to 31st December 2005) year unless otherwise specified.*

**Domain 1: Policy and Legislative Framework.**

1- What year is the last version of the country's mental health policy?

***2-*** Which of the components below are included in the mental health policy? ***(Answer with Yes, No, Unknown or Not applicable for each alternative accordingly)***

a) Organization of services: developing community mental health services
b) Organization of services: downsizing large mental hospitals
c) Organization of services: developing a mental health component in PHC
d) Human resources
e) Involvement of *users* and families
f) Advocacy and promotion
*g) Human rights protection of users*
h) Equity of access to mental health services across different groups
i) Financing
j) Quality improvement
k) Monitoring system

***3-*** Which of the following categories of psychotropic medicines are included on the essential medicines list?***(Answer with Yes, No, Unknown or Not applicable for each alternative accordingly)***

a) Antipsychotics
b) Anxiolytics
c) Antidepressants
d) Mood stabilizers
e) Antiepileptic drugs

4- What year is the last version of the mental health plan?

***5-*** Which of the following components are included in the mental health plan? ***(Answer with Yes, No, Unknown or Not applicable for each alternative accordingly)***

a) Organization of services: developing community mental health services
b) Organization of services: downsizing large mental hospitals
c) Organization of services: reforming mental hospitals to provide more
d) Comprehensive care
e) Organization of services: developing a mental health component in PHC
f) Human resources
g) Involvement of *users* and families
h) Advocacy and promotion
i) *Human rights protection of users*
j) Equity of access to mental health services across different groups
k) Financing
l) Quality improvement
m) Monitoring system

***6-*** Which of the following strategies are included in the last mental health plan? ***(Answer with Yes, No, Unknown or Not applicable for each alternative accordingly)***

A- Budget is mentioned in the last mental health plan

B- A timeframe is mentioned in the last mental health plan
C- Specific goals are mentioned in the last mental health plan
D- Have any of the goals identified in the last mental health plan been reached within the last calendar year?

7- What year is the last version of a disaster/emergency preparedness plan for mental health in emergencies? *(A disaster preparedness plan may be part of the mental health plan, health plan or a separate document)*

8- What year is the last version of mental health legislation?

***9-*** Which of the following components are included in the legislation on mental health? ***(Answer with Yes, No, Unknown or Not applicable for each alternative accordingly)***

a) Access to mental health care including access to the least restrictive care
b) Rights of mental health service consumers, family members, and other care givers
c) Competency, capacity, and guardianship issues for people with mental illness
d) Voluntary and involuntary treatment
e) Accreditation of professionals and facilities
f) Law enforcement and other judicial system issues for people with mental illness
g) Mechanisms to oversee involuntary admission and treatment practices
*h)* Mechanisms to implement the provisions of *mental health legislation*

***10-*** In how many of the components of the mental health legislation do procedures and standardized documentation exist? (these may include guidance on procedures, instruments or forms of use) ***(Tick only one response that applies)***

A- No components of the mental health legislation
B- A few components of the components of the mental health legislation
C- Some components of the mental health legislation
D- The majority of the components of the mental health legislation
E- All or almost all components of the mental health legislation
F- Unknown
G- Not applicable

***11-*** Do national level or regional level bodies for assessing human rights protection of users exist that have the authority to do the following? ***(Answer with Yes, No, Unknown or Not applicable for each alternative accordingly)***

1) Oversee regular inspections in mental health facilities
2) Review involuntary admission and discharge procedures
3) Review complaints investigation processes
4) The review body has the authority to impose sanctions (e.g. withdraw accreditation, impose penalties, or close facilities that persistently violate human rights).

12- How many mental hospitals, *out of the existing total number* had at least a one yearly external review/inspection of human rights protection of patients?
(Such a review is one that is conducted by an external body, independent of the mental health facility)

13- How many community-based inpatient psychiatric units and community residential facilities *out of the existing total number* had at least one yearly external review/inspection of human rights protection for patients?
(Such a review is one that is conducted by an external body, independent of the mental health facility)

14- How many mental hospitals have had at least a one-day training meeting or other types of working sessions on human rights protection of patients in the last 2 years?

15- How many community based inpatient and community residential facilities have had at least a one-day training meeting or other types of working sessions on human rights protection of patients in the last 2 years?

*16-* How much money was spent on mental health services *out of the total government expenditure on health?*

*17-* How much money was spent on mental hospitals services *out of the total government expenditure on mental health services?*

18- How much coverage did mental disorders have in the social insurance schemes?
   A- No mental disorder is covered by social insurance schemes
   B- Only severe mental disorders are covered by social insurance schemes
   C- All severe and some mild mental disorders are covered
   D- All mental disorders are covered
   E- All mental disorders and all mental health problems of clinical concern are covered
   F- Unknown
   G- Not applicable
19- What proportion of the population had free access to essential psychotropic medicines? (Number that has free access out of the general population)
   Note: Free access means that either the drugs are provided at no cost or there is reimbursement of more than 80% of the cost.
20- What was the proportion of the daily minimum wage needed to pay for one day's antipsychotic medication by a user without any reimbursement, using the cheapest available antipsychotic drug? (cost of one day of antipsychotic medication divided by *one day minimum wage*)
21- What was the cost of one day's antidepressant medication by a user without any reimbursement, using the cheapest available antidepressant drug?

**Domain 2: Mental Health Services**

22- Is there a national/<u>regional</u> mental health authority in existence?
   *(Mental health authority is an organizational entity responsible for mental health care within a country or region)*
   b) I s the authority involved in the following*: (For each alternative, answer with Yes, No or Not applicable)*
      1- Providing advice to the government on mental health policies and legislation
      2- Mental health service planning
      3- Mental health service management
      4- Monitoring and quality assessment of mental health services
23- Are there catchment areas or service areas as a way of organizing mental health services to the communities?
   *(A catchment/service area is a defined geographical area whose residents have access to mental health services from assigned facilities located in the area)*
24- What was the number of mental health hospitals organizationally integrated with mental health outpatient facilities?
25- What was the number of mental health outpatient facilities available in the country?
26- What was the number of users treated through mental health outpatient facilities?
27- What was the number of female users treated through mental health outpatient facilities?
28- What was the number of the users treated through mental health outpatient facilities for the following ICD-10 diagnoses?
   1) Mental and behavioural disorders due to psychoactive substance use
   2) Schizophrenia, schizotypal and delusional disorders
   3) Mood [affective] disorders
   4) Neurotic, stress-related and somatoform disorders
   5) Disorders of adult personality and behaviour
   6) Other (e.g. epilepsy, organic mental disorders, mental retardation, behavioural and emotional disorder with onset usually occurring in childhood and adolescence, disorders of psychological development)
   7) Unknown
   8) Not applicable
29- What was the cumulative number of outpatient contacts provided in the previous year through mental health outpatient facilities?

30- What was the number of children and adolescents (17 years and below) among users treated through mental health outpatient facilities?
31- What was the number of available outpatient mental health facilities for children and adolescents only?
32- How many mental health outpatient facilities provided routine follow-up and community care?
33- How many mental health outpatient facilities had mobile clinic teams that provided regular mental health care outside of the mental health facility?
34- What was the number of mental health day treatment facilities available?
35- What was the number of users treated in mental health day treatment facilities?
36- What was the number of female users treated in mental health day treatment facilities?
*37*- What was the cumulative number of days on which users were present in mental health day treatment facilities in the previous year*? (This is the sum of the number of days across all users and across all day treatment facilities)*
38- What was the number of children and adolescents (users 17 years and below) treated in the mental health day treatment facilities?
39- What was the number of available mental health day treatment facilities for children and adolescents only?
40- How many community-based psychiatric inpatient units were available?
41- What was the total number of beds in community-based psychiatric inpatient units available?
*42*- What was the number of female admissions to community-based psychiatric inpatient units *out of the total number of admissions?*
43- What was number of admissions to community-based psychiatric inpatient units for each of the ICD-10 diagnoses below?
    1) Mental and behavioural disorders due to psychoactive substance use
    2) Schizophrenia, schizotypal and delusional disorders
    3) Mood [affective] disorders
    4) Neurotic, stress-related and somatoform disorders
    5) Disorders of adult personality and behaviour
    6) Other (e.g. epilepsy, organic mental disorders, mental retardation, behavioural and emotional disorder with onset usually occurring in childhood and adolescence, disorders of psychological development)
    7) Unknown
    8) Not applicable
44- What was the number of involuntary admissions to community-based psychiatric inpatient units?
45- What was the average number of days spent in community-based psychiatric inpatient units per discharge?
46- What is the percentage of patients who were physically restrained or secluded at least once in the past year in community-based psychiatric inpatient units?
        A- Over 20%
        B- 11-20%
        C- 6-10%
        D- 2-5%
        E- 0-1%
        F- Unknown
47- What was the number of children and adolescent admissions to community-based psychiatric inpatient units?
48- How many of the community-based psychiatric inpatient beds were for children and adolescents only?
49- What was the number of community residential facilities available?
50- What was the number of beds in the community residential facilities***?***
51- What was the number of users treated in community residential facilities?

52- What proportion were the female users among all those treated in the community residential facilities? (or give number of the female users)
53- What was the average number of days spent in the community residential facility?
54- What was the number of users 17 years of age and below treated in community residential facilities?
55- What was the number of beds in the community residential facilities for children and adolescents only?
56- What was the number of mental health hospitals available?
57- What was the number of beds in the mental hospitals?
58- What is the number of beds in mental hospitals currently, and what was the number five years ago?
59- What was the number of female patients treated in the mental hospitals out of the total number of patients treated?
60- What was the number of patients treated in the mental health hospitals last year for each of the diagnostic groups below?
    1) Mental and behavioural disorders due to psychoactive substance use
    2) Schizophrenia, schizotypal and delusional disorders
    3) Mood [affective] disorders
    4) Neurotic, stress-related and somatoform disorders
    5) Disorders of adult personality and behaviour
    6) Other (e.g. epilepsy, organic mental disorders, mental retardation, behavioural and emotional disorder with onset usually occurring in childhood and adolescence, disorders of psychological development)
61- Of the total number of admissions to mental hospitals, how many were involuntary admissions?
62- What was the number of patients for each grouping of length of stay in mental hospitals below?
    Length of stay:
        1- More than 10 years
        2- 5-10 years
        3- 1-4 years
        4- Less than 1 year
63- What was the average number of days spent in mental hospitals?
64- What was the occupancy rate in the mental hospitals?
    ii- What was the cumulative number of days spent in mental hospitals (total of all patients)
65- What was the percentage of patients who were physically restrained or secluded at least once in mental hospitals last year?
        A- Over 20%
        B- 11-20%
        C- 6-10%
        D- 2-5%
        E- 0-1%
        F- Unknown
66- What was the total number of children and adolescents among the patients treated in mental hospitals?
67- What was the number of mental hospital beds that were for children and adolescents only?
68- What was the total number of beds in forensic inpatient units?
69- What was the number of beds in forensic inpatient units by type of facility?
    Type of facility:
        1- Mental hospitals
        2- Forensic units in mental hospitals
        3- Forensic units in general hospitals
        4- Prison mental health treatment facilities
70- What was the number of patients for each grouping of length of stay below?
    Length of stay:

A- More than 10 years
B- 5-10 years
C- 1-4 years
D- Less than 1 year

71- What is the number of other residential facilities within or outside the health system that provided care for people with mental disorders by type of facility as below?

Number of residential facilities:

a) Specifically for people (of any age) with mental retardation
b) Specifically for youth aged 17 years and younger with mental retardation
c) Specifically for people with substance abuse (including alcohol) problems (e.g. detoxification inpatient facilities)
d) Specifically for people with dementia that are not mental health facilities but where, nevertheless, the majority of the people residing in the facilities have diagnosable mental disorders (e.g. mental retardation, substance abuse, dementia, epilepsy, psychosis)

72- What is the number of beds in other residential facilities within or outside the health system that provided care for people with mental disorders by type of facility as below?

1- Beds in residential facilities specifically for people with mental retardation
2- Beds in residential facilities specifically for youths aged 17 years and younger with mental retardation
3- Beds in residential facilities specifically for people with substance abuse (including alcohol) problems (e.g detoxification inpatient facilities)
4- Beds in residential facilities specifically for people with dementia
5- Beds with residential facilities that formally are not mental health facilities but where, nevertheless, the majority of people residing in the facility have diagnosable mental disorders. E.g facilities for the homeless or destitute and detoxification centres.

73- What is the percentage of patients who received one or more psychosocial interventions in mental hospitals last year?

A- None
B- A few (1-20%)
C- Some (21-50%)
D- The majority (50-80%)
E- All or almost all (81-100%)
F- Unknown
G- Not applicable

74- What is the percentage of patients who received one or more psychosocial interventions in community-based psychiatric inpatient units last year?

A- None
B- A few (1-20%)
C- Some (21-50%)
D- The majority (50-80%)
E- All or almost all (81-100%)
F- Unknown
G- Not applicable

75- What is the percentage of users who received one or more psychosocial interventions in mental health outpatient facilities in the last year?

A- None
B- A few (1-20%)
C- Some (21-50%)
D- The majority (50-80%)
E- All or almost all (81-100%)
F- Unknown
G- Not applicable

76- What is the number of mental hospitals in which at least one psychotropic medicine of each therapeutic category (antipsychotic, antidepressant, mood stabilizer, anxiolytic and antiepileptic medicines) was available in the facility all year long?
77- What is the number of community-based psychiatric inpatient units in which at least one psychotropic medicine of each therapeutic category (antipsychotic, antidepressant, mood stabilizer, anxiolytic and antiepileptic medicines) was available in the facility all year long?
78- What is the number of mental health outpatient facilities in which at least one psychotropic medicine of each therapeutic category was available in the facility or in the nearby pharmacy all the year long?
79- What was the number of psychiatric beds in community-based psychiatric inpatient units and number of mental hospital beds in or near the largest city per 100,000 city population?
*80-* What was the proportionate use of mental health outpatient services by rural users in comparison to their relative sample size? *(Tick one that applies)*
    - A- Substantially under-represented in their use of outpatient services
    - B- Roughly equally represented in their use of outpatient services
    - C- Substantially over-represented in their use of outpatient services
    - D- Unknown
    - E- Not applicable
81- What was the percentage of mental health outpatient facilities that employed a specific strategy to ensure that linguistic minorities can access mental health services in a language in which they are fluent? *(Tick one that applies)*
    - A- None
    - B- A few (1-20%)
    - C- Some (21-50%)
    - D- The majority (50-80%)
    - E- All or almost all (81-100%)
    - F- Unknown
    - G- Not applicable
82- What was the proportionate use of mental health outpatient services by ethnic and religious minority groups in comparison to their relative population size? *(Tick one that applies)*
    - A- Substantially under-represented in their use of outpatient services
    - B- Roughly equally represented in their use of outpatient services
    - C- Substantially over-represented in their use of outpatient services
    - D- Unknown
    - E- Not applicable
83- What was the proportionate number of ethnic and religious group admissions to mental hospitals in comparison to their relative population size? *(Tick one that applies)*
    - A- Substantially larger proportion of admissions to mental hospitals
    - B- Roughly equal proportion of admissions to mental hospitals
    - C- Substantially smaller proportion of admissions to mental hospitals
    - D- Unknown
    - E- Not applicable
*84-* Is there a substantial difference (i.e greater than 50%) between government administered and private mental health care facilities on selected indicators of care below? (*for each alternative, answer with Yes, No, Unknown or Not applicable)*
    - A- Average duration of the waiting list for an initial non-emergency psychiatric outpatient appointment
    - B- Average number of minutes of an outpatient consultation with a psychiatrist
    - C- Average number of beds per nurse in psychiatric inpatient facilities.

**Domain 3: Mental Health in PHC**

85- What was the number of undergraduate training hours devoted to psychiatry and mental health-related subjects for medical doctors out of the total number of undergraduate training

hours for medical doctors in university? *(for total, count both theoretical and practical training)*

86- What was the number of primary health care doctors with at least two days of refresher training in psychiatry/mental health out of the total number of primary health care doctors who were working in primary health care clinics last year?

87- In how many of the physician-based primary health care clinics were assessment and treatment protocols for key mental health conditions available? ***(Tick one that applies)***

- A- No physician-based primary health care clinic (0%)
- B- A few physician-based primary health care clinics (1-20%)
- C- Some physician-based primary health care clinics (21-50%)
- D- The majority of physician-based primary health care clinics (51-80%)
- E- All or almost all physician-based primary health care clinics (81-100%)
- F- Unknown
- G- Not applicable

88- How many full-time primary health care doctors made on average at least one referral per month to a mental health professional? ***(Tick one that applies)***

- A- None (0%)
- B- A few (1-20%)
- C- Some (21-50%)
- D- The majority (50-80%)
- E- All or almost all (81-100%)
- F- Unknown
- G- Not applicable

89- How many primary health care doctors got into interaction with a mental health professional at least monthly last year*? (Interaction includes meetings, review of individual cases, coordination of activities and referral issues as well as mental health training sessions)* ***(Tick one that applies)***

- A- None (0%)
- B- A few (1-20%)
- C- Some (21-50%)
- D- The majority (50-80%)
- E- All or almost all (81-100%)
- F- Unknown
- G- Not applicable

90- To what extent do health regulations authorize primary health care doctors to prescribe and/or to continue prescription of psychotropic medicines? ***(Tick one that applies)***

- A- Not allowed
- B- PHC doctors are allowed to prescribe but with restrictions (e.g they are not allowed to initiate prescription but are allowed to continue prescription, or they are allowed to continue prescription, or they are allowed to prescribe in emergencies only)
- C- PHC doctors are allowed to prescribe without restrictions
- D- Not applicable

91- What is the percentage of physician based health care clinics in which at least one psychotropic medicine of each therapeutic category was available in the facility or in the nearby pharmacy all year long? *(Tick one that applies)*

- A- None of the clinics (0%)
- B- A few of the clinics (1-20%)
- C- Some of the clinics (21-50%)
- D- The majority of the clinics (50-80%)
- E- All or almost all of the clinics (81-100%)
- F- Unknown
- G- Not applicable

92- What is the number of undergraduate training hours that were devoted to psychiatry and mental health-related subjects in nursing schools *out of the total number of undergraduate training hours? (for total, count both theoretical and practical training)*

93- What is the number of training hours that were to devoted psychiatry and mental health-related subjects for non-doctor/non-nurse primary health care workers in colleges/vocational schools *out of the total number of training hours? ( for total, count both theoretical and practical training)*

94- What is the number of primary health care nurses who got at least two days of refresher training in psychiatry/mental health in the last year out of the total number of PHC nurses who were working in PHC clinics by the end of the year?

95- What is the number of non-doctor/non-nurse primary health care workers who got at least two days of refresher training in psychiatry/mental health in last year out of their total number?

*96*- In how many non-physician-based primary health care clinics were assessment and treatment protocols for key mental health conditions available*? (Assessment and treatment protocols include clinical guidelines, manuals or videos on mental health for PHC staff)*

97- How many full-time primary care providers in non-physician-based primary health care clinics made on average at least one mental health referral to a higher level of care per month?

A- None (0%)
B- A few (1-20%)
C- Some (21-50%)
D- The majority (50-80%)
E- All or almost all (81-100%)
F- Unknown
G- Not applicable

98- How many of the non-physician-based primary health care clinics had at least one psychotropic medicine of each therapeutic category available in the facility or nearby pharmacy all year long?

A- None of the clinics (0%)
B- A few of the clinics (1-20%)
C- Some of the clinics (21-50%)
D- The majority of the clinics (50-80%)
E- All or almost all of the clinics (81-100%)
F- Unknown
G- Not applicable

99- To what extent do health regulations authorize primary health care nurses to prescribe and/or to continue prescription of psychotropic medicines?

A- Not allowed
B- PHC nurses are allowed to prescribe but with restrictions (e.g they are not allowed to initiate prescription but are allowed to continue prescription, or they are allowed to continue prescription, or they are allowed to prescribe in emergencies only)
C- PHC nurses are allowed to prescribe without restrictions
D- Not applicable

100- To what extent do health regulations authorize non-doctor/non-nurse primary health care workers to prescribe and/or to continue prescription of psychotropic medicines?

A- Not allowed
B- Non-doctor/non-nurse PHC workers are allowed to prescribe but with restrictions (e.g they are not allowed to initiate prescription but are allowed to continue prescription, or they are allowed to continue prescription, or they are allowed to prescribe in emergencies only)
C- Non-doctor/non-nurse PHC workers are allowed to prescribe without restrictions

D- Not applicable

101- How many physician-based primary health care clinics got involved into interaction with complementary/alternative/traditional practitioners at least once in the last year?
- A- None (0%)
- B- A few (1-20%)
- C- Some (21-50%)
- D- The majority (50-80%)
- E- All or almost all (81-100%)
- F- Unknown
- G- Not applicable

102- How many non-physician-based primary health care clinics got involved into interaction with complementary/alternative/traditional practitioners at least once in the last year?
- A- None (0%)
- B- A few (1-20%)
- C- Some (21-50%)
- D- The majority (50-80%)
- E- All or almost all (81-100%)
- F- Unknown
- G- Not applicable

103- How many mental health facilities were in interaction with complementary alternative/traditional practitioners at least once in the last year?
- A- None (0%)
- B- A few (1-20%)
- C- Some (21-50%)
- D- The majority (50-80%)
- E- All or almost all (81-100%)
- F- Unknown
- G- Not applicable

**Domain 4: Human Resources**

104- What was the number of human resources working in or for mental health facilities or private practice by profession as below?
- A- Psychiatrists
- B- Other medical doctors not specialized in psychiatry
- C- Nurses
- D- Psychologists
- E- Social workers
- F- Occupational therapists
- G- Psychiatric clinical officers
- H- Other health or mental health workers (including auxiliary staff, non-doctor/non-physician primary health care workers, health assistants, medical assistants, professional and paraprofessional psychosocial counselors)

105- What was the number of psychiatrists working in each mental health sector below out of the total number of psychiatrists working in mental health?
- 1- Only in or for government-administered mental health facilities
- 2- Only in or for mental health NGOs/for profit mental health facilities/private practice
- 3- For both government-administered facilities as well as private practice

106- What was the number of psychologists, social workers, PCOs, nurses and occupational therapists working in each mental health sector below out of the total number of all of them working in mental health?
- A- Only in or for government-administered mental health facilities

B- Only in or for mental health NGOs/for profit mental health facilities/private practice
C- For both government-administered facilities as well as private practice

107- What was the number of full-time or part-time mental health professionals working in or for mental health outpatient facilities?
Number of mental health professionals:
A- Psychiatrists
B- Other medical doctors not specialized in psychiatry
C- Nurses
D- Psychologists
E- Social workers
F- Occupational therapists
G- Psychiatric clinical officers
H- Other health or mental health workers

108- What was the number of full-time or part-time mental health professionals working in community-based psychiatric inpatient units?
Number of mental health professionals:
A- Psychiatrists
B- Other medical doctors not specialized in psychiatry
C- Nurses
D- Psychologists
E- Social workers
F- Occupational therapists
G- Psychiatric clinical officers
H- Other health or mental health workers

109- What was the number of full-time or part mental health professionals in the mental hospitals?
A- Psychiatrists
B- Other medical doctors not specialized in psychiatry
C- Nurses
D- Psychologists
E- Social workers
F- Occupational therapists
G- Psychiatric clinical officers
H- Other health or mental health workers

*110*- What was the number of psychiatrists working in mental health facilities that are based in or near the largest city per 100,000 city population out of the number of psychiatrists working in mental health facilities in the entire country per 100,000 country population? *(Choose the largest city in terms of population. Exclude professionals exclusively engaged in private practice)*

111- What was the number of nurses working in mental health facilities that are based in or near the largest city per 100,000 city population out of the number of nurses working in mental health facilities in the entire country per 100,000 country population? *(Choose the largest city in terms of population)*

112- What is the number of professionals who graduated in the last year in academic and educational institutions?
Number of mental health professionals:
A- Medical doctors
B- Nurses
C- Psychiatrists
D- Psychologists with at least 1 year training in mental health care
E- Nurses with at least 1 year training in mental health care
F- Social workers with at least 1 year training in mental health care
G- Occupational therapists with at least 1 year training in mental health care
H- Psychiatric clinical officers

113- What is the number of mental health staff by profession as below working in or for mental health facilities who got at least two days of refresher training on the rational use of psychotropic drugs in the last year? *(One day training is equivalent to 8 hours)*
    1- Psychiatrists
    2- Other medical doctors, not specialized in psychiatry
    3- Nurses
    4- Psychiatric clinical officers
    5- Other mental health workers

114- What is the number of mental health staff by profession as below working in or for mental health facilities who got at least two days of refresher training on psychosocial interventions in the last year?
*(One day training is equivalent to 8 hours)*
    1- Psychiatrists
    2- Other medical doctors, not specialized in psychiatry
    3- Nurses
    4- Psychologists, social workers and occupational therapists
    5- Psychiatric clinical officers
    6- Other mental health workers

115- What is the number of mental health staff by profession as below working in or for mental health facilities that got at least two days of refresher training in child and adolescent mental health issues in the last year? *(One day training is equivalent to 8 hours)*
    1- Psychiatrists
    2- Other medical doctors, not specialized in psychiatry
    3- Nurses
    4- Psychologists, social workers and occupational therapists
    5- Psychiatric clinical officers
    6- Other mental health workers

116- What is the proportion of psychiatrists who emigrate to other countries within 5 years of the completion of their training?
    A- None (0%)
    B- A few (1-20%)
    C- Some (21-50%)
    D- The majority (50-80%)
    E- All or almost all (81-100%)
    F- Unknown
    G- Not applicable

117- What is the aggregate number of users/consumers that were members of consumer associations?

118- What is the aggregate number of family members that were members of family associations?

119- Does government provide economic support to user/consumer associations for mental health initiatives?

120- Does government provide economic support to family associations for mental health initiatives?

121- Were the user/consumer associations involved in the formulation or implementation or mental health policies and plans or legislation in the last two years?

122- Were the family associations involved in the formulation or implementation or mental health policies and plans or legislation in the last two years?

123- How much interaction was there between mental health facilities and user/consumer associations in the last year?
    A- No interaction (0% of facilities)
    B- A few facilities have had interaction (1-20% of facilities)
    C- Some facilities have had interaction (21-50% of facilities)
    D- A majority of facilities have had interaction (51-80% of facilities)

E- All or almost all facilities have had interaction (81-100%)
F- Unknown
G- Not applicable

124- How much interaction was there between mental health facilities and family associations last year?

A- No interaction (0% of facilities)
B- A few facilities have had interaction (1-20% of facilities)
C- Some facilities have had interaction (21-50% of facilities)
D- A majority of facilities have had interaction (51-80% of facilities)
E- All or almost all facilities have had interaction (81-100%)
F- Unknown
G- Not applicable

125- What is the number of user/consumer associations that were involved in community and individual assistance activities e.g counseling, housing, support groups etc?

126- What is the number of family associations that were involved in community and individual assistance activities e.g counseling, housing, support groups etc?

127- What is the number of other NGOs involved in policies, legislation or mental health advocacy?

128- What is the number of other NGOs involved in community and individual assistance activities e.g counseling, housing, support groups etc?

**Domain 5: Public Education and Links with Other Sectors**

129- Are there some bodies for coordinating public education and awareness campaigns on mental health and mental disorders?

*130*- Have the agencies/institutions below promoted public education and awareness campaigns on mental health and mental disorders in the last five years? *(for each agency, answer with Yes, No or Unknown)*

1- Government agencies (e.g MOH or Department of mental health services)
2- NGOs
3- Professional associations
4- Private trusts and foundations
5- International agencies

131- What populations have been targeted by public education and awareness campaigns on mental health in the last five years? *(for each alternative, answer with Yes, No or Unknown)*

Campaigns exist targeted at:

A- The general population
B- Children
C- Adolescents
D- Women
E- Trauma survivors
F- Ethnic groups
G- Other vulnerable or minority groups

132- What professional groups have been targeted by specific education and awareness campaigns on mental health in the last five years? *(for each alternative, answer with Yes, No or Unknown)*

Campaigns exist targeted at:

A- Health care providers (conventional, modern, allopathic)
B- Complementary/alternative/traditional sector
C- Teachers
D- Social services staff
E- Leaders and politicians
F- Other professional groups linked to the health sector

*133*- Is there any legislative provisions concerning a legal obligation for employers to hire a certain percentage of employees that are mentally disabled*? (Tick one that applies)*

A- No such legislative provisions exist
B- Legislative provisions exist but are not enforced
C- Legislative provisions exist and are enforced

134- Is there any legislative provision for protection from discrimination at work (dismissal, lower wages etc) solely on account of mental disorder?

A- No such legislative provisions exist
B- Legislative provisions exist but are not enforced
C- Legislative provisions exist and are enforced

135- Is there any legislative or financial provision concerning priority in state housing and in subsidized housing schemes for people with severe mental disorder?

A- No such legislative provisions exist
B- Legislative provisions exist but are not enforced
C- Legislative provisions exist and are enforced

136- Is there any legislative or financial provision concerning protection from discrimination in allocation of housing for people with severe mental disorder?

A- No such legislative provisions exist
B- Legislative provisions exist but are not enforced
C- Legislative provisions exist and are enforced

*137*- Are there any formal collaborative programmes addressing the needs of people with mental health issues between the department responsible for mental health and departments/agencies responsible for the following? *(for each alternative, answer with Yes, No or Unknown)*

A- Primary health care/community health
B- HIV/AIDS
C- Reproductive health
D- Child and adolescent health
E- Child protection
F- Education
G- Employment
H- Housing
I- Welfare
J- Criminal justice
K- The elderly
L- Other departments/agencies (please specify)

**Note: Here a formal collaborative programme is one that involves a written agreement of collaboration and/or joint activity or publication**

138- In how many mental health facilities did users have access to programmes that provide employment through activities outside the mental health facility?

A- None (0%)
B- A few mental health facilities (1-20%)
C- Some mental health facilities (21-50%)
D- The majority of the mental health facilities (50-80%)
E- All or almost all mental health facilities (81-100%)
F- Unknown
G- Not applicable

139- What is the proportion of primary and secondary schools with either a part-time or full-time mental health professional (e.g Psychologist, Social worker, Nurse specialized in mental health)?
(Give number of those that have out of the total number of primary and secondary schools)

140- How many primary and secondary schools had school-based activities to promote mental health and prevent mental disorders in place? ***(Tick one that applies)***

***(Examples of such activities include those aimed at improving social skills, emotional communication, stress management and skills for coping with adversity)***
Promotion or prevention activities are provided in:

A- No primary and secondary schools (0%)
B- A few primary and secondary schools (1%-20%)
C- Some primary and secondary schools (21%-50%)
D- Majority of primary and secondary schools (51%-80%)
E- All or almost all primary and secondary schools (81%-100%)
F- Unknown

141- How many police officers have participated in educational activities on mental health in the last five years? ***(Tick one that applies)***

A- No police officers (0%)
B- Few police officers (1%-20%)
C- Some police officers (21%-50%)
D- Majority of police officers (51%-80%)
E- All or almost all police officers (100%)
F- Unknown

142- How many judges and lawyers have participated in educational activities on mental health in the last five years? ***(Tick one that applies)***

A- No judges and lawyers (0%)
B- Few judges and lawyers (1%-20%)
C- Some judges and lawyers (21%-50%)
D- Majority of judges and lawyers (51%-80%)
E- All or almost all judges and lawyers (100%)
F- Unknown

143- What is the percentage of prisoners with psychotic illness? ***(Tick one that applies)***

A- Less than 2%
B- 2-5%
C- 6-10%
D- 11-15%
E- Greater than 15%
F- Unknown

144- What is the percentage of prisoners with mental retardation?

A- Less than 2%
B- 2-5%
C- 6-10%
D- 11-15%
E- Greater than 15%
F- Unknown

145- What is the percentage of prisons who had at least one prisoner per month in treatment contact with a mental health professional, either within the prison or outside in the community?

A- No prisons (0%)
B- A few prisons (1%-20%)
C- Some prisons (21%-50%)
D- Majority of prisons (51%-80%)
E- All or almost all prisons (100%)
F- Unknown

146- What is the number of people who received social welfare benefits because of disability due to mental disorder out of the total number that received social welfare benefits due to disability of any kind?
*(Social welfare benefits are benefits from public funds that are payable, as part of a legal right, to people with health conditions that reduce a person's capacity to function. They are also called disability pensions)*

**Domain 6: Monitoring and Research**

147- Is there a formally defined list of individual data items that ought to be collected by all mental health facilities?

148- What is the number of mental hospitals that routinely collected and compiled data by type of information as below?

- A- Number of beds
- B- Number of inpatient admissions
- C- Number of days spent in hospital
- D- Number of involuntary inpatient admissions
- E- Number of user who are physically restrained or secluded
- F- Diagnoses
- G- Unknown

149- What is the number of community-based psychiatric inpatient units that were involved in routinely collecting and compiling data by type of information as below?

- A- Number of beds
- B- Number of inpatient admissions
- C- Number of days spent in hospital
- D- Number of involuntary inpatient admissions
- E- Number of user who are physically restrained or secluded
- F- Diagnoses
- G- Unknown

150- What is the number of mental health outpatient facilities that routinely collected and compiled data by each type of information as below?

- A- Number of users treated
- B- Number of user contacts
- C- Diagnoses

151- What is the number of mental health facilities from which the government health department received data last year?

- 1- Mental hospitals
- 2- Community-based psychiatric inpatient units
- 3- Mental health outpatient facilities

152- Is there a report covering mental health data that has been published by the government health department in the last year?

- A- No report
- B- Mental health data have been published in a report without comments on the data
- C- Mental health data have been published in a report with comments on the data
- D- Unknown

153- What is the percentage of mental health professionals working in mental health services who in the last five years have been involved in mental health research as investigators or co-investigators (including through a dissertation or thesis)

- A- Psychiatrists
- B- Psychologists
- C- Social workers
- D- Nurses
- E- Others

***(None = 0%, few = 1%-20%, some = 21%-50%, the majority = 51%-80%, all or almost all = 100%, UN = Unknown***)

*154-* What is the total number of mental health publications on the country or region in the last five years as identified on PubMed out of the total number of health publications on the country? (*proportion of indexed mental health publication)*
(Studies need to involve respondents of the country or region though Investigators may be foreign researchers)

155- What is the type of mental health research that was conducted in the last five years?

A- Epidemiological studies in community samples
B- Epidemiological studies in clinical samples
C- Non-epidemiological clinical/questionnaires assessments of mental disorders
D- Services research
E- Biology and genetics
F- Policy, programmes, financing/economics
G- Psychosocial interventions/psychotherapeutic interventions
H- Pharmacological, surgical and electroconvulsive interventions
I- Unknown

## Definitions from WHO-AIMS

**Bed:** A bed that is continuously available for use by people with mental disorders for round the clock (day and night) care.
**Community-based facility:** A mental health facility outside of a *mental hospital*.
**Community-based psychiatric inpatient unit:** A psychiatric unit that provides inpatient care for the management of mental disorders within a *community-based facility*. These units are usually located within general hospitals, they provide care to *users* with acute problems, and the period of stay is usually short (weeks to months).
**Includes:** Both public and private non-profit and for-profit facilities; *community-based psychiatric inpatient units* for children and adolescents only; *community-based psychiatric inpatient units* for other specific groups (e.g. elderly).
**Excludes**: *Mental hospitals*; *community residential facilities*; facilities that treat only people with alcohol and substance abuse disorder or mental retardation.
**Community residential facility:** A non-hospital, community-based mental health facility that provides overnight residence for people with mental disorders. Usually these facilities serve *users* with relatively stable mental disorders not requiring intensive medical interventions.
**Includes:** Supervised housing; un-staffed group homes; group homes with some residential or visiting staff; hostels with day staff; hostels with day and night staff; hostels and homes with 24-hour nursing staff; halfway houses; therapeutic communities. Both public and private non-profit and for-profit facilities are included. *Community residential facilities for children and adolescents only* and *community residential facilities* for other specifics groups (e.g. elderly) are also included.
**Excludes:** Facilities that treat only people with a diagnosis of alcohol and substance abuse disorder or mental retardation; residential facilities in *mental hospitals*; generic facilities that are important for people with mental disorders, but that are not planned with their specific needs in mind (e.g. nursing homes and rest homes for elderly people, institutions treating mainly neurological disorders, or physical disability problems).
**Community residential facility for children and adolescents only:** A facility that meets the definition for *community residential facility* and exclusively serves children or adolescents.
**Excludes:** Facilities for children with social problems (e.g. orphans, children from disrupted families) but without necessarily a mental disorder.

**Complementary/alternative/traditional practitioner:** A practitioner who primarily practices traditional or complementary/alternative medicine rather than allopathic/modern medicine.

**Forensic inpatient unit:** An inpatient unit that is exclusively maintained for the evaluation or treatment of people with mental disorders who are involved with the criminal justice system. These units can be located in *mental hospitals,* general hospitals, or elsewhere.

**Human rights protection of users/patients:** Action related to the following issues to ensure the protection of *users*' human rights: least restrictive care, informed consent to treatment, confidentiality, avoidance of restraint and seclusion when possible, voluntary and involuntary admission and treatment procedures, discharge procedures, complaints and appeals processes, protection from abuse by staff, and
protection of *user* property.

**Medical doctor:** A health professional with a degree in modern medicine who is authorized/licensed to practice medicine under the rules of the country.

**Mental health day treatment facility:** A facility that typically provides care for *users* during the day. The facilities are generally: (1) available to groups of *users* at the same time (rather than delivering services to individuals one at a time), (2) expect *users* to stay at the facilities beyond the periods during which they have face-to-face contact with staff (i.e. the service is not simply based on *users* coming for
appointments with staff and then leaving immediately after the appointment) and (3) involve attendances that last half or one full day.

**Includes:** day centres; day care centres; sheltered workshops; club houses; drop-in centres; employment/rehabilitation workshops; social firms. Both public and private non-profit and for-profit facilities are included. *Mental health day treatment facilities for children and adolescents only* and *mental health day treatment facilities* for other specifics groups (e.g. elderly) are also included.

**Excludes:** Facilities that treat only people with a diagnosis of alcohol and substance abuse disorder or mental retardation without an accompanying mental disorder diagnosis; generic facilities that are important for people with mental disorders, but that are not planned with their specific needs in mind; day treatment facilities for inpatients are excluded.

**Mental health day treatment facility for children and adolescents only:** A facility that meets the definition for *mental health day treatment facility* and exclusively serves children or adolescents.

**Mental health legislation:** Legal provisions related to mental health. These provisions typically focus on issues such as: civil and human rights protection of people with mental disorders, treatment facilities, personnel, professional training, and service structure.

**Mental health outpatient facility:** A facility that focuses on the management of mental disorders and the clinical and social problems related to it on an outpatient basis.

**Includes:** Community mental health centres; mental health ambulatories; outpatient services for specific mental disorders or for specialized treatments; mental health outpatient departments in general hospitals; mental health policlinics; specialized NGO clinics that have mental health staff and provide mental health outpatient care (e.g. for rape survivors or homeless people). Both public and private non-profit and for-profit facilities are included. *Mental health outpatient facilities for children and adolescents only* and *mental health outpatient facilities* for other specifics groups (e.g. elderly) are also included.

**Excludes:** Private practice; facilities that treat only people with alcohol and substance abuse disorder or mental retardation without an accompanying mental disorder diagnosis.

**Mental health outpatient facility for children and adolescents only:** A facility that meets the definition for *mental health outpatient facility* and exclusively serves children or adolescents.

**Mental hospital:** A specialized hospital-based facility that provides inpatient care and long-stay residential services for people with mental disorders. Usually these facilities are independent and standalone, although they may have some links with the rest of the health care system. The level of specialization varies considerably: in some cases only long-stay custodial services are offered, in others
specialized and short-term services are also available (rehabilitation services, specialist units for children and elderly, etc.)

**Includes:** Both public and private non-profit and for-profit facilities; *mental hospitals* for children and adolescents only and *mental hospitals* for other specifics groups (e.g., elderly) are also included**.**

**Excludes:** *Community-based psychiatric inpatient units*; *forensic inpatient units* and forensic hospitals. Facilities that treat only people with alcohol and substance abuse disorder or mental retardation without an accompanying mental disorder diagnosis.

**Non-doctor/non-nurse primary health care worker**: A *primary health care clinic* staff member who provides basic health services and links with other aspects of the health care system. These staff members include medical assistants, aide-level workers, multi-purpose health workers, health assistants, community health workers, among others. The training and functions of these workers vary across countries, but are usually less than those for doctors and *nurses*. Doctors, *nurses* and other health professionals may supervise their work.

**Non-physician based primary health care clinic:** A *primary health care clinic* without a *primary health care doctor* as part of their regular staff.

**Number of admissions:** The *number of admissions* in one year is the sum of all admissions to the facility within that year. In WHO-AIMS, this number is a duplicated count. In other words, if one user is admitted twice, it is counted as two admissions.

**Number of patients treated in a *mental hospital:*** (a) the *number of patients* in the *mental hospital* at the beginning of the year plus (b) the *number of admissions* during the year.

**Number of *users* treated in a *community residential facility*:** (a) the number of *users* in the facility at the beginning of the year plus (b) the *number of admissions* to the facility during the year.

**Number of *users* treated through a *mental health day treatment facility*:** The number of *users* with at least one attendance for treatment at the facility within the year.

**Number of *users* treated in a *mental health outpatient facility*:** The number of *users* with at least one outpatient contact with the facility. A contact refers to a mental health intervention provided by a staff member of a *mental health outpatient facility*, whether the intervention occurs within the facility or elsewhere.

**Nurse:** A health professional having completed a formal training in nursing at a recognized, universitylevel school for a diploma or degree in nursing.

**Occupational therapist:** A health professional having completed a formal training in occupational therapy at a recognized, university-level school for a diploma or degree in occupational therapy.

**Other health or mental health worker:** A health or mental health worker that possesses some training in health care or mental health care but does not fit into any of the defined professional categories (e.g.
*medical doctors, nurses, psychologists, social workers, occupational therapists*).

**Includes:** *Non-doctor/non-nurse primary care workers*, professional and paraprofessional psychosocial counsellors, special mental health educators, and auxiliary staff

**Excludes:** This group does not include general staff for support services within health or mental health care settings (e.g. cooking, cleaning, security).

**Other residential facility:** A residential facility that houses people with mental disorders but does not meet the definition for *community residential facility* or any other mental health facility defined for this instrument (*community-based psychiatric inpatient unit, community residential facility, forensic inpatient unit, mental hospital*).

**Includes:** Residential facilities specifically for people with mental retardation, for people with substance abuse problems, or for people with dementia. Included are also residential facilities that formally are not mental health facilities but where, nevertheless, the majority of the people residing in the facilities have diagnosable mental disorders.

**Physician-based primary health care clinic:** A *primary health care clinic* with *primary health care doctors* as part of their regular staff.

**Primary health care clinic:** A clinic that often offers the first point of entry into the health care system. *Primary health care clinics* usually provide the initial assessment and treatment for common health conditions and refer those requiring more specialized diagnosis and treatment to facilities with staff with a higher level of training.

**Primary health care doctor:** A general practitioner, family doctor, or other non-specialized medical doctor working in a *primary health care clinic*.

**Primary health care nurse:** A nurse working in a *primary health care clinic*.

**Psychiatrist:** A *medical doctor* who has had at least two years of post-graduate training in psychiatry at a recognized teaching institution. This period may include training in any sub-specialty of psychiatry.

**Psychologist**: A professional having completed a formal training in psychology at a recognized, university-level school for a diploma or degree in psychology. WHO-AIMS asks for information only on *psychologists* working in mental health care.

**Psychosocial intervention**: An intervention using primarily psychological or social methods for the treatment and/or rehabilitation of a mental disorder or substantial reduction of psychosocial distress.

**Includes**: psychotherapy; counselling; activities with families; psycho-educational treatments; the provision of social support; rehabilitation activities (e.g. leisure and socializing activities, interpersonal and social skills training, occupational activities, vocational training, sheltered employment activities).

**Excludes**: Do not include intake interviews; assessment; follow-up psychopharmacology appointments as psychosocial interventions.

**Public education and awareness campaign:** An organized, coordinated effort to educate the public and raise their awareness about issues related to mental health using a variety of tools (e.g. media, brochures, face-to-face initiatives).

**Excludes:** Commercial advertisements (e.g. by pharmaceutical companies); advertisements for research studies.

**Refresher training in psychiatry/mental health:** The provision of essential knowledge and skills in the identification, treatment, and referral of people with mental disorders. *Refresher training* occurs after university (or vocational school) degree training. Eight hours of training is equivalent to one day of training.

**Includes:** In-service training.

**Excludes:** Training exclusively in neurology.

**Social worker:** A professional having completed a formal training in social work at a recognized, university-level school for a diploma or degree in social work. WHO-AIMS asks for information only on *social workers* working in mental health care.

**User/Consumer/Patient:** A person receiving mental health care. These terms are used in different places and by different groups of practitioners and people with mental disorders, and are used synonymously in WHO-AIMS.

## 7.3 Appendix 3: WHO CHECKLIST FOR EVALUATING A MENTAL HEALTH POLICY.

**Introduction**

Once a policy/draft policy has been drawn up in a country, it is important to conduct an assessment of whether certain processes have been followed that are likely to lead to the success of the policy; and whether various content issues have been addressed and appropriate actions included in the policy. This checklist is intended to assist with this evaluation.

While the checklist is limited in that it does not enable assessment of the *quality* of the processes or contents of the policy, evaluators are encouraged, when completing the checklist, to consider the *adequacy* of both the process and content. Particularly where a response is "no" or "to some extent", it is suggested that they provide either an action plan to remedy the situation or a comment.. (In some instances the comment may, for example, merely be that a particular action is covered in a different policy, or that it is not possible to implement given the current resources available). The different modules in the WHO *Mental Health Policy and Service Guidance Package* can be consulted for more guidance on how to address relevant sections and for a better understanding of the policy issues mentioned in the checklist.

This checklist may usefully be completed by those who drafted the policy and/or by employees in the government itself. However, it is also important to have *independent reviewers.* Those involved in drawing up the policy may have personal or political interests or may be "too close" to the policy to see anomalies or provide critical input. Ideally, therefore, an independent multidisciplinary team should be convened to conduct an evaluation. A team is also advantageous as no single person is likely to have all the relevant information required, and debate is crucial for arriving at an optimal policy for the country. Furthermore, when relevant interest groups have been involved in the process of the development of the policy and/or in their evaluation, which leads to changes being made to the policy, it is likely that they will be more effectively implemented. It would be useful to include consumer organizations, family organizations, service providers, professional organizations and NGOs, as well as representatives of other government departments affected by the policy.

Finally, although the checklist should be "scored" in terms of the mental health policy document, it is important to have, or be familiar with, other relevant and related documentation. Often items are not covered in the mental health policy because they are comprehensively covered elsewhere. For example, policies on health information systems or human resources may include mental health and are therefore deliberately not repeated in the mental health policy. This explanation should then be noted in the relevant section.



**This checklist has been developed by Dr Michelle Funk, Ms Natalie Drew and Dr Faydi, Mental Health Policy and Service Development, Department of Mental Health and Substance Abuse, World Health Organisation, Prof Melvyn Freeman, Human Sciences Research Council, Pretoria, South Africa and Dr Sheila Ndyanabangi, Ministry of Health Uganda.**

| CHECKLIST FOR EVALUATING A MENTAL HEALTH POLICY | | | |
|---|---|---|---|
| Please use the following rating scale to rate each item:<br>1 = yes/ to great degree 3 = no/not at all<br>2 = to some extent 4 = unknown | **Rating** | **If "yes" or "to some extent" please state how.**<br>**If not, please state reason(s).** | **Action required (if any)** |
| ***PROCESS ISSUES*** | | | |
| 1a. Was there a high-level mandate to develop the policy (e.g. from the Minister of Health)? | **1** | Mandated the coordinator of Mental health to push on the exercise in 2000. | Need to revise and finalize the policy, currently in draft form. |
| 1b. At what level has the policy been officially approved and adopted? (e.g., the department of mental health, Ministry of Health, Cabinet, Minister of Health). | | Department level. Ministry of health top management can't approve it while still in draft form. | |
| 2. Is the policy based on relevant data: | | | |
| -- From a situation assessment? | **2** | A few baseline studies had been done independently, and findings of such studies were utilized in the process. | There is need to conduct studies specifically designed to inform policy. |
| -- From a needs assessment? | **2** | | |
| 3. Have policies relating to mental health that have been utilized within the country and in other countries with similar cultural and demographic patterns been examined and integrated where relevant? | **2** | Though no exchange was done, the team was aware of policies in some other countries and able to copy from them. | |
| 4. Has a thorough consultation process taken place with the following groups: | | | |
| -- Representatives from the Health Sector, including planning, pharmaceutical , human resource development, child health, HIV/AIDs, epidemiology and surveillance, epidemic and disaster preparedness divisions. | 2 | There was representation from some departments. However, the consultation wasn't thorough at all and many stakeholders were left out. | There is need to widen the consultation at the time of revising and updating the policy. |
| -- Representatives from the Finance Ministry? | **3** | | |
| -- Representatives from Social Welfare and Housing Ministries? | **2** | | |
| -- Representatives from the criminal justice system? | **3** | | |
| -- Consumers, or representatives of consumer groups? | **2** | | |
| -- Family members or their representatives? | **3** | | |
| -- Other NGOs? | **3** | | |
| -- Private sector? | **3** | | |
| -- Any other key stakeholder groups? If so, please list them | **3** | | |
| 5. Has an exchange taken place with other countries concerning their mental health policies and experiences? | **3** | Though no exchange was done, the professionals involved in the formulation of this policy | |

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| | | brought in ideas from a few other MH policies they knew about. | |
| 6. Has relevant research been undertaken to inform policy development, (e.g. pilot studies)? | **2** | There was some baseline survey at the inception of the Health Sector Strategic Plan. Findings from this and the few other studies (not specifically policy related) were used. | There is need to have studies specifically to inform policy development. |
| **CONTENT ISSUES** | | | |
| 1. Is there a realistic vision statement? | **3** | | Overall health policy vision should be re-emphasized. |
| 2. Are values and associated principles which inform the policy included? | **1** | Emphasized a number of issues. These were however not developed out of a situational analysis. | |
| 3. Do these values and associated principles emphasize and/or promote: | | | |
| -- Human rights? | 2 | | Need emphasis |
| -- Social inclusion? | 2 | | Need emphasis |
| -- Community care? | 2 | | Need emphasis |
| -- Integration? | 1 | Reasonably emphasized | |
| -- Evidence-based practice? | 2 | Reasonably emphasized | |
| -- Intersectoral collaboration? | 1 | Reasonably emphasized | |
| -- Equity with physical health care? | 1 | Reasonably emphasized | |
| 4. Have clear objectives been defined? | | | |
| 5. Are objectives consistent: | | | |
| -- With the vision? | **1** | Consistent with the overall health sector's vision statement | |
| -- With the values and principles? | **1** | | |
| 6. Are the areas for action clearly described to indicate the main policy directions and what will be achieved? | **3** | These are mostly just implied, but is not stated clearly. | Need to state clearly the areas of action. |
| 7. Are the areas for action written in a way that commits the Government (e.g. do they state "will" instead of "should")? | **3** | | Areas need to be written in a way that commits government. |
| 8. To what extent do the areas for action comprehensively address **coordination & management?** | | | |
| (a) Does the policy specify a dedicated mental health position/post within the Ministry of Health to coordinate mental health functions and services? | **1** | At a post of Principal Medical Officer | |
| (b) Does the policy establish or refer to a multisectoral coordinating body to oversee major decisions in mental health? | **1** | | There are provisions for this, though not yet in place. |
| 9) To what extent do the areas for action comprehensively address **financing?** | | | |
| (a) Does the policy indicate how funding will be utilized to promote equitable mental health services? | **2** | Mental health has a separate budget line | |

| | | | |
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| (b) Does the policy state that equitable funding between mental health and physical health will be provided? | **3** | | |
| (c) If health insurance is utilized in the country, does the policy indicate whether/how mental health would be part of it? | **4** | | Health insurance is not yet in place. |
| 10. To what degree do the areas for action comprehensively address **legislation and/or human rights?** | | | |
| (a) Does the policy promote human rights? | **2** | The policy doesn't clearly outline the rights of the mentally ill in different situations and settings. | Could be better addressed by the mental health legislation. |
| (b) Does the policy promote the development and implementation of human-rights-oriented legislation? | **2** | | |
| (c) Is the setting up of a review body envisaged to monitor different aspects of human rights? | **2** | This is one of those activities expected of the Mental health board, but doesn't come out vividly in the areas of actions. | |
| 11. To what extent do the areas for action comprehensively address **organization of services?** | | | |
| (a) Does the policy promote the integration of mental health services into general health services? | **1** | Integration of mental health in primary health care is strongly emphasized. | These aspects need to be stated more clearly. |
| (b) Does the policy promote a community-oriented mental health approach? | **1** | | |
| (c) Does the policy promote deinstitutionalization? | **1** | Program components not yet in place | |
| 12. To what extent do the areas for action comprehensively address **promotion, prevention and rehabilitation?** Does the policy make provision for: | | A provision for interventions aimed at these is available. Institutional rehabilitation also needs to be emphasized. | Should be more specific on rehabilitation institutions, stating clearly the areas of action that commit government. |
| (a) The prevention of mental disorders? | **1** | | |
| (b) Interventions that promote mental health? | **1** | | |
| (c) Interventions for the rehabilitation of people with mental disorders? | **1** | | |
| 13. To what extent do the areas for action comprehensively address **advocacy?** | | | |
| (a) Is the policy supportive of consumers and family organizations? | **1** | | |
| (b) Is there emphasis on raising awareness of mental disorders and their effective treatment? | **1** | This is emphasized | Advocacy as an area, especially consumer groups needs more attention. |
| (c) Does the policy promote advocacy on behalf of people with mental disorders? | **1** | | |
| 14. To what extent do the areas for action comprehensively address **quality improvement?** Does the policy | | A process to measure and ensure quality of services is implied. | |

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| (a) Make a commitment to providing high quality, evidence- based interventions? | **2** | | |
| (b) Include a process to measure and improve the quality of services? | **2** | | |
| 15. To what extent do the areas for action comprehensively address **information systems?** | | | |
| (a) Will mental health information systems be set up to guide decision-making for future policy, planning and service development? | **1** | There is clear emphasis on an audit system for mental health human resource. | |
| 16. To what extent do the areas for action comprehensively address **human resources and training?** | | These items are rather implied. The policy doesn't comprehensively address the issue of human resource and training. | Need to put in place appropriate working conditions and strategies to improve recruitment and retention of mental health service providers. |
| (a) Does the policy commit to putting in place suitable working conditions for mental health providers? | **2** | | |
| (b) Have appropriate management strategies been discussed to improve recruitment and retention of mental health providers? | **2** | | |
| (c) Are training in core competencies and skills seen as central to human resources development? | **2** | | |
| 17. To what extent do the areas for action comprehensively address **research and evaluation?** | | | |
| (a) Does the policy emphasize the need for research and evaluation of services and of the policy and strategic plan? | **1** | Emphasized at all levels. | There is however no system in place to check for the success of implementation of the programme and this needs to be addressed. |
| 18. To what extent do the areas for action comprehensively address **intrasectoral collaboration** within the health sector? Does the policy:: | | | |
| (a) Emphasize collaboration with planning, pharmaceutical, human resource development, child health, HIV/AIDs, epidemiology and surveillance, epidemic and disaster preparedness divisions,.within the health sector? | **2** | The policy broadly mentions the need for coordination and cooperation at all levels. | This needs to be emphasized and come out more clearly especially in the areas of action. |
| (b) Contain clear statements of what role each department will play in each area for action? | **3** | | Should be stated clearly. |
| 19. To what extent do the areas for action comprehensively address **intersectoral collaboration?** Does the policy: | | | |
| (a) Emphasize collaboration with all other relevant government departments? | **1** | Collaboration with other government departments and NGOs is emphasized. | Roles of different sectors aren't specified. This needs to come out clearly in the areas of action. |
| (b) Emphasize collaboration with all relevant | **1** | | |

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| NGOs, including consumer and family groups? | | | |
| (c) Contain clear statements of what role each sector will play in each area for action? | **1** | | |
| 20. Have all of the following groups been considered: | | | |
| -- People with severe mental disorders? | **1** | Vulnerable groups are generally given due attention in the policy document. Areas of action to help support these are however not clearly stated; and concentration has mainly been on HIV/AIDS. | Minority groups are not mentioned and considered as vulnerable groups. |
| -- Children and adolescents? | **1** | | |
| -- Older persons? | **1** | | |
| -- People with intellectual disability? | **1** | | |
| -- People with substance dependence? | **1** | | |
| -- People with common mental disorders? | **1** | | |
| -- People affected by trauma? | **1** | | |
| 21. Given resources available in the country, has a reasonable balance been achieved between the above groups? | **3** | | |
| 22. To what degree have the key mental health policy issues been integrated with/or are consistent with the country's: | | | |
| -- Mental health law? | **3** | The current MH law is obsolete and not in operation | |
| -- General health law? | **2** | | |
| -- Patients rights charter? | **3** | | |
| -- Disability law? | **3** | | |
| -- Health policy? | **2** | Integration of the policy into the general health policy is only to some extent. | |
| -- Social welfare policy? | **3** | | |
| -- Poverty reduction policy? | **3** | | |
| -- Development policy? | **4** | | |

**Taking into account the financial and human resources available in the country, comment on the general feasibility for implementation of the policy.**

**Comments:**

The policy is modest and can be implemented given the serious commitment of all concerned. There are, however a number of issues that need to be incorporated in the policy. The policy requires urgent review and updating.

**Challenges**

- There is challenge in the area of attitude change especially by the district staff whose training never included adequate mental health input in the curricula and yet they are the key players in the mainstreaming of mental health in the general PHC in addition to dealing with the majority of the population at the grassroot.
- The area of intersectoral collaboration is generally weak and needs emphasis if policy review takes place.

# 7.4 Appendix 4: WHO Checklist on Mental Health Legislation

World Health Organization

WHO Checklist on
Mental Health Legislation

**This checklist has been developed by WHO staff, Dr Michelle Funk, Ms Natalie Drew, Dr Margaret Grigg and Dr Benedetto Saraceno, in collaboration with Professor Melvyn Freeman, WHO faculty member for legislation, with contributions from Dr Soumitra Pathare and Dr Helen Watchirs, also WHO faculty for legislation. It is derived from the WHO Resource Book on Mental Health Legislation, which has been prepared by the Mental Health Policy and Service Development Team, Department of Mental Health and Substance Abuse, World Health Organization.**

## Introduction and how to use this checklist

This checklist is a companion to the *WHO Resource Book on Mental Health, Human Rights and Legislation*. Its objectives are to: a) assist countries in reviewing the comprehensiveness and adequacy of existing mental health legislation; and b) help them in the process of drafting new law. This checklist can help countries assess whether key components are included in legislation, and ensure that the broad recommendations contained in the Resource Book are carefully examined and considered.

*A committee* to work through the checklist is recommended. While an individual in, for example, the ministry of health, may be able to complete the checklist, this has certain limitations. First, no single person is likely to have all the relevant information that a well-selected team would have. Secondly, different individuals or representatives of different groups are likely to have differing views on various issues. An evaluation committee that allows critical debate and the development of a for consensus are invaluable. Although countries should decide for themselves on the composition of the committee, it is advisable to include a legal practitioner familiar with the various national laws, the governmental mental health focal point, representatives of service user and family groups, and representatives of mental health professionals, NGOs and different government departments. It is recommended that the process be led and mediated by an independent human rights and/or legal expert.

This checklist should generally *not be utilized without thoroughly studying the Resource Book itself*. A number of important items included in the checklist are explained in the Resource Book, and the rationale and different options for legislation are discussed. The Resource Book emphasizes that countries should make their own decisions about various alternatives and ways of drafting legislation as well as about a number of content issues. The format of this checklist allows for such flexibility, and aims to encourage internal debate; it thus permits countries to make decisions based on their own unique situations.

The checklist covers issues from a broad perspective, and many of the provisions will need to be fleshed out or elaborated upon with respect to details and country specifications. Moreover, not all provisions will be equally relevant to all countries due to different social, economic, cultural and political factors. For example, not all countries will choose to have community treatment orders; not all countries have provision for “non-protesting patients”; and in most countries, sterilization of people with mental disorders will not be relevant. However, while each country in its evaluative process may determine that a particular provision is not relevant, this determination should be made part of the checklist exercise. All provisions in the checklist should be considered and discussed carefully before it is decided that one (or more) of the provisions is not relevant to a country’s particular context.

The Resource Book points out that countries may have laws that affect mental health in a single statute or in numerous different statutory laws relating to areas such as general health, employment, housing, discrimination and criminal justice. Moreover, some countries utilize regulations, orders and other mechanisms to complement a statutory act. It is therefore essential, when conducting this audit, to collect and collate all legal provisions pertaining to mental health, and to make decisions based on comprehensive information.

The Resource Book makes it clear that drawing up or changing mental health legislation is a “process”. Establishing what needs to be included in the legislation is an important element of that process, and this checklist can be a useful aid to achieving this goal. Nonetheless, the objective of drafting a law that can be implemented in a country must never be separated from the “content”, and must always be a central consideration.

For each component included in the checklist, three questions need to be addressed: a) Has the issue been adequately covered in the legislation? b) Has it been covered, but not fully and comprehensively? c) Has it not been covered at all? If the response is either (b) or (c), the committee conducting the assessment must decide on the feasibility and local relevance of including the issue, leading to the drafting of locally appropriate legislation.

This checklist does not cover each and every issue that could or should be included in legislation. This does not mean that other items are unimportant and that countries should not pursue them; however, for the sake of simplicity and ease of use, the scope of this checklist has been limited.

| **Legislative issue** | Extent to which covered in legislation (tick one)<br><br>***a)*** Adequately covered<br>b) Covered to some extent<br>c) Not covered at all | If (b), explain:<br>• Why it is not adequately covered<br>• What is missing or problematic about the existing provision<br><br>If (c), explain why it is not covered in current legislation<br>(Additional information may be added to new pages if required) | If (b) or (c), explain how/whether it is to be included in new legislation |
|---|---|---|---|
| **A. Preamble and objectives**<br><br>1) Does the legislation have a preamble which emphasizes:<br>a) the human rights of people with mental disorders?<br><br>b) the importance of accessible mental health services for all? | <br><br><br><br>**a)**<br>*b)*<br>*c) X*<br><br><br>**a)**<br>*b)*<br>*c) X* | 1) The Act does not have a preamble, although the long title is quite descriptive.<br><br>The human rights of people with mental disorders must be strongly protected because these people consist of an extremely vulnerable group, easily and often subject to various forms of abuse. It is important that protection of human rights is clearly understood to be a <u>legal obligation</u> through which each clause of the new law must be interpreted, and not merely a political consideration behind the drafting of a new law. This is why it is advantageous to include a preamble addressing human rights and accessibility. | |

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| 2) Does the legislation specify that the purpose and objectives to be achieved include:<br>a) non-discrimination against people with mental disorders?<br>b) promotion and protection of the rights of people with mental disorders?<br>c) improved access to mental health services?<br>d) a community-based approach? | **a)**<br>*b)*<br>*c) X*<br>**a)**<br>*b)*<br>*c) X*<br>**a)**<br>*b)*<br>*c) X*<br>**a)**<br>*b)*<br>*c) X* | If it is not customary to include a preamble in a law, it is possible to include a list of objectives into the law itself. This kind of clause is written directly into an Act to clarify the intent of the legislature, and also to legally bind future interpretation of the Act to the stated intent.<br><br>Sometimes "notes" are appended to a law to indicate the intent of the legislature (for instance in Scotland or Quebec). These are *not* legally binding, although they may be useful and considered "persuasive" for the purposes of legal interpretation.<br><br>2) The long title of the Act implies that there are two main purposes of the act: to make provision for care of persons with mental disorders, and to manage mental hospitals.<br><br>There is no express statement of the importance of human rights, accessibility to services, or community care approaches. | |

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| **B. Definitions**<br><br>1) Is there a clear definition of mental disorder/mental illness/mental disability/mental incapacity?<br><br>2) Is it evident from the legislation why the particular term (above) has been chosen?<br><br>**3) Is the legislation clear on whether or not mental retardation/intellectual disability, personality disorders and substance abuse are being covered in the legislation?**<br><br>4) Are all key terms in the legislation clearly defined?<br><br>5) Are all the key terms used consistently throughout the legislation (i.e. not interchanged with other terms with similar meanings)?<br><br>**6) Are all "interpretable" terms (i.e. terms that may have several possible interpretations or meanings or may be ambiguous in terms of their meaning) in the legislation defined?** | **a)**<br>*b)*<br>*c) X*<br><br>**a)**<br>*b)*<br>*c) X*<br><br>**a)**<br>*b)*<br>*c) X*<br><br>**a)**<br>*b)*<br>*c) X*<br><br>**a)**<br><br>**b) X**<br><br>**c)**<br><br>**a)**<br>*b)*<br>*c) X* | 1) The act uses the term "persons of unsound mind" rather than using separate definitions of mental disorder, illness, disability or incapacity (as appropriate).<br><br>2) No.<br><br>3-4) "Person of unsound mind" is defined as "an idiot or a person who is suffering from mental derangement". It is not clear what is meant by this, i.e. whether this term encompasses mental retardation, personality disorders, substance abuse, or other mental disorders/illnesses. This term and definition within the Act perpetuates the stigma and discrimination associated with mental disorders. Furthermore the term unsound mind implies that a person lacks capacity to understand things and make choices and decisions whereas in majority of cases people with mental disorders have full capacity in this respect. Danger that assumption of lack of capacity for everyone coming into contact with mental health system.<br><br>This legislation specifically <u>does not apply to mentally ill offenders</u>.<br><br>5) "Person of unsound mind" and "unsoundness of mind" are consistently used in the legislation – however inappropriate the term may be.<br><br>6) If a magistrate suspects that a person of unsound mind is not under "**proper care and control"** they may have them brought before the magistrate for the purposes of inquiry (s. 3(2)). The fact that "proper care and control" is not defined means there is very wide room for abuse<br><br>"Detention of the person in any place including mental hospital" (3.3). " Any place" is too broad. The law should be specific as to where a person might be detained. Detention should ideally involve a therapeutic purpose.<br><br>A police officer or another **suitable person** may take charge of a person of | |

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| | | unsound mind and conduct the person to a mental hospital (s. 5(2)). Since the "suitable person" has such a grave responsibility, it is important to define this term and ensure that such a person is properly trained in the care and humane treatment of persons with mental illnesses.<br><br>The difference between an 'urgency order' and a regular order for detention is unclear in the Act (7).<br><br>If a patient has property that is "**more than sufficient to maintain any members of his family dependent on him"**, the Chief Medical Officer may charge a daily rate for his care in a mental hospital or other facility (s. 12(1)). "More than sufficient" should probably be defined.<br><br>Section 24 provides for visitors to mental hospitals, and states that "**fit persons**" shall be appointed by the Minister. It could be useful to have more specific criteria regarding the experience and background of who is considered "fit".<br><br>There is no mention of consent, or informed consent, in the legislation. Similarly, there is no mention of voluntary patients, or distinction made between involuntary and voluntary patients.<br><br>There is no formal definition or process mentioned for guardianship, proxy decision-making, or the appointment of personal representatives. | |
| **C. Access to mental health care**<br><br>1) Does the legislation make provision for the financing of mental health services?<br><br>2) Does the legislation state that mental health services should be provided on an | ***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b)* | 1-2) No, the legislation focuses exclusively on institutional care. Legislation can help to direct funding for mental health, for example, by stating that mental health service users must be treated on an equitable basis with physical health service users. This helps to increase the access and availability of mental health services.<br><br>3) No. Because most of Africa has a large rural population that is often marginalized, focus on these vulnerable and disadvantaged groups is critical | |

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| equal basis with physical health care?<br><br>3) Does the legislation ensure allocation of resources to underserved populations and specify that these services should be culturally appropriate?<br><br>4) Does the legislation promote mental health within primary health care?<br><br>5) Does the legislation promote access to psychotropic drugs?<br><br>6) Does the legislation promote a psychosocial, rehabilitative approach?<br><br>7) Does the legislation promote access to health insurance in the private and public health sector for people with mental disorders?<br><br>8) Does the legislation promote community care and deinstitutionalization? | *c) X*<br><br>***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b)*<br>*c) X* | to improving access to and availability of services. Emphasis on community-based services can prompt the authorities to allocate the appropriate resources to mental health services.<br><br>Legislation can set up criteria for establishing the needs of communities that have poor access to services. Cultural values may be incorporated into the law when dealing with certain issues, such as doctor-patient confidentiality<br><br>4) No. Most developing countries have comprehensive primary care services that are aimed at promoting physical health care with a focus on conditions such as malaria, TB, and HIV and many others. By emphasizing that mental health services be delivered through general health services it is possible to increase the access of under-served populations to mental health services.<br><br>5) No. Specific mention of "equal availability of medication" can help mentally ill patients to have access to psychotropic drugs.<br><br>6) No.<br><br>7) No. Legislation may contain provisions to prevent discrimination against people with mental disorders in their efforts to obtain health insurance coverage.<br><br>8) The legislation makes some mention of discharging patients should friends or relatives undertake to care for the person (s. 19). This is not specifically promoted as community care, and there is no mention of whether the family, friends or patient have access to community-based programs for persons with mental illness and their caregivers.<br><br>Statutory language can provide that, if at all possible, patients should be treated in their communities and as voluntary patients unless there are clearly-articulated reasons why hospital-based care is required. By emphasizing | |

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| | | community-based care, services are more likely to be incorporated into the general health care system, thus resulting in better access and availability of care for people with mental disorders.<br><br>Including these issues in legislation encourages governments to meet policy goals by providing legal incentive. | |
| **D. Rights of users of mental health services**<br><br>1) Does the legislation include the rights to respect, dignity and to be treated in a humane way?<br><br>2) Is the right to patients' confidentiality regarding information about themselves, their illness and treatment included?<br><br>a) Are there sanctions and penalties for people who contravene patients' confidentiality?<br>b) Does the legislation lay down exceptional circumstances when confidentiality may be legally breached?<br>c) Does the legislation allow patients and their personal representatives the right to ask for judicial review of, or appeal against, decisions to release information? | ***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b)*<br>*c) X* | 1) The legislation implicitly addresses some issues of patient rights. Procedural rights are included, presumably to prevent persons without mental illness from being wrongly institutionalized. Sections of the legislation also address cruelty to persons with mental illness, stating that if such persons are not properly cared for they will be removed to an institution. Section 14 states that patients are "subject to the directions and control" of hospital staff. While rules may be necessary, such a blatant statement of control over patients is a direct attack on patient autonomy and dignity. On the whole, the methods used for the protection and care of persons with mental illnesses are outdated and should be revised putting people with mental disorders squarely at the centre of decisions concerning them.<br><br>2) There is no mention of patient confidentiality. In many countries, patient information has been used to deny basic rights such as the right to vote, the right to work, the right to live in the community, the right to communicate, and other civil and political rights. Legislation should thus expressly protect the confidentiality of patients.<br><br>Although the Act deals generally with penalties, it does not specify penalties for breach of confidentiality. Legislation should also determine the exceptional cases under which confidentiality may be breached appropriately. These include life-threatening emergencies or cases of substantial likelihood of imminent harm to others. It is important that any such exceptions be narrowly drawn. Issues concerning the rights of families and caregivers to information also need to be discussed and worked through. | |

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| 3) Does the legislation provide patients free and full access to information about themselves (including access to their clinical records)?<br><br>a) Are circumstances in which such access can be denied outlined?<br><br>b) Does the legislation allow patients and their personal representatives the right to ask for judicial review of, or appeal against, decisions to withhold information?<br><br>4) Does the law specify the right to be protected from cruel, inhuman and degrading treatment?<br><br>5) Does the legislation set out the minimal conditions to be maintained in mental health facilities for a safe, therapeutic and hygienic environment?<br><br>6) Does the law insist on the privacy of people with mental disorders?<br><br>a) Is the law clear on minimal levels of privacy to be respected? | ***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b)*<br>*c) X*<br><br>***a) X***<br>*b)*<br>*c)*<br><br>***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b)* | 3) There is no mention of access to information. As a matter of equity, people with mental disorders should have as free and full access to information concerning their health as people with physical health problems. Legitimate exceptions to access must be narrowly defined.<br><br>4) A magistrate can order an inquiry if he or she is given information under oath that a person who is mentally ill is cruelly treated or neglected (s.3(2)). It is also an offence, punishable by fine or imprisonment, for hospital employees to hit, ill-treat or neglect a patient (s.32). But this is not sufficient and the law needs to outline complaints mechanisms and remedies for patients and families or other witnesses to abuse. As a general point the Act fails to put in place proper mechanisms for redress eg. appeals and complaints mechanisms. Also it is clear from the Act that seclusion and restraints are used (see clause 16), but the law fails to put in safeguards against its abuse.<br><br>5) No. Provisions should set out specific standards of what constitutes a safe, therapeutic and humane environment. Language should also clearly ensure hygiene and safety, dignity and human rights of the patient.<br><br>6) No. While private rooms for every patient may not be feasible where there are poor or no resources, legislation can still require that patients admitted for mental health care be treated as close to those admitted for physical health care.<br><br>Legislation can also precisely define conditions of privacy (ex. minimum living space for each patient, maximum number of beds in a ward, and private areas where personal belongings can be stored) to ensure a minimum of | |

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| 7) Does the legislation outlaw forced or inadequately remunerated labour within mental health institutions?<br><br>8) Does the law make provision for:<br>• educational activities,<br>• vocational training,<br>• leisure and recreational activities, and<br>• religious or cultural needs of people with mental disorders?<br><br>9) Are the health authorities compelled by the law to inform patients of their rights?<br><br>10) Does legislation ensure that users of mental health services are involved in mental health policy, legislation development and service planning? | *c) X*<br><br>***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b)*<br>*c) X*<br><br>a)<br>b)<br>c) X | privacy per patient.<br><br>7) There is no mention of labour within mental health institutions. Forced labour and inadequately remunerated labour should be made illegal (cf. international labour law). Labour that is part of an occupational therapy program or for therapeutic purposes may be exempted from the general rule. The law may state that, with patient consent, performance of specific tasks should be remunerated accordingly.<br><br>8) There is no mention of training of patients. If the environment within a mental health facility is intended to be as close as possible to the patient's home environment, then the patient's needs should be viewed in a holistic manner. These basic rights are enshrined in the MI Principles (Principle 13). Furthermore, out-patient care should, as much as possible, help patients to be active and autonomous members of the community. Education and vocational training can help in this regard.<br><br>9) No. Because, for a variety of reasons, patients are sometimes not aware of their rights, legislation should include a provision for informing patients of their rights vis-à-vis mental health services. This information should be made available in a simple yet comprehensive manner. The law may also stipulate that rights be conveyed in a language and at a level of complexity that the patient understands.<br><br>10) No. Mental health service users have a fundamental role make in such decision making processes. They are in the best position to indicate what is needed to improve the functioning of mental health systems, and ameliorate mental health service design and provision etc. Including such a provision in the law also encourages the formation of user groups and makes their contribution to the development of the mental health service system more transparent. | |

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| **E. Rights of families or other carers**<br><br>1) Does the law entitle families or other primary carers to information about the person with a mental disorder (unless the patient refuses the divulging of such information)?<br><br>2) Are family members or other primary carers encouraged to become involved in the formulation and implementation of the patient's individualized treatment plan?<br><br>3) Do families or other primary carers have the right to appeal involuntary admission and treatment decisions?<br><br>4) Do families or other primary carers have the right to apply for the discharge of mentally ill offenders?<br><br>5) Does legislation ensure that family members or other carers are involved in the development of mental health policy, legislation and service planning? | ***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b)*<br>*c) X*<br><br>***a) X***<br>*b)*<br>*c)*<br><br>***a)***<br>*b)*<br>*c) X* | 1) There is no mention of sharing information with caregivers. Because families often carry the burden of care for people with mental disorders, legislation should recognize their role. In most African cultures, the family plays a crucial role in decision making, support and care, particularly when a family member is ill. Therefore, it may become necessary for certain family members to be informed of a person's situation. While family members' access to information must be balanced against a right to confidentiality, cultural values may counsel more rather than less information sharing. Potential conflicts of interest need to be examined, the views of the person with the mental disorder must be taken into account, and only information relevant for the support and care of the person should be considered.<br><br>2) There is no mention of treatment plans or other care for the patient after leaving an institution. Family members often take responsibility for ensuring that an out/patient takes his/her medication, attends reviews, and participates in other rehabilitation exercises in the community. Involving family members means that out-patient care may be more consistent, and there is a lower likelihood of the family resorting to alternative treatments (such as traditional medicines) when they are involved in and understand the treatment plan.<br><br>3) There is no mention of appeal of admissions or treatment decisions.<br><br>4) Relatives or friends may apply to have a patient discharged into their care (s. 19).<br><br>5) No. Family members also have an extremely important contribution to make in these decision making processes (see mh service users above) and provision for their involvement should be included in national mh laws | |
| **F. Competence, capacity and guardianship**<br><br>1) Does legislation make provision for | ***a)*** | 1) No. The legislation implies that other legislation or customs deal with the issue of management, as the legislation states explicitly that payments must be made to hospitals for patient care where the patient has been admitted by request of the family and friends (rather than by the magistrate). | |

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| the management of the affairs of people with mental disorders if they are unable to do so?<br><br>2) Does the law define "competence" and "capacity"?<br><br>3) Does the law lay down a procedure and criteria for determining a person's incapacity/incompetence with respect to issues such as treatment decisions, selection of a substitute decision-maker, making financial decisions?<br><br>4) Are procedures laid down for appeals against decisions of incapacity/ incompetence, and for periodic reviews of decisions?<br><br>5) Does the law lay down procedures for the appointment, duration, duties and responsibilities of a guardian to act on behalf of a patient?<br><br>6) Does the law determine a process for establishing in which areas a guardian may take decisions on behalf of a patient?<br><br>7) Does the law make provision for a systematic review of the need for a guardian? | *b)*<br>*c) X*<br><br>***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b)*<br>*c) X* | 2-3) No. The law makes no mention of capacity or competence, though the general sense one gets from the law is that people with mental disabilities are assumed to lack capacity (see comment on 'unsoundness of mind above). Yet the presence of mental illness does not automatically mean that an individual lacks capacity (the ability to make decisions) or competence (the legal consequences of not having mental capacity). All persons must be presumed to have capacity and be competent, even if suffering from a mental disorder, unless reliably determined otherwise. The legislation should clearly reflect this by including definitions of capacity and competence, and consequences of lack of capacity.<br><br>4-8) The law does not set out a procedure for determining incapacity or incompetence, nor does it provide for guardianship or surrogate decision-making.<br><br>Guardianship may become necessary if a patient becomes unable to make important decisions and is incapable of managing his or her affairs. However, guardianship also takes away a person's right to make their own decisions (either in whole, or in part) and it therefore a major limitation to one's civil rights. Therefore, it <u>should only be used after less restrictive alternatives have been exhausted and due process procedures have been followed</u>. These include notice (of a guardianship application), hearing, appeal, and periodic review.<br><br>The Act allows for the liquidation of a persons assets to pay for treatment and/or the upkeep of the family. MH law should emphasise in stronger terms the need for a proper court hearing on such matters, with the specific attendance of the person concerned or his/her personal representative. Another related issue is that the liquidation of a person's assets to pay for treatment could have devastating consequences for an already impoverished | |

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| 8) Does the law make provision for a patient to appeal against the appointment of a guardian? | ***a)***<br>*b)*<br>*c) X* | family. The Act does not make it clear whether mental health care is free for those who do not have the means to pay. | |
| **G. Voluntary admission and treatment**<br><br>1) Does the law promote voluntary admission and treatment as a preferred alternative to involuntary admission and treatment?<br><br>2) Does the law state that all voluntary patients can only be treated after obtaining informed consent?<br><br>3) Does the law state that people admitted as voluntary mental health users should be cared for in a way that is equitable with patients with physical health problems?<br><br>4) Does the law state that voluntary admission and treatment also implies the right to voluntary discharge/refusal of treatment?<br><br>5) Does the law state that voluntary patients should be informed at the time of admission that they may only be denied the right to leave if they meet the conditions for involuntary care? | <br><br>***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b)*<br>*c) X* | 1-5) There is no mention of voluntary admission and treatment. While a person's family or caregiver may choose to have them admitted to the hospital, the opinion of the patient is not considered.<br>This is probably the biggest flaw of the 1964 Act. The law never talks about voluntary or involuntary patients but just refers to people of unsound mind. This implies that the mere presence of a mental disorder is cause for total removal the patient's autonomy and right to make decisions for him/herself. The failure of the law to make a distinction between voluntary and involuntary patients (or indeed cover the issue of voluntary patients) means that even patients who enter a facility of their own volition may nevertheless be subject to involuntary conditions and limitations of the Act (eg. cannot discharge themselves Art 18)<br><br>Legislation should promote voluntary admission and treatment over involuntary admission and treatment, and emphasize that every effort should be made to avoid involuntary admission. This includes obtaining informed consent (or substituted consent for those who are unable to give consent), the right to discharge oneself (on par with the rights of those who admit themselves for physical illnesses), and a provision requiring that voluntary patients be advised if future requests for discharge may be denied (and under what circumstances). | |

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| **H. Non-protesting patients**<br><br>1) Does the law make provision for patients who are incapable of making informed decisions about admission or treatment, but who do not refuse admission or treatment?<br><br>2) Are the conditions under which a non-protesting patient may be admitted and treated specified?<br><br>3) Does the law state that if users admitted or treated under this provision object to their admission or treatment they must be discharged or treatment stopped unless the criteria for involuntary admission are met? | ***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b)*<br>*c) X* | There are no provisions for non-protesting patients.<br><br>In cases of non-protesting patients (those who are incapable of making informed decisions about treatment, and yet do not refuse treatment) the need for hospitalization alone can be sufficient to warrant such an admission. Although the criteria for admission as a non-protesting patient are generally considered to be not as rigid as for involuntary patients, non-protesting patients should nevertheless qualify for automatic review procedures. | |
| **I. Involuntary admission (when separate from treatment) and involuntary treatment (where admission and treatment are combined)**<br><br>1) Does the law state that involuntary admission may only be allowed if:<br><br>a) there is evidence of mental disorder of specified severity? and;<br><br>b) there is serious likelihood of | ***a)***<br>*b) X*<br>*c)* | 1a-b) Before a person may be involuntarily admitted, a magistrate must hold an inquiry and obtain two medical certificates stating that a person is "of unsound mind" (s. 4(1)). The inquiry will only be held if the magistrate is convinced that the person "is at large or is dangerous to himself or others, or is not under proper care and control or is cruelly treated or neglected by any relative or other person having the care or charge of him" (s. 3(2)). The Act, therefore, makes some attempt to only admit persons who pass a certain threshold of severity of mental illness, or who may be at risk or be a risk to others.<br><br>Failure to provide "proper care and control" or the fact that someone is being "cruelly treated or neglected by any relative or other person having the care or charge of him" <u>should not</u> form the basis for involuntary detention. | |

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| harm to self or others and/or substantial likelihood of serious deterioration in the patient's condition if treatment is not given? and;<br><br>c) admission is for a therapeutic purpose?<br><br>2) Does the law state that two accredited mental health care practitioners must certify that the criteria for involuntary admission have been met?<br><br>3) Does the law insist on accreditation of a facility before it can admit involuntary patients?<br><br>4) Is the principle of the least restrictive environment applied to involuntary admissions?<br><br>5) Does the law make provision for an independent authority (e.g. review body or tribunal) to authorize all involuntary admissions?<br><br>6) Are speedy time frames laid down | ***a)***<br>*b) X*<br>*c)*<br><br>***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b) X*<br>*c)*<br><br>***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b)*<br>*c)*<br><br>***a)*** | The WHO Resource book indicates that both criteria must be present in order for a person to be admitted against their will. The Uganda law, however, states that a person may simply meet one of these three criteria.<br><br>Having a mental illness alone should not be used to justify involuntary admission and treatment. The law needs to provide substantive guidance regarding reasons for involuntary admission *beyond* the mere presence of mental illness. Because reasons for admission can vary from one doctor to another, there is a need for consistency in the law. It is therefore necessary to specifically stipulate reasons that can lead to involuntary admission such as: the presence of a diagnosable mental disorder **coupled with** i) danger to self; ii) danger to others; iii) high risk of serious deterioration in mental condition.<br><br>Note also that, in many societies, people with mental disorders are perceived to be threats to public safety simply because they suffer from a mental disorder. Yet people with mental disorders are no more dangerous than the general population (and for some mental disorders may be considerably less so). There could be a requirement of acts demonstrating dangerousness to ensure that non-dangerous persons are not involuntarily admitted.<br><br>1c) There is no explicit mention that admissions must be for therapeutic purposes only. This creates a risk that persons may be admitted for other reasons than treatment. Involuntary admissions criteria could reference the therapeutic purpose of admission, rather than admission for custodial or non-therapeutic purposes.<br><br>2) Two medical practitioners must provide certificates that a person is of unsound mind before a magistrate can order the person's admission to a mental hospital. However, only one of the practitioners needs to be "duly registered" (s.4(1)).<br><br>3) There is no mention of hospital accreditation – it seems to be assumed. | |

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| within which the independent authority must make a decision?<br><br>7) Does the law insist that patients, families and legal representatives be informed of the reasons for admission and of their rights of appeal?<br><br>8) Does the law provide for a right to appeal an involuntary admission?<br><br>9) Does the law include a provision for time-bound periodic reviews of involuntary (and long-term "voluntary") admission by an independent authority?<br><br>10) Does the law specify that patients must be discharged from involuntary admission as soon as they no longer fulfil the criteria for involuntary admission? | *b) X*<br>*c)*<br><br>***a)***<br>*b)X*<br>*c)*<br><br>***a)***<br>*b)X*<br>*c)*<br><br>***a)***<br>*b) X*<br>*c)*<br><br>***a)***<br>*b)* X<br>*c)* | 4) No.<br><br>5) Yes. The magistrate, a judicial authority, authorizes all involuntary admissions by issuing "reception orders".<br><br>6) Yes. Once a magistrate has begun an inquiry, they may adjourn for no more than 14 days for the purpose of a medical examination or the production of evidence. However, there is no mention of how long an inquiry may be. In order to ensure that inquiries are short and the would-be patient is not held against their will for an extended period of time, it is important to have clear timeframes within which the magistrate's inquiry must be closed and the decision to admit or not admit the patient is made.<br><br>7-8) The magistrate must inform the person when the order is made that they have a right to appeal (s.47). There is no mention of informing families or legal representatives. The law fails to specify the details surrounding an appeals process (what types of appeals - against involuntary status, against appointment of guardian; how to make the appeal; timeframes for entertaining and addressing appeals etc.) and puts this extremely important clause right at the end, in the 'miscellaneous' section.<br><br>9) Reception orders (orders by magistrates for a person "of unsound mind" to be admitted to a mental hospital) are valid for one year, and may only be continued by sending a special report to a magistrate. The magistrate may then either renew the patient's stay or discharge the patient. The first renewal is for a period of one year and subsequent renewals are for periods of three years (9.3). 1 year before the first review of a patient's case is too long and 6 months would probably be more appropriate. Also, the review of involuntary cases needs to be more than just a report (as per 9.4). There needs to be a new assessment to determine whether patient meets involuntary criteria. There also needs to be a hearing in which patients and families can attend and | |

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| | | actively participate etc. etc. The law should spell these details out. The Act currently only allows for 'an examination' if the magistrate thinks fit (presumably after having read the report).<br><br>Given that patients may not initiate review of their own files, a three-year waiting period is quite long.<br><br>10) (s.18). Patients are discharged once considered fit.<br><br>Article 19 is problematic because it allows the discharge of patients of families who are willing (and financially able) to take care of them. But either patients are involuntary (ie. Danger to self or others) and therefore should be provided with professional mental health care and not be living with the family, or the patient does not pose a danger to self or others, is voluntary, and therefore in a position to decide for him/herself where to live. Can we deduce from this clause that if a family is unable to care for (including financially) the person, then he/she should remain in the institution? The failure of a family to be able to take care of their family member should not be a reason for continued detention. Only meeting the criteria for involuntary admission constitutes a reason for continued detention. Clause 19 is ambiguous and needs to be clarified. | |
| **J. INVOLUNTARY TREATMENT (WHEN SEPARATE FROM INVOLUNTARY ADMISSION)**<br><br>1) Does the law set out the criteria that must be met for involuntary treatment, including:<br>• Patient suffers from a mental disorder?<br>• Patient lacks the capacity to make informed treatment | *a)*<br>*b)*<br>*c)*<br><br>***a)***<br>*b)* | **The law does not distinguish involuntary treatment from involuntary admission.** | |

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| decisions?<br>• Treatment is necessary to bring about an improvement in the patient's condition, and/or restore the capacity to make treatment decisions, and/or prevent serious deterioration, and/or prevent injury or harm to self or others? | *c)*<br>***a)***<br>*b)*<br>*c)* | | |
| 2) Does the law ensure that a treatment plan is proposed by an accredited practitioner with expertise and knowledge to provide the treatment? | ***a)***<br>*b)*<br>*c)* | | |
| 3) Does the law make provision for a second practitioner to agree on the treatment plan? | ***a)***<br>*b)*<br>*c)* | | |
| 4) Has an independent body been set up to authorize involuntary treatment? | ***a)***<br>*b)*<br>*c)* | | |
| 5) Does the law ensure that treatment is for a limited time period only? | ***a)***<br>*b)*<br>*c)* | | |
| 6) Does the law provide for a right to appeal involuntary treatment? | ***a)***<br>*b)*<br>*c)* | | |
| 7) Are there speedy, time-bound, periodic reviews of involuntary treatment in the legislation? | ***a)***<br>*b)*<br>*c)* | | |

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| **K. Proxy consent for treatment**<br><br>1) Does the law provide for a person to consent to treatment on a patient's behalf if that patient has been found incapable of consenting?<br><br>2) Is the patient given the right to appeal a treatment decision to which a proxy consent has been given?<br><br>3) Does the law provide for use of "advance directives" and, if so, is the term clearly defined? | <br><br>***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b)*<br>*c) X* | There are no provisions on proxy consent. | |
| **L. Involuntary treatment in community settings**<br><br>1) Does the law provide for involuntary treatment in the community as a "less restrictive" alternative to an inpatient mental health facility?<br><br>2) Are all the criteria and safeguards required for involuntary inpatient treatment also included for involuntary community-based treatment? | <br><br>***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b)*<br>*c) X* | There are no provisions on involuntary treatment in the community.<br><br>In accordance with Principle 9(1) of the MI Principles, every patient shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient's health needs and the need to protect the physical safety of others. Examples of less restrictive environments could include home-based care, day hospital treatment and out-patient treatment. Community supervised orders can also be used where patients are required to reside at a specific location and attend regular treatment programmes in the community. | |
| **M. Emergency situations**<br><br>1) Are the criteria for emergency admission/treatment limited to situations where there is a high probability of immediate and imminent danger or harm | <br><br>***a)***<br>*b)*<br>*c) X* | 1) The act states that if it is "necessary for the public safety, or for the welfare of a person alleged to be of unsound mind", an "urgency order" may be issued to have the person to a hospital or other place of detention. While this acknowledges that persons with mental disorders should not be confined unless "necessary", it does not provide sufficient protection to ensure that persons are only confined without due process in emergency situations. The | |

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| to self and/or others?<br><br>2) Is there a clear procedure in the law for admission and treatment in emergency situations?<br><br>3) Does the law allow any qualified and accredited medical or mental health practitioner to admit and treat emergency cases?<br><br>4) Does the law specify a time limit for emergency admission (usually no longer than 72 hours)?<br><br>5) Does the law specify the need to initiate procedures for involuntary admission and treatment, if needed, as soon as possible after the emergency situation has ended?<br><br>6) Are treatments such as ECT, psychosurgery and sterilization, as well as participation in clinical or experimental trials outlawed for people held as emergency cases?<br><br>7) Do patients, family members and personal representatives have the right to appeal against emergency admission/treatment? | ***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b)*<br>*c) X* | terms 'public safety' and for the 'welfare of the person' are too broad and too similar to criteria for 'ordinary' involuntary admission and treatment. The law needs to be more precise as to what constitutes an emergency situation (ie. Demonstrate that the need for detention and treatment is immediate and that the time required to follow substantive procedures would cause considerable delay, resulting in harm to the concerned person or others.) The law should also spell out the procedures to follow in emergency situations.<br><br>Admitting a person simply because he or she has a mental disorder cannot be regarded as an emergency, and constitutes a violation of human rights. Emergency admissions should be certified by a registered medical practitioner.<br><br>2-3) No specific procedure for emergency admissions is stated, other than to list persons who may issue an urgency order (s. 7).<br><br>4) The time limit is ten days, after which a person will be released unless proceedings have taken place for involuntary admittions (s.8). However, this time limit should not be longer than 72 hours as a lengthy period of emergency detention (without further justification for detention) raises serious human rights issues. There should also be a time limit for the initiation of involuntary admissions procedures as soon as possible after an emergency admission.<br><br>5) No.<br><br>6) No. Emergency patients should not be subject to major or irreversible treatments, or be included in clinical or experimental trials. The law should outline what is not permitted during emergency proceedings (eg. the use of depot neuroleptics; ECT; sterilization; psychosurgery and other irreversible treatment.) | |

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| | | 7) No. | |
| **N. Determinations of mental disorder**<br><br>1) Does the legislation:<br><br>a) Define the level of skills required to determine mental disorder?<br><br>b) Specify the categories of professionals who may assess a person to determine the existence of a mental disorder?<br><br>2) Is the accreditation of practitioners codified in law and does this ensure that accreditation is operated by an independent body? | ***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b) X*<br>*c)*<br><br>***a)***<br>*b)*<br>*c) X* | 1a) The Act implies that one must be a registered or non-registered medical practitioner (s. 4: "one at least of whom shall be a duly registered medical practitioner…"). There is no statement of the skill of the practitioners. The statute could state that at least one practitioner should be experienced in psychiatry, and could also state the level of experience in terms of years worked in psychiatry or other mental health qualifications. Experience in psychiatry does not mean experience as a psychiatrist as in many community settings there will be no psychiatrist.<br><br>1b) The act states that medical practitioners may certify a person as being "of unsound mind". No other detail is mentioned.<br><br>The law needs to be clear on the different categories of mental health and health professionals who may determine mental disorder. In many African countries, primary health care is predominantly provided by trained general nurses. If decentralization of services is to be effective, the role of the primary health care provider should be clearly defined. It is not always possible in resource poor settings to expect only mental health professionals to assess mental disorders. It may become necessary to empower primary health care workers with the skill of simple identification of mental disorders through community-level training programs. This should be reflected in the law, with clear specifications as to who may make mental health assessments.<br><br>2) There is no mention of an independent accreditation body. This may be covered by a different law. If so, reference should be made to that law in the mental health legislation. Alternatively if it is not present in another law, accreditation should be covered in the mental health Act. | |
| **O. Special treatments** | | The law makes no mention of special treatments. | |

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| 1) Does the law prohibit sterilization as a treatment for mental disorder?<br><br>a) Does the law specify that the mere fact of having a mental disorder should not be a reason for sterilization or abortion without informed consent?<br><br>2) Does the law require informed consent for major medical and surgical procedures on persons with a mental disorder?<br><br>a) Does the law allow medical and surgical procedures without informed consent, if waiting for informed consent would put the patient's life at risk?<br><br>b) In cases where inability to consent is likely to be long term, does the law allow authorization for medical and surgical procedures from an independent review body or by proxy consent of a guardian?<br><br>3) Are psychosurgery and other | ***a)***<br>*b)*<br>*c)X*<br><br>***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b)*<br>*c)X*<br><br>***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b)*<br>*c) X* | The law is silent with respect to sterilization, abortion, major medical and surgical procedures, psychosurgery, and ECT. It is not clear how many of these treatments are actually in use in Uganda. For example, in many African countries, abortion is illegal, although the rights of people with mental disorders have been known to have been violated simply because society perceived sterilization to be appropriate. | |

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| irreversible treatments outlawed on involuntary patients?<br><br>a) Is there an independent body that makes sure there is indeed informed consent for psychosurgery or other irreversible treatments on involuntary patients?<br><br>4) Does the law specify the need for informed consent when using ECT?<br><br>5) Does the law prohibit the use of unmodified ECT?<br><br>6) Does the law prohibit the use of ECT in minors? | <br><br>***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b)*<br>*c) X* | | |
| **P. Seclusion and restraint**<br><br>1) Does the law state that seclusion and restraint should only be utilized in exceptional cases to prevent immediate or imminent harm to self or others?<br><br>2) Does the law state that seclusion and restraint should never be used as a means of punishment or for the | <br><br>***a)***<br>*b)*<br>*c) X* | The law discusses seclusion and restraint only to say that use of these methods should be recorded by the hospital (s.16).<br><br>The law needs to be clear on issues of restraint and seclusion because these practices lead to some of the most common forms of human rights violations regarding people with mental disorders. Seclusion and restraint should only be used - if at all - when they are the only means available to prevent immediate or imminent harm to self or others, and then for the shortest period of time necessary (for minutes or, at most, a few hours). | |

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| convenience of staff?<br><br>3) Does the law specify a restricted maximum time period for which seclusion and restraints can be used?<br><br>4) Does the law ensure that one period of seclusion and restraint is not followed immediately by another?<br><br>5) Does the law encourage the development of appropriate structural and human resource requirements that minimize the need to use seclusion and restraints in mental health facilities?<br><br>6) Does the law lay down adequate procedures for the use of seclusion and restraints, including:<br>• who should authorize it,<br>• that the facility should be accredited,<br>• that the reasons and duration of each incident be recorded in a database and made available to a review board, and<br>• that family members/carers and personal representatives be immediately informed when the patient is subject to seclusion and/or restraint? | ***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b)*<br>*c) X* | Seclusion and restraint are never appropriate as means of punishment or for the convenience of staff.<br><br>Procedures must address who can authorize seclusion and restraint, in which facilities seclusion and restraint may take place (ex. Accredited facilities with the proper physical resources), limitations on the purposes and duration of seclusion and restraint, documentation of purpose, duration, and date of restraint for independent outside review, and immediate notice to family members, caregivers, and personal representatives when such procedures are used. | |

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| **Q. Clinical and experimental research**<br><br>1) Does the law state that informed consent must be obtained for participation in clinical or experimental research from both voluntary and involuntary patients who have the ability to consent?<br><br>2) Where a person is unable to give informed consent (and where a decision has been made that research can be conducted):<br><br>a) Does the law ensure that proxy consent is obtained from either the legally appointed guardian or family member, or from an independent authority constituted for this purpose?<br><br>b) Does the law state that the research cannot be conducted if the same research could be conducted on people capable of consenting, and that the research is necessary to promote the health of the individual and that of the population represented? | ***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b)*<br>*c) X*<br><br>*a)*<br>*b)*<br>*c) X* | The law does not mention clinical or experimental research. | |
| **R. Oversight and review mechanisms** | | 1) The law provides that magistrates will determine whether or not a person is of unsound mind, and issue "reception orders". Magistrates also review | |

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| 1) Does the law set up a judicial or quasi-judicial body to review processes related to involuntary admission or treatment and other restrictions of rights?<br><br>**A) DOES THE ABOVE BODY:** | ***a)***<br>*b) X*<br>*c)* | appeals and yearly renewals of reception orders. As the magistrates are members of the judiciary, they are not specialized or have particular experience with respect to mental health issues and rights. The law places a lot of responsibility and a large workload on magistrates (eg. review all cases and meet people concerned, oversee enquiries etc.) and it would be important to ensure that magistrates with the responsibility for mental health issues have the adequate knowledge, resources and time to devote to these activities. Too often this is not the case in many countries, and magistrates end up doing little more than 'rubber stamping' authorisations for involuntary admission and treatment. | |
| (i) Assess each involuntary admission/ treatment? | ***a)***<br>*b) X*<br>*c)* | 1a.i) Yes, but in the absence of clear criteria for what an "involuntary admission" is, such assessment may be biased and fail to properly protect the interests of persons with mental illnesses. | |
| (ii) Entertain appeals against involuntary admission and/or involuntary treatment? | ***a)***<br>*b) X*<br>*c)* | 1a.ii) Appeals are made directly to the High Court, another branch of the regular judiciary. See comment above concerning the need to strengthen clauses related to appeals mechanisms. | |
| (iii) Review the cases of patients admitted on an involuntary basis (and long-term voluntary patients)? | ***a)***<br>*b) X*<br>*c)* | 1a.iii) Magistrates regularly review involuntary admissions based on a special report of the superintendent. Magistrates may also request more information in order to properly conduct the review. After the first year, however, reviews are only conducted every three years. This is quite a long period to be involuntarily admitted if one is no longer ill; a shorter time period would be more in line with the principle of least restrictive treatment. | |
| (iv) Regularly monitor patients receiving treatment against their will? | | 1a.iv) The judiciary has no role where it regularly monitors patients. | |
| (v) Authorize or prohibit intrusive and irreversible treatments (such as psychosurgery and | ***a)***<br>*b)*<br>*c) X* | 1a.v) No. Intrusive and irreversible treatments are not discussed in the law. | |

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| electroconvulsive therapy)?<br><br>b) Does the composition of this body include an experienced legal practitioner and an experienced health care practitioner, and a "wise person" reflecting the "community" perspective?<br><br>c) Does the law allow for appeal of this body's decisions to a higher court? | ***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b)*<br>*c) X* | 1b) No. The magistrate is one person and a legal authority. The High Court is composed of several legal authorities - it is not clear how many would hear a request for an inquiry, but likely only one judge would be present.<br><br>1c) Yes. Appeals are allowed to the High Court. | |
| 2) Does the law set up a regulatory and oversight body to protect the rights of people with mental disorders within and outside mental health facilities?<br><br>a) Does the above body:<br><br>(i) Conduct regular inspections of mental health facilities?<br><br>(ii) Provide guidance on minimizing intrusive treatments?<br><br>(iii) Maintain statistics on, for example, the use of intrusive and irreversible treatments, seclusion | ***a) X***<br>*b)*<br>*c)*<br><br>***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b) X* | 2) There is no regulatory or oversight body. However, the law states that the Minister shall appoint two or more persons to be "visitors" for each mental hospital. Visiting boards need to be impartial and independent (including from the Ministry of Health) and this needs to be made clear in the law. The fact that the Minister may 'remove such persons (visitors) or any of them and may appoint others in their place' would indicate that there is a serious lack of independence of visitors. It would be important to have expertise (mental health, legal and human rights) on the panel of visitors. Also it is important to ensure that visitors are provided with the necessary training, resources and time to undertake their activities. | |

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| and restraints? | *c)* | | |
| (iv) Maintain registers of accredited facilities and professionals? | ***a)***<br>*b)*<br>*c) X* | 2a.i) Yes. Visits are made at least once every three months. However, no criteria for the visits, or how hospitals are held accountable to visitors' reports, is mentioned. | |
| (v) Report and make recommendations directly to the appropriate government minister? | ***a)***<br>*b)*<br>*c) X* | 2a.ii) No.<br><br>2a.iii) No. However, each mental hospital is supposed to keep records of the use of restraints and seclusions. | |
| (vi) Publish findings on a regular basis? | ***a)***<br>*b) X*<br>*c)* | 2a.iv) No. | |
| b) Does the composition of the body include professionals (in mental health, legal, social work), representatives of users of mental health facilities, members representing families of people with mental disorders, advocates and lay persons? | ***a)***<br>*b)*<br>*c) X* | 2a.v) Unclear. The Minister appoints and directs hospital visitors. The act thus implies that reports are sent directly to the Minister. This could be make explicit. | |
| c) Is this body's authority clearly stated in the legislation? | ***a)***<br>*b)*<br>*c) X* | 2a.vi) No. | |
| 3)<br>a) Does the legislation outline | | 2b) No. | |

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| procedures for submissions, investigations and resolutions of complaints?<br><br>b) Does the law stipulate:<br><br>• the time period from the occurrence of the incident within which the complaint should be made?<br><br>• a maximum time period within which the complaint should be responded to, by whom and how?<br><br>• the right of patients to choose and appoint a personal representative and/or legal counsel to represent them in any appeals or complaints procedures?<br><br>• the right of patients to an interpreter during the proceedings, if necessary?<br><br>• The right of patients and their counsel to access copies of their medical records and any other relevant reports and documents during the complaints or appeals procedures? | ***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b)*<br>*c) X* | 2c) While the body's *existence* is clearly stated in the legislation (s.24), the body's authority is unclear.<br><br>3) Complaints procedures fail to be covered adequately in the Act. Article 24 is problematic as it states that "any action brought by any person who has been detained as a person of unsound mind against any person for anything done under this Act shall be commenced within twelve months after the release of the party bringing the action". It is not clear from this wording if action prior to release is permissible but in any event complaints should be authorised to be made immediately, otherwise there is a danger that abuse may be allowed to continue with impunity until release. | |

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| • the right of patients and their counsel to attend and participate in complaints and appeals procedures? | ***a)***<br>*b)*<br>*c) X* | | |
| **S. Police responsibilities**<br><br>1) Does the law place restrictions on the activities of the police to ensure that persons with mental disorders are protected against unlawful arrest and detention, and are directed towards the appropriate health care services?<br><br>2) Does the legislation allow family members, carers or health professionals to obtain police assistance in situations where a patient is highly aggressive or is showing out-of-control behaviour?<br><br>3) Does the law allow for persons arrested for criminal acts, and in police custody, to be promptly assessed for mental disorder if there is suspicion of mental disorder?<br><br>4) Does the law make provision for the police to assist in taking a person to a mental health facility who has been involuntarily admitted to the facility? | ***a)***<br>*b) X*<br>*c)*<br><br>***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b)*<br>*c) X*<br><br>***a)***<br>*b)*<br>*c) X* | 1) To a certain extent. Only police officers above a certain rank can detain a person of unsound mind under an "urgency order". The police officer may then either direct the person to a hospital, or to another "suitable place of detention", if that person is in danger of causing harm to him/herself or others. However, there is no mention of procedures when a person "of unsound mind" is arrested for a crime. It is possible that this is dealt with in other legislation.<br><br>2) There is no specific mention of family members, caregivers, or health professionals being able to obtain police assistance.<br><br>3) No. This may be dealt with in other legislation, as mentally ill criminals are specifically excluded from this Act.<br><br>4) There is no mention of a police role in bringing an involuntary patient to be admitted.<br><br>5) Yes. Any patient who escapes a mental hospital before discharge may, within 28 days, be retaken by "any police officer, or any officer or servant of a mental hospital, or any other person authorised in writing…" | |

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| 5) Does the legislation make provision for the police to find an involuntarily committed person who has absconded and return him/her to the mental health facility? | ***a) X***<br>*b)*<br>*c)* | | |
| **T. Mentally ill offenders**<br><br>1) Does the legislation allow for diverting an alleged offender with a mental disorder to the mental health system in lieu of prosecuting him/her, taking into account the gravity of the offence, the person's psychiatric history, mental health state at the time of the offence, the likelihood of detriment to the person's health and the community's interest in prosecution?<br><br>2) Does the law make adequate provision for people who are not fit to stand trial to be assessed, and for charges to be dropped or stayed while they undergo treatment?<br><br>a) Are people undergoing such treatment given the same rights in the law as other involuntarily admitted persons, including the right to judicial review by an independent body? | ***a)***<br>*b)*<br>*c)*<br><br>***a)***<br>*b)*<br>*c)*<br><br>***a)***<br>*b)*<br>*c)* | The law specifically excludes mentally ill offenders. | |

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| 3) Does the law allow for people who are found by the courts to be "not responsible due to mental disability" to be treated in a mental health facility and to be discharged once their mental disorder sufficiently improves?<br><br>4) Does the law allow, at the sentencing stage, for persons with mental disorders to be given probation or hospital orders, rather than being sentenced to prison?<br><br>5) Does the law allow for the transfer of a convicted prisoner to a mental health facility if he/she becomes mentally ill while serving a sentence?<br><br>a) Does the law prohibit keeping a prisoner in the mental health facility for longer than the sentence, unless involuntary admission procedures are followed?<br><br>6) Does the legislation provide for secure mental health facilities for mentally ill offenders? | ***a)***<br>*b)*<br>*c)*<br><br>***a)***<br>*b)*<br>*c)*<br><br>***a)***<br>*b)*<br>*c)*<br><br>***a)***<br>*b)*<br>*c)*<br><br>***a)***<br>*b)*<br>*c)* | | |
| **U. Discrimination** | | The law does not consider issues of discrimination or housing. | |

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| 1) Does the law include provisions aimed at stopping discrimination against people with mental disorders?<br><br>**V. Housing**<br><br>1) Does the law ensure non-discrimination of people with mental disorders in the allocation of housing?<br><br>2) Does the law make provision for housing of people with mental disorders in state housing schemes or through subsidized housing?<br><br>3) Does the legislation make provision for housing in halfway homes and long-stay, supported homes for people with mental disorders? | ***a)***<br>*b)*<br>*c)*<br><br>***a)***<br>*b)*<br>*c)*<br><br>***a)***<br>*b)*<br>*c)*<br><br>***a)***<br>*b)*<br>*c)* | | |
| **W. Employment**<br><br>1) Does the law make provision for the protection of persons with mental disorders from discrimination and exploitation in the work place?<br><br>2) Does the law provide for "reasonable accommodation" for employees with mental disorders, for example by providing for a degree of flexibility in working hours to enable those employees to seek mental health | ***a)***<br>*b)*<br>*c)*<br><br>***a)***<br>*b)*<br>*c)* | The law does not mention employment of persons with mental illnesses. | |

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| treatment?<br><br>3) Does the law provide for equal employment opportunities for people with mental disorders?<br><br>4) Does the law make provision for the establishment of vocational rehabilitation programmes and other programmes that provide jobs and employment in the community for people with mental disorders? | ***a)***<br>*b)*<br>*c)*<br><br>*a)*<br>*b)*<br>*c)* | | |
| **X. Social security**<br><br>1) Does legislation provide for disability grants and pensions for people with mental disabilities?<br><br>2) Does the law provide for disability grants and pensions for people with mental disorders at similar rates as those for people with physical disabilities? | ***a)***<br>*b)*<br>*c)*<br><br>***a)***<br>*b)*<br>*c)* | The law does not mention social security for persons with mental illness. | |
| **Y. Civil issues**<br><br>1) Does the law uphold the rights of people with mental disorders to the full range of civil, political, economic, social and cultural rights to which all people are entitled? | ***a)***<br>*b)*<br>*c)* | The law does not mention civil rights. | |

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| **Z. Protection of vulnerable groups**<br><br>***Protection of minors***<br><br>1) Does the law limit the involuntary placement of minors in mental health facilities to instances where all feasible community alternatives have been tried?<br><br>2) If minors are placed in mental health facilities, does the legislation stipulate that<br>a) they should have a separate living area from adults?<br><br>b) that the environment is age-appropriate and takes into consideration the developmental needs of minors?<br>3) Does the law ensure that all minors have an adult to represent them in all matters affecting them, including consenting to treatment?<br><br>4) Does the law stipulate the need to take into consideration the opinions of minors on all issues affecting them (including consent to treatment), depending on their age and maturity?<br><br>5) Does legislation ban all irreversible treatments for children? | ***a)***<br>*b)*<br>*c)*<br><br>***a)***<br>*b)*<br>*c)*<br><br>***a)***<br>*b)*<br>*c)*<br><br>***a)***<br>*b)*<br>*c)*<br><br>***a)***<br>*b)*<br>*c)*<br><br>***a)***<br>*b)*<br>*c)* | The law does not mention vulnerable groups. | |

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| **1.1.1.1 Protection of women**<br><br>1) Does legislation allow women with mental disorders equal rights with men in all matters relating to civil, political, economic, social and cultural rights?<br><br>2) Does the law ensure that women in mental health facilities :<br><br>a) have adequate privacy?<br><br>b) are provided with separate sleeping facilities from men?<br><br>3) Does legislation state that women with mental disorders should receive equal mental health treatment and care as men, including access to mental health services and care in the community, and in relation to voluntary and involuntary admission and treatment? | ***a)***<br>*b)*<br>*c)*<br><br>***a)***<br>*b)*<br>*c)*<br><br>***a)***<br>*b)*<br>*c)*<br><br>***a)***<br>*b)*<br>*c)*<br><br>***a)***<br>*b)*<br>*c)* | | |
| **1.1.1.2 Protection of minorities**<br><br>1) Does legislation specifically state that persons with mental disorders should not be discriminated against on the grounds | ***a)***<br>*b)* | | |

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| of race, colour, language, religion, political or other opinions, national, ethnic or social origin, legal or social status?<br><br>2) Does the legislation provide for a review body to monitor involuntary admission and treatment of minorities and ensure non-discrimination on all matters?<br><br>3) Does the law stipulate that refugees and asylum seekers are entitled to the same mental health treatment as other citizens of the host country? | *c)*<br><br>***a)***<br>*b)*<br>*c)*<br><br>***a)***<br>*b)*<br>*c)* | | |
| *1.1.1.2.1 AZ. Offences and penalties*<br><br>1) Does the law have a section dealing with offences and appropriate penalties?<br><br>2) Does the law provide appropriate sanctions against individuals who violate any of the rights of patients as established in the law? | ***a)X***<br>*b)*<br>*c)*<br><br>*a)X*<br>*b)*<br>*c)* | The Act has a section particularly devoted to offences | |

**Additional comments:**

- Probably the most significant flaw of the 1964 Act is its failure to make a distinction between involuntary versus voluntary care. It focuses almost entirely on issues to do with detention and as a consequence fails to adequately promote and protect the rights of people with mental disabilities both within the health care context (including access to adequate standard of mh care) and within the wider community.

- The Miscellaneous section of the law is a 'catch all' for many different legal matters. It deals with and 'mixes up' many different issues and is very confusing as a result.

# 7.5 Appendix 5: Sample of the SSI and FGD guides

## Macro level

### TOOL 2.1 SEMI-STRUCTURED INTERVIEW GUIDE FOR PROGRAMME MANAGERS AT NATIONAL LEVEL

**Background to interview**

The purpose of this interview is to look for information regarding perceptions of:

- The health context
- Mental health
- Public perceptions of mental health and stigma
- Mental health policy development
- Key stakeholders in mental health policy and law development
- Mental health policy implementation

This interview is important to understand how **programme managers at national level** regard mental health. Programme managers at national are key stakeholders. They have the responsibility to provide policy advice on mental health and oversee the implementation of mental health policies and programmes.

| | **QUESTION** | |
|---|---|---|
| **a.** | Can you briefly tell me about yourself, your background and interest in mental health? | |
| | **A. I would like to ask you some general background questions.** | |
| **b.** | How health services are organised in this country? | |
| **c.** | What economic, political and social factors do you think affect health care delivery in this country? | |
| **d.** | What are the key challenges that face the health system? | |
| **e.** | How do international factors, or international organisations, influence the health system in this country? | |
| **f.** | What types of assistance does this country receive from the international community?<br>(Prompt: *Overall level of assistance. How is the assistance changing over time)* | |
| | **B. Now I would like to ask you some questions about mental health** | |
| **g.** | How is mental ill-health perceived in this country by different groups? (prompts: international, government, non-government organizations, families, traditional healers, community leaders, media, faith healers etc)<br>Why do you think that is the case?<br>What is your view? | |
| **h.** | How important is mental health for the government compared to other health conditions?<br>Why is that?<br>(Prompt: *For example - funding patterns; media coverage; mutual links with poverty)* | |
| **i.** | How important is mental health compared to other health conditions for international agencies funding health programmes?<br>Why is that? | |

| | QUESTION | |
|---|---|---|
| **j.** | Can you tell me any government policies outside of health that have an influence on mental health?<br>*For each policy mentioned:*<br>• How does that policy affect mental health?<br>(Prompt: *For example – education, social welfare, prisons, women affairs.)* | |
| **k.** | What do you believe are the key mental health issues in this country? Are they given adequate attention by different government sectors? Can you provide some examples? How does the ministry link with other sectors on mental health issues? | |
| **l.** | Is mental health on the development agenda in this country? If so, what are the links that have been made? What sort of contributions are being made by the government financially and technically? | |
| **m.** | Why do you think mental health issues are not higher on the health agenda? Or on the development agenda? | |
| | **C. Now I would like to ask you some questions about mental health laws and policies and how they are developed in this country.** | |
| **n.** | Is there a mental health policy? (Probe: *Where is it set out (which documents)?* | |
| **o.** | How was the mental health policy developed? | |
| **p.** | Do you feel the laws and the policies are adequate? How can they be improved?<br>(Prompt: *Ask if there are any gaps)* | |
| **q.** | Do you think there is a link between mental illness and poverty? | |
| **r.** | How well do mental health policies and laws address the needs of people living in poverty?<br>How can the situation be improved? (Prompt: *For example, anti stigma initiatives)* | |
| **s.** | What key initiatives are needed to address stigma and discrimination toward people with mental health problems? | |
| **t.** | Are there policy issues affecting children and adolescents which should be included in mental health laws and policies? | |
| **u.** | Are there policy issues affecting boys and men, and girls and women which should be included in mental health laws and policies? What are these? *(*Prompt*: Explore gender related issues)* | |
| **v.** | How well integrated is mental health policy with other health policies? (*Prompt for examples)* | |
| **w.** | Are you satisfied with the way mental health laws and policies are developed in the country? If not, how could this be improved? | |
| **x.** | Should the government provide support to people with mental health problems to influence policies which impact on mental health? (Probe: *What is done already? What is still needed?)* | |
| | **D. Now I would like to ask you about how mental health laws and policies are implemented.** | |
| **y.** | What are the key challenges that face the health sector in implementing mental health policies? | |
| **z.** | Is mental health policy well implemented? (*Prompt for examples)* | |
| **aa.** | What are the most important reasons why mental health laws/policies are not implemented effectively?<br>• What can be done to overcome these problems?<br>(Prompt: *Only ask if implementation is not happening effectively)* | |
| **bb.** | To what extent are mental health policies translated into plans and budgets?<br>(Prompt: *National, provincial, district mental health plans and budgets)* | |

| | QUESTION | |
|---|---|---|
| **cc.** | Who are the important organisations or individuals involved in implementing mental health laws and policies. How are they involved? (Prompt: *List of individuals and organisations mentioned)* | |
| **dd.** | Are there individuals or organisations who are not involved in the implementation of mental health laws and policies, but you think should be?<br>a. Why are they not involved?<br>b. Can you think of any practical ways in which they could be better involved? | |
| | **E. Finally I would like to ask you for some more general comments** | |
| **ee.** | Are there any other comments you would like to make about the mental health policies in your country, and in particular, the role of different people and organisations in the policy making process? | |
| **ff.** | Do you have any reports or documents that we might find useful for this research, for example, any statements of policy and objectives, annual reports and so on?<br>(Prompt: *Only collect if the reports are new to the project.)* | |
| **gg.** | Do you know of any meetings or other events in the near future that you think would be useful for us to attend? | |
| **hh.** | Can you suggest other individuals who we need to interview? | |

**TOOL 1.1: SEMI-STRUCTURED INTERVIEW GUIDE FOR POLICY MAKERS AT NATIONAL LEVEL**

| | QUESTION | |
|---|---|---|
| 1. | Can you briefly tell me about yourself, your background and your interest in mental health? | |
| 2. | What are the main development priorities in this country?<br>(Prompt: *If health is not mentioned, ask what the position of health is)* | |
| 3. | What economic, political and social factors do you think affect health care delivery in this country? | |
| 4. | What are the key challenges that face the health system? | |
| 5. | How do international factors, or international organisations, influence the health system in this country?<br>(Prompt: *for example NGOs, UN, WHO*) | |
| 6. | What types of assistance does this country receive from the international community? | |
| | **B. Now I would like to ask you some questions about mental health** | |
| 7. | How does the general public in this country view mental illness? Have their views changed over time?<br>(Prompt: *Are there any differences between different groups, e.g. rural farmers vs urban workers. )*<br>How do you view mental illness? | |
| 8. | How important is mental health for this government compared to other health conditions? Why is that?<br>(Prompt: *For example - funding patterns; media coverage; mutual links with poverty)* | |
| 9. | How important is mental health for international agencies funding health programmes in this country? Why is that? | |

| | QUESTION | |
|---|---|---|
| 10 | How significant do you feel other sectors' policies and programmes are for mental health? (Prompt: *Examples - education, social welfare, prisons, women affairs.)* | |
| 11 | How does the Ministry of Health link with other sectors over mental health policies? | |
| 12 | What do you believe are the key mental health issues in this country? Are they given adequate attention by different government sectors? Can you provide some examples? How does the ministry link with other sectors on mental health issues? | |
| 13 | Is mental health on the development agenda in this country? If so, what are the links that have been made? What sort of contributions are being made by the government financially and technically? | |
| 14 | Why do you think mental health issues are not higher on the health agenda? Or on the development agenda? | |
| 15 | Which organisations and individuals are involved in the processes of policy making? | |
| | **D. Now I would like to ask you about mental health laws and policies and their development.** | |
| 16 | How was the mental health policy developed? | |
| 17 | Do you feel that the mental health policies and law are adequate? (Prompt: *Ask if there are any gaps?)* Which of the laws and policies are not adequate? How could they be improved? (Prompt: *Only ask if the respondent thinks they are inadequate)* | |
| 18 | How well do the mental health policies and law address the needs of people living in poverty? How can the situation be improved? (Prompt: *For example anti-stigma initiatives)* | |
| 19 | What key initiatives are needed to address stigma and discrimination toward people with mental health problems? (Prompt: *E.g., anti-stigma campaigns, support for user advocacy/organisation, inclusion in government activities, etc)* | |
| 20 | How well integrated is mental health policy with other health policies and relevant policies in other sectors? How can the situation be improved? (Prompt: *Including degree of multisectoralism)* | |
| 21 | How over time, will the policies and law be updated? (Prompt: *Process of updating the policy and law)* | |
| 22 | Are there policy issues affecting children and adolescents which should be included in mental health laws and policies? | |
| 23 | Are there policy issues affecting boys and men, and girls and women which should be included in mental health laws and policies? What are these? *(*Prompt*: Explore gender related issues)* | |
| 24 | Do you know of any NGOs, community groups or patient groups who focus primarily on mental health? Are they involved in developing mental health laws and policies in this country? How can this be improved? (Prompt: *Is their involvement appropriate and adequate?)* | |
| 25 | Should the government provide support to people with mental health problems to influence policies which impact on mental health? (Prompt: *What is done already? What is still needed?)* | |
| 26 | Are you satisfied with the way mental health policies are developed in this country? If not how could this be improved? | |
| 27 | Are there any individuals or organisations who are not involved in developing mental health laws and policies in this country, but you think should be?<br>• Why are they not involved?<br>• Can you think of any practical ways in which they could be better involved?<br>(Prompt: *List individuals or organisations mentioned.)* | |

| | QUESTION | |
|---|---|---|
| | **E. Now I would like to ask you about how mental health laws and policies are implemented.** | |
| 28 | What are the key challenges that face the health sector in implementing mental health policies and laws? | |
| 29 | Is mental health policy well implemented?<br>Is mental health law well implemented? (Prompt: *Please give examples.)* | |
| 30 | What are the most important reasons why mental health laws and policies are not implemented effectively?<br>• What can we do to overcome these problems?<br>(Prompt: *Only ask if implementation is not happening effectively)* | |
| 31 | To what extent are national mental health policies translated into plans and budgets?<br>(Prompt: *national, provincial and district mental health plans and budgets)* | |
| 32 | What tools and procedures are in place for the implementation of mental health legislation?<br>(Prompt: *Written regulations, professional codes of conduct, educational materials for different stakeholders?)* | |
| 33 | Who is responsible for implementing mental health legislations (laws)? Is there implementation agency?<br>(Prompt: *Examples are tribunals, review boards, or visiting committees which are functional)* | |
| 34 | Who are the important organisations or individuals involved in implementing mental health laws and policies in this country? (Prompt: *List individuals or organisations mentioned.)* | |
| 35 | Are there any individuals or organisations who are not involved in implementing mental health laws and policies in this country, but you think should be?<br>• Why are they not involved?<br>• Can you think of any practical ways in which they could be better involved?<br>(Prompt: *List individuals or organisations mentioned.)* | |
| | **F. Finally I would like to ask you for some more general comments.** | |
| 36 | Are there any other comments you would like to make about the mental health policies in your country, and in particular, the role of different people and organisations in the policy-making process? | |
| 37 | Do you have any reports or documents that we might find useful for this research, for example, any statements of policy and objectives, annual reports and so on?<br>*(Only collect if the reports are new to the project.)* | |
| 38 | Can you suggest other individuals who we need to interview? | |

**TOOL 6.1: STRUCTURED INTERVIEW GUIDE FOR POLITICIANS AT NATIONAL AND REGIONAL LEVELS**

| | QUESTION | |
|---|---|---|
| 1 | Can you briefly introduce yourself, tell me about your background and your interest in mental health? | |
| | **A. I would like to ask you some general background questions.** | |
| 2 | What are the main development priorities in this country?<br>(Probe: *If health is not mentioned, ask what the position of health is)* | |
| | What are the key challenges that face the health system in your country? | |

| | QUESTION | |
|---|---|---|
| **3** | What type of assistance does the government receive from international community?<br>(Probe: *The extent and types of assistance to the health sector)* | |
| | **B. Now I would like to ask you some questions about mental health in this country.** | |
| **4** | How does the general public in this country view mental illness? Have their views changed over time?<br>(Prompt: *Are there any differences between different groups, e.g. rural farmers vs urban workers.)* How do you view mental illness? | |
| **5** | How important is mental health for this government compared to other health conditions? Why is that?<br>(Probe: *For example, funding patterns; media coverage; mutual links with poverty?)* | |
| **6** | How important is mental health for international agencies funding health programmes in this country? Why is that? (Prompt: *Include multilateral, bilateral and non-governmental organisations)* | |
| **7** | Can you tell which of the government policies have an influence on mental health?<br>(Prompt: *List of policies)* | |
| **8** | What do you believe are the key mental health issues in this country? Are they given adequate attention by the government?, or non-government sectors? Can you provide some examples? | |
| **9** | Is mental health on the political agenda in this country? If so, how?<br>Why do you think mental health issues are not higher on the political agenda? | |
| **10** | What in your view are some of the steps that would need to be taken in order for mental health issues to have greater visibility on the government agenda? | |
| | **C. Now I would like to ask you some questions about how policies are made in this country.** | |
| **11** | Generally, can you describe the processes of developing policies in this country?<br>(Prompt: *Stages of policy development,participatory nature, use of evidence, etc.)* | |
| **12** | Are you satisfied with the current process of policy making?<br>What can be improved? | |
| **13** | Which organisations and individuals are involved in the process of policy developing? | |
| | **D. Now I would like to ask you about mental health laws and policies and their development.** | |
| **14** | Are there mental health laws and policies? What are they about? | |
| **15** | Do you feel the current mental health laws and policies are adequate?<br>(Prompt: *Ask if there are any gaps)* | |
| **16** | Which of the laws and policies are not adequate?<br>How could they be improved? (Prompt: *Only ask if the respondent thinks they are inadequate)* | |
| **17** | How well do the mental health laws and policies address the needs of people living in poverty?<br>How can the situation be improved? (*Prompt: For example anti-stigma initiatives*) | |
| **18** | What key initiatives are needed to address stigma and discrimination toward people with mental health problems? (Prompt: *E.g., anti-stigma campaigns, support for user advocacy/organisation, inclusion in government activities, etc)* | |
| **19** | Are there policy issues affecting children and adolescents which should be included in mental health laws and policies? | |
| **20** | Are there policy issues affecting boys and men, and girls and women which should be included in mental health laws and policies? What are these? *(*Prompt*: Explore gender related issues)* | |

| | QUESTION | |
|---|---|---|
| **21** | How over time, will the laws and policies be updated? (Prompt: *Process of updating the policy)* | |
| **22** | Who are the important organisations or individuals involved in developing mental health laws and policies in this country? | |
| **23** | Should the government provide support to people with mental health problems to influence policies which impact on mental health? (Prompt: *What is done already? What is still needed?)* | |
| **24** | Does your sector have access to sufficient information and support on mental health issues to be able to integrate mental health into your own policies?<br>(Prompt: *What is needed? E.g. staffing, resources, information)* | |
| | **E. Now I would like to ask you about how mental health laws and policies are implemented.** | |
| **25** | What are the key challenges in implementing mental health laws and policies? | |
| **26** | Are mental health laws and policies well implemented? (Prompt: *Check for evidence, ask for examples.)* | |
| **27** | What are the most important reasons why mental health laws and policies are not implemented effectively?<br>What can be done to overcome these problems?<br>(Prompt: *Only ask if implementation is not happening effectively)* | |
| **28** | Who are the important organisations or individuals involved in implementing mental health laws and policies in this country? | |
| | **F. Finally I would like to ask you for some more general comments** | |
| **29** | Are there any other comments you would like to make about the mental health policies in your country, and in particular, the role of different people and organisations in the policy-making process? | |
| **30** | Do you have any reports or documents that we might find useful for this research, for example, any statements of policy and objectives, annual reports and so on?<br>(Prompt: *Only collect if the reports are new to the project.)* | |
| **31** | Do you know of any meetings or other events in the near future that you think would be useful for us to attend? | |
| **32** | Can you suggest other individuals who we need to interview? | |

## TOOL 4.1: SEMI-STRUCTURED INTERVIEW GUIDE FOR EXTERNAL DEVELOPMENT PARTNERS

| | QUESTION | |
|---|---|---|
| 1. | Can you briefly introduce yourself, tell me about your background and your interest in mental health? | |
| | **A. I would like to ask you some general background questions.** | |
| 2. | What are the main development priorities in this country? How have these priorities been determined?<br>(Prompt: *If health is not mentioned, ask what is the position of health)* | |
| 3. | What economic, political and social factors affect health care delivery in this country? | |
| 4. | To what extent do you think external trends are influencing the country's health sector?<br>(Prompt: *international, regional)* | |

| | QUESTION | |
|---|---|---|
| 5. | What do you think is the overall level of foreign support for health and health care?<br>How is this changing over time?<br>(Prompt: *What form does foreign support take?)* | |
| 6. | What is the extent of your organisation's support to the health sector in this country?<br>How is this changing over time? | |
| 7. | What key organizations are supporting health? What sort of technical and financial contributions are being made by the different organizations? | |
| | **B. Now, I would like to ask you questions about mental health** | |
| 8. | What do you think is the position of mental health compared to other health problems in this country? Is mental health on the development agenda in this country? Why do you think this is the case? | |
| 9. | What do you think is the overall level of foreign support for mental health and mental health care in this country? | |
| 10. | What is the extent of your organisation's support to mental health programmes in this country? | |
| 11. | In your opinion, are there links between mental health/mental ill-health and development? What are they? | |
| 12. | To what degree are people with mental disorders considered a vulnerable group to be included in the development agenda? | |
| 13. | How could the foreign aid support for mental health be increased? | |
| 14. | Can you describe some development programmes and the extent to which mental health issues are addressed in these programmes? | |
| | **C. Now I would like to ask you about mental health laws and policies and their development in this country.** | |
| 15. | Do you know of the mental health policy in this country? | |
| 16. | Do you feel the policy is adequate? (Prompt: *Ask if there are gaps)* | |
| 17. | How well integrated is mental health policy with other health and social policies?<br>How can the situation be improved? (Prompt: *Including degree of multisectoralism)* | |
| 18. | How well do mental health policies and laws address the needs of people living in poverty? How can the situation be improved? (Prompt: *E.g. anti-stigma initiatives*) | |
| 19. | What key initiatives are needed to address stigma and discrimination toward people with mental health problems? (Prompt: *E.g., anti-stigma campaigns, support for user advocacy/organisation, inclusion in government activities, etc)* | |
| 20. | How are external development partners involved in the development of mental health policies?<br>(Prompt: At what stages are they involved?) *How could their involvement be improved?)* | |
| 21. | What inputs do external development partners provide in the development of mental health laws and policies? How could this be improved? | |
| 22. | Are there any individuals or organisations who are not but should be involved in developing Laws and policies? (Prompt: *List individuals and organisations*<br>*At what stages?*<br>*How should they be involved?*<br>*At what level should they interact)* | |
| | **D. Now I would like to ask you some questions about the appropriateness of mental health policies and Mental Health Law** | |

| | QUESTION | |
|---|---|---|
| 23. | Are mental laws and policies consistent with the principles/standards of human rights? | |
| 24. | Do you think any evidence/information is used into current mental health policies? If so, what types of evidence? (Prompt: *research results, experience, users' views, service providers' opinions etc)* | |
| 25. | What mental health issues do you feel are not accommodated in health policies?<br>How the situation can be improved? | |
| 26. | Do existing mental health law and policy require institutional development/reform? If so, what should be the interventions? | |
| 27. | Are there policy issues affecting children and adolescents which should be included in mental health laws and policies? | |
| 28. | Are there policy issues affecting boys and men, and girls and women which should be included in mental health laws and policies? What are these? *Explore gender related issues* | |
| 29. | How can donors such as your organisation support these interventions? | |
| | **E. Now I would like to ask you about how mental health laws and policies are implemented.** | |
| 30. | What are the key challenges that face the health sector in implementing mental health policies? | |
| 31. | Is mental health policy well implemented? (Prompt: *Please give examples.)* | |
| 32. | What are the most important reasons why mental health laws and policies are not implemented effectively? What can be done to overcome these problems? | |
| 33. | What is the role of external development partners in the implementation of mental health laws and policies? | |
| 34. | What can be done by external development partners to facilitate the implementation of mental health laws and policies? How should these be done? | |
| | **F. Finally I would like to ask for some more general comments.** | |
| 35. | Are there any other comments you would like to make about the mental health policies in this country? | |
| 36. | What suggestions or comments would you like to make regarding this study? | |
| 37. | Do you have any reports or documents that we might find useful for this research, for example, any statements of policy and objectives, annual reports and so on?<br>Prompt: *Only collect if the reports are new to the project.)* | |
| 38. | Do you know of any meetings or other events in the near future that you think would be useful for us to attend? | |
| 39. | Can you suggest other individuals who we need to interview? | |

**TOOL 7.1: SEMI-STRUCTURED INTERVIEW GUIDE FOR ACADEMICS AND RESEARCHERS**

| | **QUESTION** | |
|---|---|---|
| **ii.** | Can you briefly introduce yourself, tell me about your background and your interest in mental health? | |
| | **A. I would like to ask you some general background questions.** | |
| **jj.** | Can you tell me what types of health research you have been involved in (apart from mental health research)? (Prompt: *What were they about, who funded them and why you have done this work?)* | |
| **kk.** | What types of assistance do research institutions receive from the government?<br>(Prompt: *Check the overall level for health and health related research?*<br>*How is this assistance changing over time?)* | |
| **ll.** | What is the overall level of international assistance for health and health related research?<br>How is this assistance changing over time?<br>(Prompt: *Enquire about names of international organisations that provide support to research institutions)* | |
| | **B. Now I would like to ask you some questions about mental health in this country.** | |
| **mm.** | How does the general public in this country view mental illness? Have their views changed over time?<br>(Prompt: *Are there any differences between different groups, e.g. rural farmers vs urban workers.)*<br>• How do you view mental illness? | |
| **nn.** | Compared to other health research, how much of a priority is mental health for the government? Why is that? (Prompt: *For example - funding patterns; making use of research data)* | |
| **oo.** | Compared to other health research, how much of a priority is mental health for international agencies who are funding health research in this country? Why is that? | |
| | **C. Now I would like to ask you some questions about mental health research in this country** | |
| **pp.** | Have you been involved in any research or study that specifically relates to mental health?<br>If so, what were they, when were they done and who funded them?<br>(Prompt: check the *Purpose of the research)* | |
| **qq.** | Are you aware of any other research or studies that are related to mental health?<br>If so, what were they, when were they done and who funded them? | |
| | **D. Now I would like to ask you some questions about how mental health laws and policies are made in this country.** | |
| **rr.** | Are you aware of the existence of any mental health legislation and policy in this country?<br>(Prompt: *Where are they set out? Which documents)* | |
| **ss.** | How was the mental health policy developed? | |
| **tt.** | To what extent is the policy influenced by the research and studies that are conducted in the country? | |
| **uu.** | How do you see the role of research in the development of mental health policy in this country? | |
| **vv.** | Were academic and research institutions involved in the development of the mental health policy?<br>⇒ How were they involved?<br>⇒ How could they be better involved?<br>(Prompt: *At what stage? Please give examples.)* | |
| | **E. Now I would like to ask you about how mental health laws and policies are implemented.** | |

| | QUESTION | |
|---|---|---|
| **ww.** | What do you consider to be the key challenges that face the health sector in implementing mental health legislation and policy? | |
| **xx.** | Is the mental health Treatment Act and policy well implemented?<br>(Prompt: *What is the evidence? Please give examples.)* | |
| **yy.** | How is the mental treatment Act and Mental health policy implemented in the country (at national, regional and district levels)? Do you think it is effective? Why is that? | |
| **zz.** | What are the most important reasons why the mental health Act and policy are not implemented effectively?<br>⇒ What can be done to overcome these problems?<br>(Prompt: *Only ask if implementation is not happening effectively)* | |
| **aaa.** | To what extent are academic institutions involved in translating national mental health policy to:<br>a. national mental health plans<br>b. national mental health implementation programmes<br>If not currently involved, how could they be involved? | |
| **bbb.** | To what extent are academic institutions involved in developing appropriate tools and procedures for the implementation of mental health treatment Act?<br>If not currently involved, how could they be involved?<br>(Prompt: *For example written regulations, professional codes of conduct, educational materials for different stakeholders?)* | |
| **ccc.** | Is there a system of monitoring the implementation of the mental health Act and policy?<br>If no, what suggestions would you like to make? | |
| **ddd.** | How are mental health laws and the policy evaluated?<br>⇒ Who evaluates them?<br>⇒ How often are they evaluated?<br>⇒ How are evaluation results used?<br>(Prompt: *Only ask if evaluation is done)* | |
| **eee.** | What role can academic and research institutions play in monitoring the implementation and evaluation of mental health laws and policies?<br>⇒ What can be done to enhance this role? | |
| | **F. Finally I would like to ask for some more general comments.** | |
| **fff.** | Are there any comments you would like to make about the mental health policies in your country, and in particular, the role of academic and research institutions in the policy making process? | |
| **ggg.** | Do you have any reports or documents that we might find useful for this research, for example, any statements of policy and objectives, annual reports and so on?<br>(Prompt: *Only collect if the reports are new to the project.)* | |
| **hhh.** | Do you know of any meetings or other events in the near future that you think would be useful for us to attend? | |
| **iii.** | Can you suggest other individuals who we need to interview? | |

## TOOL 5.1: SEMI STRUCTURED INTERVIEW GUIDE FOR MEDIA REPRESENTATIVES

| | **QUESTION** | |
|---|---|---|
| 1. | Can you briefly introduce yourself, tell me about your background and your interest in mental health? | |
| | **A. I would like to ask you some general background questions.** | |
| 2. | What economic, political and social factors do you think affect health care delivery in this country? | |
| 3. | To what degree is health an important issue for the media compared to other development issues? | |
| 4. | What are the key health issues attracting the media's attention? | |
| 4. | What are the key challenges that face the health system? | |
| 6. | How does the media influence the health care system in this country? | |
| | **B. Now I would like to ask you some questions about mental health** | |
| 7. | How does the general public in this country view mental illness? Have their views changed over time?<br>(Prompt: *Are there any differences between different groups, e.g. rural farmers vs urban workers.)*<br>How do you view mental illness? | |
| 8. | Is mental health an issue that gets a lot of attention? In what context does it get attention? | |
| 9. | What role does the media play in the development of mental health programmes? | |
| 10. | What factors would promote more reporting on mental health issues in the media? | |
| 11. | How does the media portray people with mental illness? Why do you think this is the case? | |
| 12. | To what degree are the media informed and educated about key mental health issues? Can you give examples? How does this compare to other health areas? | |
| 13. | How does the Ministry of Health link with the media on issues related to mental health policies and programmes? | |
| 14. | Can you describe the relationship between the media and the ministry of health and other organizations or individuals working in mental health? | |
| | **C. Now I would like to ask you about mental health laws and policies and their development.** | |
| 15. | Are you aware of mental health laws and policies that exist in this country? If yes, where is the mental health policy set out? (Prompt: *Which documents?)* | |
| 16. | Do you know how the mental health policy was developed? | |
| 17. | How well do the mental health policies and laws address the needs of people living in poverty? How can the situation be improved? (prompt: *For example anti-stigma/anti poverty initiatives)* | |
| 18 | What key initiatives are needed to address stigma and discrimination towards people with mental health problems? (Prompt: *E.g., anti-stigma campaigns, support for user advocacy/organisation, inclusion in government activities, etc)* | |
| 19 | What role does the media play in the development of mental health laws and policies in this country? Has this been effective? In what way?<br>(Prompt: *e.g. advocacy, raising mental health issues on policy agenda? Ask for examples.)* | |

| | QUESTION | |
|---|---|---|
| 20 | How can the role of the media in the development of mental health laws and policies be improved? (Prompt: *Is their involvement appropriate and adequate?)* | |
| 21 | Are there any individuals or organisations who are not involved in developing mental health laws and policies in this country, but you think should be?<br>• Why are they not involved?<br>• Can you think of any practical ways in which they could be better involved?<br>(Prompt: *List individuals or organisations mentioned.)* | |
| | **D. Now I would like to ask you about how mental health laws and policies are implemented.** | |
| 22. | Are mental health laws and policies well implemented?<br>(Prompt: *Ask for examples)* | |
| 23. | What are the key challenges that the health sector faces in implementing mental health laws and policies? | |
| 24. | What are the most important reasons why mental health laws and policies are not implemented effectively?<br>• What can we do to overcome these problems?<br>(Prompt: *Only ask if implementation is not happening effectively)* | |
| 25. | What role does the media play in the implementation of mental health laws and policies in this country? Has this been effective? In what way?<br>(Prompt: *e.g. advocacy, raising mental health issues on policy agenda? Ask for examples.)* | |
| 26 | How can the role of the media in the implementation of mental health laws and policies be improved? (Prompt: *Is their involvement appropriate and adequate?)* | |
| 27 | Are there any individuals or organisations who are not involved in implementing mental health laws and policies in this country, but you think should be?<br>• Why are they not involved?<br>• Can you think of any practical ways in which they could be better involved?<br>(Prompt: *List individuals or organisations mentioned)* | . |
| | **E. Finally I would like to ask you for some more general comments.** | |
| 28 | Are there any other comments you would like to make about the mental health policies in your country, and in particular, the role of the media and different people and organisations in the policy-making process? | |
| 29 | Do you have any reports or documents that we might find useful for this research, for example, any statements of policy and objectives, annual reports and so on?<br>(Prompt: *Only collect if the reports are new to the project.)* | |
| 30 | Do you know of any meetings or other events in the near future that you think would be useful for us to attend? | |
| 31 | Can you suggest other individuals who we need to interview? | |

**TOOL 3.1: SEMI STRUCTURED INTERVIEW GUIDE FOR NATIONAL POLICY MAKERS OF OTHER GOVERNMENT SECTORS (EDUCATION, INTERIOR, PRISONS, SOCIAL WELFARE, WOMEN AFFAIRS AND OTHERS)**

| | **QUESTION** | |
|---|---|---|
| 1. | Can you briefly introduce yourself; tell me about your background and your interest in mental health? (Prompt: *Note down the sector which the respondent represents, e.g. education, social services, etc)* | |
| | **A. I would like to ask you some general background questions.** | |
| 2. | What are main social and development priorities in this country?<br>(Prompt: *For example: poverty alleviation, health service coverage, universal education, etc.)* | |
| | **B. Now I would like to ask you some questions about your department and mental health** | |
| 3. | What is the focus of the work of your department?<br>(Prompt: *For example: health, prison services, social welfare, women affairs, etc.)* | |
| 4. | What are the policies of your department which have an impact on health?<br>How about mental health?<br>(Prompt: *For example: policies in education, interior, prisons, social welfare, women affairs and others)* | |
| 5. | Does the work of your department involve issues related to mental health? What is this work? | |
| 6. | If it does involve issues related to mental health, what particular groups or individuals does your department deal with on mental health issues?<br>(*Prompt: specific gender, social and age groups, e.g. men, women, children, adolescents, prisoners, etc)* | |
| 7. | Are you satisfied by the services that are provided by your department in relation to mental health? Could they be improved?<br>(Prompt: *Services could include school mental health, care of victims, the elderly and children under the care of social services, care of prisoners with mental health problems, the drug addicts, etc)* | . |
| 8. | What key initiatives are needed to address stigma and discrimination toward people with mental health problems?<br>(Prompt: *E.g., anti-stigma campaigns, support for user advocacy/organisation, inclusion in government activities, etc)* | |
| 9. | How does the general public in this country view mental illness? Have their views changed over time? (Prompt: *Are there any differences between different groups, e.g. rural farmers vs urban workers?)* How do you view mental illness? | |
| | | |
| | **C. Now I would like to ask you about mental health laws and policies and about how they are developed in this country** | |
| 10. | Are you familiar with the current mental health laws and policy?<br>How do current mental health laws and policies relate to the work of your department?<br>*Do the law and policy require specific activity of your department?)* | |
| 11. | How consistent is mental health policy with the policy of your department? | |
| 12. | Do you feel the laws and policies relating to mental health are adequate? How could they be improved? | |
| 13. | How well do the mental health policies and laws address the needs of people living in poverty? How can the situation be improved? | |
| 14. | Are there mental health policy issues affecting children and adolescents which should be included in mental health laws and policies and the and policies of your department? | |

| | QUESTION | |
|---|---|---|
| 15. | Are there gender-related mental health policy issues which should be included in mental health laws and policies and the policies of your department? What are these? | |
| 16. | Has your department been involved in mental health policy development? How?<br>*Are you satisfied with this level of involvement? If no, how could this be improved?)*<br>What role could your department play in this process? | |
| 17. | How does your department collaborate with the department of health over policies related to mental health? (Prompt: *How did you get involved? Task force, working groups, consultation? Are you satisfied with this?)* | |
| 18. | Does your department have access to sufficient information and support on mental health issues to be able to integrate mental health into your own policies?<br>(Prompt: *What is needed? E.g. staff, resources*) | |
| 19. | Are there any individuals or organisations who are not involved in the development of mental health policies, but you think should be?<br>• Why are they not involved?<br>• Can you suggest any practical ways in which they could be better involved | |
| | **D. Now I would like about how mental health laws and policies are implemented** | |
| 20. | For your department, what are the key challenges in the implementation of existing mental health laws and policies? (Prompt: *Possible challenges could include: resource constraints, lack of capacity, inadequate trained personnel, lack of clarity of the policy, etc.)* | |
| 21. | Are mental health policies and laws well implemented by your department?<br>(Prompt: *Please give examples)* | |
| 22. | What are the most important reasons why mental health laws and policies are not implemented effectively within your department? What can we do to overcome these problems? | |
| 23. | What tools and procedures are in place for the implementation of mental health laws in your department? (Prompt: *Written regulations, professional codes of conduct, educational materials for different stakeholders?)* | |
| 24. | Who is responsible for implementing mental health laws in your department?<br>(Prompt: *Examples are tribunals, review boards, or visiting committees)* | |
| 25. | Who are the important organisations or individuals involved in implementing mental health laws in your department? *(Prompt: List individuals or organisations mentioned)* | |
| 26. | Who are the important organisations or individuals involved in implementing mental health policies in your department? *(Prompt: List individuals or organisations mentioned)* | |
| 27. | Are there any individuals or organisations in your department who are not involved in implementing mental health laws this country, but you think should be?<br>• Why are they not involved?<br>• Can you think of any practical ways in which they could be better involved?<br>*(Prompt: List individuals or organisations mentioned)* | |
| 28. | Are there any individuals or organisations in your department who are not involved in implementing mental health policies in this country, but you think should be?<br>• Why are they not involved?<br>• Can you think of any practical ways in which they could be better involved?<br>*(Prompt: List individuals or organisations mentioned)* | |
| | **F. Finally I would like to ask you for some more general comments.** | |
| 29. | Are there any other comments you would like to make about the mental health and MH policies, and in particular, the role of different people and government sectors or organisations in the policy making and implementation process? | |

| | QUESTION | |
|---|---|---|
| 30. | Do you have any reports or documents that we might find useful for this research, for example, any government instructions / statements, annual reports and so on?<br>(Prompt: *Only collect if the reports are new to the project)* | . |
| 31. | Do you know of any meetings or other events in the near future that you think would be useful for us to attend? | |
| 32. | Can you suggest other individuals who we need to interview? | |

## TOOL 10.1: SEMI STRUCTURED INTERVIEW GUIDE FOR PROFESSIONAL UNIONS AND ASSOCIATIONS

| | QUESTION | |
|---|---|---|
| 1 | Can you briefly introduce yourself, tell me about your background and your interest in mental health? | |
| 2 | What are the main development priorities in this country?<br>(Prompt: *If health is not mentioned, ask what the position of health is)* | |
| 3 | What economic, political and social factors do you think affect health care delivery in this country? | |
| 4 | What are the key challenges that face the health system? | |
| 5 | How do professional associations influence the health system in this country? | |
| | **B. Now I would like to ask you some questions about mental health** | |
| 6 | How does the general public in this country view mental illness? Have their views changed over time? (Prompt: *Are there any differences between different groups, e.g. rural farmers vs urban workers. )*<br>• How do you view mental illness? | |
| 7 | How important is mental health for your professional association compared to other health conditions? Why is that? (Prompt: *e.g. HIV AIDS, TB etc.)* | |
| 8 | How does the Ministry of Health link with professional associations over mental health policies and programmes? | |
| 9 | For your professional affiliation and membership, what are the key mental health issues that need to be addressed? Are these issues currently being addressed adequately? What would be needed to engage your professional organization in addressing these issues? | |
| | **C. Now I would like to ask you about mental health laws and policies and their development.** | |
| 10 | How was the mental health policy developed? | |
| 11 | Do you feel the mental health laws and policies are adequate?<br>(Prompt: *Ask if there are any gaps?)* | |
| 12 | How well do the mental health policies and laws address the needs of people living in poverty? How can the situation be improved? (Prompt: *For example anti-stigma initiatives)* | |

| | QUESTION | |
|---|---|---|
| 13 | What key initiatives are needed to address stigma and discrimination toward people with mental health problems? (Prompt: *E.g., anti-stigma campaigns, support for user advocacy/organisation, inclusion in government activities, etc)* | |
| 14 | Are there policy issues affecting children and adolescents which should be included in mental health laws and policies? | |
| 15 | Are there policy issues affecting boys and men, and girls and women which should be included in mental health laws and policies? What are these? *(*Prompt*: Explore gender related issues)* | |
| 16 | Who are the important organisations or individuals involved in developing mental health laws and policies in this country? How are they involved? | |
| 17 | In what way are unions and professional associations involved in the development of mental health policies? (Probe: *Is their involvement appropriate and adequate? How could their involvement be facilitated?)* | |
| 18 | Should the government provide support to unions and professional associations to influence policies which impact on mental health? (Probe: *What is done already? What is still needed?)* | |
| 19 | Are you satisfied with the way mental health policies and laws are developed in this country? If not, how could this be improved? | |
| 20 | Are there any individuals or organisations who are not involved in developing mental health laws and policies in this country, but you think should be?<br>• Why are they not involved?<br>• Can you think of any practical ways in which they could be better involved?<br>(Prompt: *List individuals or organisations mentioned.)* | |
| 21 | Should the government provide support to people with mental health problems to influence policies which impact on mental health? (Probe: *What is done already? What is still needed?)* | |
| | **D. Now I would like to ask you about how mental health laws and policies are implemented.** | |
| 22 | Is mental health policy well implemented? (Prompt: *Ask for examples)* | |
| 23 | What are the key challenges that face the health sector in implementing mental health policies? | |
| 24 | What are the most important reasons why mental health laws and policies are not implemented effectively?<br>• What can we do to overcome these problems?<br>(Prompt: *Only ask if implementation is not happening effectively)* | |
| 25 | Who are the important organisations or individuals involved in implementing mental health laws and policies in this country? (Prompt: *List individuals or organisations mentioned.)* | |
| 26 | Are there any individuals or organisations who are not involved in implementing mental health laws and policies in this country, but you think should be?<br>• Why are they not involved?<br>• Can you think of any practical ways in which they could be better involved?<br>(Prompt: *List individuals or organisations mentioned.)* | |
| | **E. Finally, I would like to ask you for some more general comments** | |
| 27 | Are there any other comments you would like to make about the mental health policies in your country, and in particular, the role of different people and organisations in the policy-making process? | |

| | QUESTION | |
|---|---|---|
| 28 | Do you have any reports or documents that we might find useful for this research, for example, any statements of policy and objectives, annual reports and so on?<br>(Prompt: *Only collect if the reports are new to the project.)* | |
| 29 | Do you know of any meetings or other events in the near future that you think would be useful for us to attend? | |
| 30 | Can you suggest other individuals who we need to interview? | |

## TOOL 8.4: SEMI STRUCTURED INTERVIEW GUIDE FOR RELIGIOUS AND COMMUNITY LEADERS

| | QUESTION | |
|---|---|---|
| 1 | Can you briefly tell me about yourself, tell me about your background and your interest in mental health? | |
| | **A. I would like to ask you some general background questions.** | |
| 2 | What social, religious and community factors do you think affect health care delivery in this country? | |
| 3 | How do community and religious leaders, influence the health system care in this country? | |
| | **B. Now I would like to ask you some questions about mental health** | |
| 4 | How does the general public in this country view mental illness? Have their views changed over time? (Prompt: *Are there any differences between different groups, e.g. rural farmers vs urban workers. Probe for traditional beliefs, biomedical, stress-related, alternative views)*<br>• How do you view mental illness? | |
| 5 | How does the Ministry of Health link with community and religious leaders over mental health issues of the community? | |
| | **C. Now I would like to ask you about mental health laws and policies and their development.** | |
| 6 | Are you aware of any mental health policies in this country? | |
| 7 | How important do you think it is to have mental health policy? Why? | |
| 8 | Does the mental health policy address the needs of people living in poverty?<br>*(If not aware of a mental health policy:*<br>How could mental health policy address the needs of people living in poverty?) | |
| 9 | What key initiatives are needed to address stigma and discrimination towards people with mental health problems? (Prompt: *E.g., anti-stigma campaigns, support for user advocacy/organisation, inclusion in government activities, etc)* | |
| 10 | Are there policy issues affecting children and adolescents which should be included in mental health laws and policies? | |
| 11 | Are there policy issues affecting boys and men, and girls and women which should be included in mental health laws and policies? What are these?<br>*(*Prompt*: Explore gender related issues)* | |

| | QUESTION | |
|---|---|---|
| 12 | Which community and religious leaders are involved or should be involved in developing mental health laws and policies in this country? | |
| 13 | Should government provide support to community and religious leaders to influence policies which impact on mental health? (Probe: *What is done already? What is still needed?)* | |
| | **D. Now I would like to ask you about how mental health laws and policies are implemented.** | |
| 14 | What are the key challenges that face the health sector in implementing mental health policies? | |
| 15 | Is mental health policy well implemented? *(Probe for examples*) | |
| 16 | What are the most important reasons why mental health laws and policies are not implemented effectively?<br>• What can we do to overcome these problems?<br>(Prompt: *Only ask if implementation is not happening effectively)* | |
| 17 | Are you involved in the implementation of mental health policies and laws?<br>If yes, how are you involved? | |
| 18 | If you are not involved, do you think you should be involved in implementing mental health policies in this country?<br>• Can you think of any practical ways in which you could better involved? | |
| | **E. Are there any other comments you would like to make about the mental health policies in your country, and in particular, the role of different people and organisations in the policy-making process?** | |

## TOOL 8.2: SEMI STRUCTURED INTERVIEW GUIDE FOR PRIVATE SECTOR AND NGOS (PRESSURE/ADVOCACY GROUPS AND SERVICE PROVIDERS)

| | QUESTION | |
|---|---|---|
| 1. | Can you briefly tell me about yourself, background & your interest in mental health? | |
| | **A. I would like to ask you some general background questions.** | |
| 2. | Can you describe the focus of the work of your organisation in this country?<br>(Prompt: *If not mentioned, ask if health and, more specifically, mental health is of importance)* | |
| 3. | Does your organisation focus on the general population or particular social group(s)? | |
| 4. | What are the key challenges faced by the health system in this country? What are the reasons? | |
| | **B. Now I would like to ask you some questions about mental health** | |
| 5. | How does the general public in this country view mental illness? Have their views changed over time?<br>(Prompt: *Are there any differences between different groups, e.g. rural farmers vs urban workers.)*<br>• How do you view mental illness? | |
| 6. | How important is mental health in terms of the work which you and your organisation are doing?<br>How important is mental health for your organisation compared to other health issues?<br>Why is that? | |

| | QUESTION | |
|---|---|---|
| 7. | How important is mental health for the government compared to other health conditions? Why is that? (Prompt: *For example, HIV/AIDS, TB and malaria)* | |
| 8. | How important do you think mental health is for the government compared to other social issues? (Prompt: *For example, education, housing)* | |
| | **C. Now I would like to ask some questions about the role of your organisation in mental health** | |
| 9. | Are you or your organisation involved in any advocacy role to change the attitude of politicians, policy makers and general public regarding mental health issues and problems? (Prompt: *Description of the role)* | |
| 10. | How do you carry out that role? What difficulties, if any do you have and how do you intend to overcome those difficulties? | |
| 11. | How much of the work of your organisation involves providing care to the mentally ill? Which social groups do you serve? What does your work involve? | |
| 12. | If your organisation provides services to the mentally ill, What challenges do you face? What could be done to overcome those challenges or difficulties? (Prompt: *If answered yes to question 11*) | |
| | **D. Now I would like to ask you about how Mental Health Policies and Mental Health Laws are developed in this country** | |
| 13. | Are you aware of any mental health Laws and policies in this country? Where are they set out? (Prompt: *Which documents?)* | |
| 14. | Are you aware of any mental health needs assessment processes that informed the policy? Do you think these are appropriate? How can the situation be improved? (Prompt: *who does this, how and how often?)* | |
| 15. | What mental health issues do you feel are not accommodated in health policies? Why do you think they are not included? How can the situation be improved? | |
| 16. | Who sets priorities within mental health laws and policies? How is this done? How can the process be improved? | |
| 17. | How well do mental health policies and laws address the needs of people living in poverty? How can the situation be improved? (Prompt: *For example anti-stigma initiatives)* | |
| 18. | What key initiatives are needed to address stigma and discrimination toward people with mental health problems? (Prompt: *E.g., anti-stigma campaigns, support for user advocacy/organisation, inclusion in government activities, etc)* | |
| 19. | Are there policy issues affecting children and adolescents which should be included in mental health laws and policies? | |
| 20. | Are there policy issues affecting boys and men, and girls and women which should be included in mental health laws and policies? What are these? *(*Prompt*: Explore gender related issues)* | |
| 21. | Did your organisation have any input in the development of any of the mental health laws and/or policies? How did you manage to provide those inputs? (Prompt: *What were the inputs?)* | |
| 22. | Do you know of any other NGOs, community groups or other organisations that focus primarily on mental health? Are they involved in the development of mental health laws and policies? (Prompt: *List the organisations and type of involvement)* | |
| 23. | Are you satisfied with the way mental health policies and laws are developed? If not, how could this be improved? | |
| 24. | Do the existing mental health policies and law require development/reform? If so, can you think of actions that are required? | |
| 25. | Should the government provide support to people with mental health problems to influence policies which impact on mental health? (Prompt: *What is done already? What is still needed?)* | |

| | QUESTION | |
|---|---|---|
| 26. | Are there any individuals or organisations who are not involved in the development of mental health laws and/or policies, but you think should be?<br>• Why are they not involved?<br>• Can you suggest any practical ways in which they could be better involved? | |
| | **E. Now I would like to ask you how mental health laws and policies are implemented** | |
| 27. | What are the key challenges in implementing mental health laws and policies?<br>(Prompt: *For example resource constraints; other programmes' pressures; political commitment; health sector management framework; technical capacity)* | |
| 28. | Are mental health laws and policies well implemented? (*Prompt: Ask for examples)* | |
| 29. | What are the most important reasons why mental health laws and policies are not implemented effectively? What can be done to overcome these problems?<br>(Prompt: *Only ask if implementation is not happening effectively)* | |
| 30. | Who are the important organisations or individuals involved in implementing mental health laws and policies? | |
| 31. | If not already mentioned:<br>Do you know any other NGOs, community groups or user groups who focus primarily on mental health?<br>• Are they involved in implementing mental health laws and policies?<br>• Is their involvement appropriate and adequate?<br>• How can their involvement be improved? | |
| 32. | Are there any individuals or organisations who are not involved in implementing mental health laws and policies, but you think should be?<br>o Why are they not involved?<br>o Can you suggest any practical ways in which they could be better involved? | |
| | **F. Finally I would like to ask you for some more general comments** | |
| 33. | Are there any other comments you would like to make about the mental health laws and policies, and in particular, the role of different people and organizations in the policy making and implementation process? | |
| 34. | Do you have any reports or documents that we might find useful for this research, for example, any government instructions / statements, annual reports and so on?<br>(Prompt: *Only collect if the reports are new to the project)* | . |
| 35. | Do you know of any meetings or other events in the near future that you think would be useful for us to attend? | |
| 36. | Can you suggest other individuals who we need to interview? | |

## TOOL 9.1: SEMI STRUCTURED INTERVIEW GUIDE FOR TRADITIONAL HEALERS AT NATIONAL OR REGIONAL LEVEL

| | QUESTION | |
|---|---|---|
| 1 | Can you briefly introduce yourself, tell me about your background and your interest in mental health? | |
| | **A. I would like to ask you some general background questions.** | |
| 2 | What social factors do you think affect health care delivery in this country? | |
| 3 | How do traditional healers, influence health care delivery in this country?<br>(Probe: *What is their role?)* | |
| | **B. Now I would like to ask you some questions about mental health** | |
| 4 | Can you describe a person who is mentally healthy?<br>(Probe: *how would that person look / behave / interact with others)* | |
| 5 | Can you describe a person who is mentally unhealthy?<br>(Probe: *how would that person look / behave / interact with others)* | |
| 6 | How does the general public in this country view mental illness? Have their views changed over time? (Probe: *Are there any differences between different groups, e.g. rural farmers vs urban workers)* | |
| 7 | How important is mental health in the work of traditional healers like yourself? Why is that? | |
| 8 | How does the Ministry of Health link with traditional healers over mental health policies and programmes? | |
| 9 | What are the predominant causes of mental illness? What are the common methods of treatment? Do these vary much between traditional healers? | |
| 10 | Do you see an important role for traditional healers in providing mental health treatment and care to people with mental disorders? What form should this role take? | |
| | **C. Now I would like to ask you about mental health laws and policies and their development.** | |
| 11 | Where is the mental health policy set out?(Probe: *Which documents?)* | |
| 12 | How was the mental health policy developed? | |
| 13 | Do you feel the policies are adequate? (Prompt: *Ask if there are any gaps?)* | |
| 14 | How well do the mental health policies and laws address the needs of people living in poverty? How can the situation be improved?(Prompt: *For example anti-stigma initiatives)* | |
| 15 | What key initiatives are needed to address stigma and discrimination toward people with mental health problems? (Prompt: *E.g., anti-stigma campaigns, support for user advocacy/organisation, inclusion in government activities, etc)* | |
| 16 | Are there policy issues affecting children and adolescents which should be included in mental health laws and policies? | |
| 17 | Are there policy issues affecting boys and men, and girls and women which should be included in mental health laws and policies? What are these? *(*Prompt*: Explore gender related issues)* | |
| 18 | Are you satisfied with the way mental health policies are developed in this country? If not how could this be improved? | |

| | QUESTION | |
|---|---|---|
| 19 | In what way are traditional healers involved in the development of mental health policies? (Probe: *Is their involvement appropriate and adequate?)* | |
| 20 | If they are not involved, do you think they should be involved in developing mental health policies in this country?<br>• Can you think of any practical ways in which they could be better involved?<br>(Prompt: *List individuals or organisations mentioned.)* | |
| 21 | Should government provide support to traditional healers to influence policies which impact on mental health? (Probe: *What is done already? What is still needed?)* | |
| | **D. Now I would like to ask you about how mental health laws and policies are implemented.** | |
| 22 | What are the key challenges that face the health sector in implementing mental health policies? | |
| 23 | Is mental health policy well implemented? (*Probe for examples)* | |
| 24 | What are the most important reasons why mental health laws and policies are not implemented effectively?<br>• What can we do to overcome these problems?<br>(Prompt: *Only ask if implementation is not happening effectively)* | |
| 25 | How are traditional healers involved in implementing mental health policies in this country? (Prompt: *List individuals or organisations mentioned.)* | |
| 26 | If they are not involved, do you think they should be involved in implementing mental health policies in this country?<br>• Can you think of any practical ways in which they could be better involved? | |
| | **E. Are there any other comments you would like to make about the mental health policies in your country, and in particular, the role of different people and organisations in the policy-making process?** | |

## TOOL 8.1: SEMI STRUCTURED INTERVIEW GUIDE FOR KEY INFORMANTS IN THE MENTAL HEALTH USER MOVEMENT.

| | QUESTION | |
|---|---|---|
| 1. | Can you briefly introduce yourself, tell me about your background and your interest in mental health? | |
| **A. Now I would like to ask you some questions about mental health** | | |
| 2. | What do you think is meant by "mental health" and "mental illness"?<br>(*Probe for traditional beliefs, biomedical stress-related, alternative views)* | |
| 3. | Would you say that "mental health problems", "mental illness" and "mental disability" are the same or different issues? (Prompt: *How would they define these issues?)* | |
| 4. | How does the general public view mental illness? Have their views changed over time?<br>(Prompt: *include general public, family/friends, employers etc.*<br>*Are there any differences between groups, for example rural vs. urban?))* | |
| 5. | What key services are needed to improve people's mental health?<br>(Prompt: *Are they available? How can this be improved.)* | |

| | QUESTION | |
|---|---|---|
| 6. | What key services are needed to treat mental health problems?<br>(Prompt: *Are they available? How can this be improved.)* | |
| 7. | Do you know of any non-medical, non Western services which are effective for the treatment of mental health problems? (prompt: ask to describe) | |
| 8. | What key initiatives are needed to address stigma and discrimination toward people with mental health problems? (Prompt: *E.g., anti-stigma campaigns, support for user advocacy and organisation, user inclusion in government activities, etc)* | |
| 9. | Are there human rights violations occurring in mental health services known to you?<br>What key initiatives are needed to address these violations, if any?<br>(Prompt: *E.g., enforced treatment, physical and emotional harm, harmful practices etc)* | |
| ***Interviewer says*:** A mental health problem may impact heavily on a person's ability to manage their activities of living, either temporarily or on a long term basis. Such people may benefit from policy support for the disabling effects of their mental health problem. In this section I will ask for your views on how government can support people with mental disability in their everyday lives. | | |
| 10. | What is your view on the housing needs of people with mental disability?<br>(Prompt: *What would be the role of Housing Department, NGO's, others?)* | |
| 11. | Should policies address the needs of people with mental disabilities to obtain enough food and basic services, such as amenities, rent, clothes, household supplies, and school fees? How?<br>(Prompt: *What would be the role of agriculture, social services, local government, NGO's, others?)* | |
| 12. | Are there any support needs with regard to accessing state benefits? What basic benefits are needed? (Prompt: *What would be the role of Social development, NGOs, others?)* | |
| 13. | Are there any support needs with regard to occupation, employment and skills training for people with mental disability?<br>(Prompt: *What would be the role of education, social development and labour, NGOs, others?)* | |
| 14. | What reasonable accommodation is needed in the work situation for people with mental disability? (Prompt: *e.g. flexible work environment, flexible work hours, supportive employer, work place disability policy to include mental health)* | |
| 15. | What is to be done regarding people with mental health problems who need help managing their daily self-care and chores at home (washing, cleaning, tidying, preparing meals, etc)<br>(Prompt: *Community based services: family support, community health worker support for supplies, skills training, day care support, regular supervision etc)* | . |
| 16. | What can government or other role-players do to support people with mental health problems to improve their social contacts, and have access to rewarding social activities within their community? (Prompt: *Community services: drop in centres, day centres, community centre/group social clubs, couple counselling, social skills training, dating line/clubs)* | |
| 17. | What do you think are the main areas of support which a person with mental health problems needs to promote recovery and enjoyment of full citizenship? | |
| | **B. Now I would like to ask you about mental health law and policies and user influence on the development of these policies and laws** | |
| 18. | What is the human rights situation for people with mental disorders in this country? Are there human rights violations occurring in mental health services and communities? If so, what types? What key initiatives are needed to address these violations? | |
| 19. | How well do the mental health policies and laws address the needs of people living in poverty? How can the situation be improved? | |
| 20. | Can people with mental health problems keep up to date with mental health laws and policies in your country? *(Probe: What is available to expose users to policy and law?)* | |
| 21. | Do people with mental health problems influence the development of laws, policies and services affecting them? How can participation be improved? | |

| | QUESTION | |
|---|---|---|
| 22. | What holds people back from influencing mental health laws, policies and services? What can be done to overcome this?<br>(Prompt: *Including issues of personal and organisational capacity, lack of recognition of users )* | |
| 23. | Are their any mental health user organizations who are involved in developing mental health laws and policies in this country?<br>(prompt: *Are they user or provider led? Is their involvement appropriate and adequate?)* | |
| 24. | Is government support for the development of the mental health user movement needed? If already available, how can this be improved?<br>(Prompt: *Explore: policy, programme, financial, technical and moral support)* | |
| 25. | Do you know of any NGOs, community groups or patient groups who focus primarily on mental health? Are they involved in developing mental health laws and policies in this country? How can this be improved?<br>(Prompt: *Any mental health policy networks and communities? Include (mental) health and relevant non-mental health organizations. How do they operate? Is their involvement appropriate and adequate?)* | |
| 26. | Is there any thing you would want to be included in mental health laws and policies? What are these things? | |
| 27. | Are there policy considerations regarding children and adolescents which should be included in mental health laws and policies? | |
| 28. | Are there policy considerations regarding boys and men, and girls and women which should be included in mental health laws and policies? What are these?<br>(Prompt: *Explore gender related issues)* | |
| 29. | Are mental health laws and policies well implemented in your country?<br>(Prompt: *If not, What are the most important reasons for this? What can be done to overcome these problems?)* | |
| 30. | If you had choice, what are the things you would do to improve the situation for people with mental disorders in this country? | |
| | **C. Finally I would like to ask you for some more general comments.** | |
| 31. | Are there any final comments you would like to make about the mental health laws and policies in your country, and in particular, the role of different people and organisations in the policy-making and implementation process? | |
| 32. | Do you have any reports or documents that we might find useful for this research, for example, any government instructions / statements, annual reports and so on?<br>(Prompt: *Only collect if the reports are new to the project.)* | |
| 33. | Can you suggest other individuals who we need to interview? | |

**Micro level**

**The Mental Health and Poverty Project**

**Semi-Structured Interview** (A): District Health Care Manager

| | QUESTION | *Notes/Key words* |
|---|---|---|
| **1. Background** | | |
| **jjj.** | Can you briefly introduce yourself; tell me your background and your role in mental health? (*Probe for policy development, policy implementation, ensuring service delivery)* | |
| **kkk.** | Where does mental health stand in relation to the many other health issues within your district? Is it a priority? | |
| **lll.** | Is there a mental health plan in place at the district level? (*separate plan or integrated into the district plan?*) | |
| **mmm** | How is mental health integrated into other programmes at the district level e.g. maternal and child health, HIV/AIDS? | |
| 2. **The following questions are about existing management frameworks and intersectoral links to support the delivery of mental health care in the district** | | |
| **nnn.** | Do you have a district management committee? *(If yes, what is the composition and what support do they provide?)* | |
| **ooo.** | Is there anyone dedicated to managing mental health care in the district? *(If yes, what training does this person have?)* | |
| **ppp.** | Do you have a multisectoral forum to ensure a multidisciplinary approach to mental heath care in the district? *(If yes, how does it operate and who is represented on this forum?)* | |
| **qqq.** | Who do you report back to on mental health? How often does this occur and in what way? | |
| **rrr.** | What kinds of things do you report on? | |
| **sss.** | Do managers responsible for mental health care in the district have a need for additional knowledge and competencies that could be addressed through tailored training programmes? | |
| **ttt.** | What kind of regional support is there for district managers managing mental health care at the district level? Could this support be improved? | |
| **3. The following questions are about the care, treatment and rehabilitation of adults with more common mental health problems which don't require hospitalization, such as anxiety and depressive disorders.** | | |
| **a.** | Where/to whom do people with common mental health problems in the district go to for help? *(probe traditional healers, priests, psychologists in private practice, psychologists within the public health care system, primary health care nurses)?* | |
| **b.** | What sort of training in mental health would they have? | |
| **c.** | Have primary health care nurses been trained to identify, counsel and refer such persons? | |
| **d.** | If so, how many have been trained out of the total number of PHC nurses and how well do you think they have been trained? | |

| | QUESTION | *Notes/Key words* | |
|---|---|---|---|
| **e.** | How well is the district health system working? | | |
| **f.** | What are the problems with the district health system? | | |
| **g.** | Where do primary health care workers e.g. PHC nurses and community health workers refer people with common mental health problems that need specialist psychological help? | | |
| **h.** | Is there a referral system in place for mental health? Please describe the referral pathway within the district. What information is included on the referral forms within the district? | | |
| **i.** | Are there any specific support groups/shelters for people with common mental health problems e.g. support groups and shelters for abused women, support groups for substance abuse problems? *(Probe number and who runs these)* | | |
| **j.** | Are there any programmes for the prevention of specific problems e.g. sexual violence, substance abuse? *(Probe for number and who runs these and what they do)* | | |
| **k.** | Have police officers and magistrates serving your district been trained to deal with issues such as sexual violence and abuse of women? *(If so, probe for what training they have received)* | | |
| **4.** | **The following questions are about the care, treatment and rehabilitation of adults with serious mental health problems requiring hospitalization and follow-up medication.** | | |
| **a.** | Who is likely to be the first contact in the health care system that would be able to identify that a person has a serious mental health problem? *(probe for PHC nurse, traditional healer)* | | |
| **b.** | What sort of mental health training would they have? | | |
| **c.** | Where are people identified as having serious mental health problems in the district referred to? Please describe the referral pathway *(Probe for referrals to district, regional hospitals or psychiatric hospital)* | | |
| **d.** | Do these district/regional hospital/s have a psychiatric ward or dedicated beds for psychiatric patients? If so, how many dedicated beds are there? If not how are the patients managed? | | |
| **e.** | What kind of referrals are made to the psychiatric hospital (*Probe: acute, long term, other?*) How many psychiatric beds are there in the hospital? Do you have specialist units for mental health at tertiary level such as …..(*which?)* | | |
| **f.** | How long is the average wait before admission into district/regional/tertiary hospitals? | | |
| **g.** | Where are patients requiring long-term hospitalization referred to? *(Probe: outpatient care only, residential facilities, long term psychiatric wards?)* How many beds are there in these facilities/wards? | | |
| **h.** | Who attends to admitted psychiatric patients at district level (district or regional hospitals), e.g. psychiatrists, psychiatric nurses, psychologists? | | |
| **i.** | Do you have a back referral system in place so that health care providers at the district level are provided with information on the patient needs when discharged back into the community from regional and psychiatric hospitals or tertiary units? What information is included in the referral forms? How well does this system operate? | | |
| **j.** | Do you have treatment guidelines that are adhered to for both in-patient and out-patient care? If so what are these? | | |
| **k.** | Have police officers and magistrates serving your district been trained to deal with persons with serious mental health problems? (If yes, probe for what training they have received) | | |

| | QUESTION | *Notes/Key words* |
|---|---|---|
| **5.** | **The following questions are about the care, treatment and rehabilitation of children and adolescents with mental and behavioural problems.** | |
| **a.** | Have teachers and primary health care nurses been trained to identify, counsel and refer children with mental health problems? | |
| **b.** | Where do carers such as PHC nurses and teachers refer children and adolescents who need specialist psychological help? | |
| **c.** | Are there any special facilities in the district or region for children and adolescents to be referred to e.g. Child and Adolescent Mental Health Unit? | |
| **d.** | Who generally provides care for mental health problems in children and adolescents? E.g. traditional healers, priests, psychologists in private practice, psychologists within the public health care system, nurses, teachers, social workers? What kind of care is provided by these different carers. | |
| **e.** | Are there any specific support programmes for problems commonly experienced by children e.g. for children who are sexually abused, children with learning difficulties, substance abuse problems? *(Probe for number, what they do and who runs these)* | |
| **f.** | Are there any programmes for the prevention of specific problems for children e.g., sexual violence, substance abuse, other high risk behaviours? *(Probe for number, what they do and who runs these)* | |
| **g.** | Have police officers and magistrates serving your district been trained to deal with issues such as child sexual abuse and neglect? (If yes, probe for what training they have received) | |
| **h.** | Are there any special facilities within the criminal justice system to cater for sexually abused children e.g. private and child friendly assessment rooms? | |
| **6.** | **The following questions are about socio-economic and cultural factors that play a role in mental health.** | |
| **a.** | What portion of the district health budget is dedicated to mental health? | |
| **b.** | How well do you manage on the current mental health budget? What would you hope to achieve if more resources were available? | |
| **c.** | Are there any vacant posts for mental health staff in this district? If yes, what are the reasons for them not being filled? | |
| **d.** | Do you think that there are any links between poverty and poor mental health? If yes, describe these links. | |
| **e.** | If yes, what is being done to eradicate these links? | |
| **f.** | Do you think that there are any links between gender and poor mental health? If yes, describe these links. | |
| **g.** | If yes, what is being done to deal with these links? | |
| **h.** | What do you think are the main reasons people develop mental health problems? *(probe for bio-medical, cultural beliefs, stress)* | |
| **i.** | What explanations do most users have for mental health problems? *(probe for bio-medical, cultural beliefs)* | |
| **j.** | What do traditional healers have to offer in caring for people with mental health problems? | |
| **7.** | **The following questions are about your knowledge of existing Mental Health Care legislation (Policies and plans).** *This must be tailored for each country* | |

| | QUESTION | *Notes/Key words* | |
|---|---|---|---|
| **a.** | What do you know about the Mental Health Treatment Act of 1964? | | |
| **b.** | Did you have any input into the Act? *(If yes, what input. If no, do you feel you should have been consulted?)* | | |
| **c.** | Have you and other staff in your district received training in the provisions of the Act? | | |
| **d.** | What impact do you feel the Act has had on the provision of mental health services at district level? | | |
| **e.** | What impact do you feel that the Act has had on your job? | | |
| **f.** | What impact do you feel that the Act has had on the lives of people with mental health problems? | | |
| **g.** | Are there any changes needed to the Act? | | |
| **h.** | How easy is it to implement the Act at district level? | | |
| **i.** | Do you think government policy and action ensures that people with mental health problems enjoy the same respect, treatment and opportunities as other people? (*Probe for details: How are rights protected, violated? What still needs to be done?*) | | |
| **j.** | Do you think that people with mental health problems can participate in developing government policies, plans and actions that affect their mental health? (*If yes, how? Are there limits, and why? If no, why not?)* | | |
| **k.** | Do you think it is necessary for people with mental health problems to be supported so that they can influence mental health policies and plans? (*If no, why not, if yes, what are they doing already? What should still be done?)* | | |
| **8. General** | | | |
| **a.** | Are there any other comments you would like to make regarding mental health in your district? | | |

## The Mental Health and Poverty Project

**Semi-Structured Interview** (B1): Community Health Centre/Clinic Manager

| | QUESTION | *Notes/Key words* |
|---|---|---|
| **9. Background** | | |
| **uu** | Can you briefly introduce yourself; tell me your background and your role in mental health? (*Probe for policy development, policy implementation, ensuring service delivery)* | |
| **vvv.** | Where does mental health stand in relation to the many other health issues within your clinic? Is it a priority? | |
| **www** | Is there a mental health plan in place at the district level? (*separate plan or integrated into the district plan?*) | |
| **xxx.** | How is mental health integrated into other programmes at the district level e.g. maternal and child health, HIV/AIDS? | |
| **10. The following questions are about existing management frameworks and intersectoral links to support the delivery of mental health care in the district** | | |
| **a.** | Do you have a district management committee? If yes, what is the composition and what support do they provide? | |
| **b.** | Do you have a multisectoral forum to ensure a multidisciplinary approach to mental heath care in the district? If yes, how does it operate and who is represented on this forum? | |
| **c.** | Who do you report back to on mental health? How often does this occur and in what way? | |
| **d.** | What kinds of things do you report on? | |
| **e.** | Do managers responsible for mental health care in the district have a need for additional knowledge and competencies that could be addressed through tailored training programmes? | |
| **f.** | What kind of regional support is there for district managers managing mental health care at the district level? How could this support be improved? | |
| **11. The following questions are about the care, treatment and rehabilitation of adults with more common mental health problems which don't require hospitalization, such as anxiety and depressive disorders.** | | |
| **l.** | Who provides care for adults with common mental health problems within the district? (traditional healers, priests, psychologists in private practice, psychologists within the public health care system, PHC nurses) | |
| **m.** | What sort of training in mental health would they have? | |
| **n.** | Have primary health care nurses been trained to identify, counsel and refer patients with more common mental health problems?<br>(If yes, how many have been trained out of the total number and how well do you think they have been trained - frequency and comprehensiveness? If limited or none, what are their training needs?) | |
| **o.** | What support mechanisms are in place currently to assist PHC personnel in work with common mental health problems? Describe these. *(If limited or none, what would be the most effective way to support personnel in work with common mental health problems?)* | |

| | QUESTION | *Notes/Key words* | |
|---|---|---|---|
| **p.** | How well is the district health system working? | | |
| **q.** | What are the problems with the district health system? | | |
| **r.** | Is there a referral system in place for mental health? Please describe the referral pathway within the district. What information is included on the referral forms? | | |
| **s.** | Are all of your mental health staff full-time members of the team or are they only available at certain times? | | |
| **t.** | Who refers users to this CHC/Clinic (*family members, traditional healers, hospitals, welfare)?* | | |
| **u.** | How long is the average wait before contact? | | |
| **v.** | Please describe in detail the procedure for mental health assessment, treatment and follow-up care? How well does this procedure work? | | |
| **w.** | Do all clinics and community health centres adhere to the norms and standards of mental health within the Primary Health Care Package? | | |
| **x.** | If there is a mobile clinic, what mental health services does it provide? | | |
| **y.** | If home visits are conducted what are the main aims of these visits? | | |
| **z.** | If there is supported employment, what form does this take and how is it run? | | |
| **aa.** | Are there any specific support groups/shelters for people with common mental health problems e.g. support groups and shelters for abused women, support groups for people with substance abuse problems. *(Probe for number, what they do and who runs these)* | | |
| **bb** | Are there any programmes for the prevention of specific problems e.g. sexual violence, substance abuse? *(Probe for number, what they do and who runs these)* | | |
| **cc.** | Have police officers and magistrates serving your district been trained to deal with issues such as sexual violence and abuse of women? (If yes, probe for what training they have received) | | |
| **12. The following questions are about the care, treatment and rehabilitation of adults with serious mental health problems requiring hospitalisation and follow-up medication.** | | | |
| **l.** | Who is likely to be the first contact in the health care system that would be able to identify that a person has a serious mental health problem? *(PHC nurse, traditional healer)* | | |
| **m.** | What sort of mental health training would they have? | | |
| **n.** | What level of training do PHC personnel receive in dealing with serious mental health problems? Describe the training in terms of frequency and comprehensiveness. *(If limited or none, what are their training needs?)* | | |
| **o.** | What support mechanisms are in place currently to assist PHC personnel in work with serious mental health problems? Describe these. *(If limited or none, what would be the most effective way to support them?)* | | |
| **p.** | Where are people identified as having serious mental health problems in the district referred to? Please describe the referral pathway *(Probe for referrals to district, regional hospitals or psychiatric hospital)* | | |
| **q.** | Does this hospital/s have a psychiatric ward or dedicated beds for psychiatric patients? If so, how many dedicated beds are there? | | |

| | QUESTION | *Notes/Key words* | |
|---|---|---|---|
| **r.** | How long is the average wait before admission? | | |
| **s.** | Do these district/regional hospital/s have a psychiatric ward or dedicated beds for psychiatric patients? If so, how many dedicated beds are there? If not how are the patients managed? | | |
| **t.** | What kind of referrals are made to the psychiatric hospital (*Probe: acute, long term, other?*) How many psychiatric beds are there in the hospital? Do you have specialist units for mental health at tertiary level (*which?)* | | |
| **u.** | If a patient becomes violent and cannot be dealt with by the family/community, what is the procedure for getting them into immediate involuntary psychiatric care? How well does this work? | | |
| **v.** | If this involves the district police, have they been trained to deal with people with mental health problems? (If yes, probe for what training they have received) | | |
| **w.** | If there is an emergency, who does the public/ referring agent contact? | | |
| **x.** | What is the procedure for involuntary admission/treatment at PHC level? | | |
| **y.** | Who attends to admitted psychiatric patients at district level (district or regional hospitals), e.g. psychiatrists, psychiatric nurses, psychologists? | | |
| **z.** | Who provides follow-up medication for psychiatric outpatients e.g. psychiatric nurses, primary health care nurses? | | |
| **aa.** | If PHC nurses are used, have they been adequately trained and how many out of the total have received psychiatric training? | | |
| **bb** | Is there a system of supervision and/or ongoing support from specialist staff to PHC nurses? | | |
| **cc.** | How often is this follow-up service provided, e.g. is it integrated into PHC so provided anytime or are there rotating psychiatric clinics which visit the area on a regular basis? | | |
| **dd** | How accessible is this follow-up service, e.g. is it provided at the nearest clinic point for patients or only at community health centres? What is the furthest distance patients would have to travel? | | |
| **ee.** | Is there a back referral system in place so that health care providers at district level are provided with information on the patient needs when discharged into the community from regional and tertiary hospitals? What information is included in the referral forms? How well does this system operate? | | |
| **ff.** | Do you have treatment guidelines that are adhered to for both in-patient and out-patient care? If so what are these? | | |
| **gg.** | Is there a referral system between the different sectors involved in patient care at district level e.g. between the psychiatric social worker and psychiatric nurse? What information is included in the referral forms? | | |
| **hh** | If a person cannot be cared for by their family, where can they be cared for? *(probe for community care, residential facilities)* | | |
| **ii.** | How are disability grants accessed and administered for people with mental illness? How well does this system operate? | | |
| **13. The following questions are about the care, treatment and rehabilitation of children and adolescents with mental and behavioural problems.** | | | |

| | QUESTION | *Notes/Key words* | |
|---|---|---|---|
| **i.** | Have primary health care nurses been trained to identify, counsel and refer children with mental health problems? Describe the training in terms of frequency and comprehensiveness. *(If limited or none, what are their training needs?)* | | |
| **j.** | What support mechanisms are in place currently to assist PHC personnel in working with children and adolescents with mental health problems? Describe these. *(If limited or none, what would be the most effective way to support them?)* | | |
| **k.** | Where do carers such as PHC nurses and teachers refer children and adolescents who need specialist psychological help? | | |
| **l.** | Are there any special facilities in the district or region for children and adolescents to be referred to e.g. Child and Adolescent Mental Health Unit? | | |
| **m.** | Who provides care for mental health problems in children and adolescents? E.g. traditional healers, priests, psychologists in private practice, psychologists within the public health care system, nurses, teachers, social workers? What kind of care do they provide? | | |
| **n.** | Is there a referral system in place and what is included on the referral forms? | | |
| **o.** | Are there any specific support programmes for problems commonly experienced by children e.g. for children who are sexually abused, children with learning difficulties, substance abuse problems? *(Probe for number and who runs these programmes)* | | |
| **p.** | Are there any programmes for the prevention of specific problems for children e.g., sexual violence, substance abuse, other high risk behaviours? *(Probe for number, what they do and who runs these programmes)* | | |
| **q.** | Have police officers and magistrates serving your district been trained to deal with issues such as child sexual abuse and neglect? *(If yes, probe for what training they have received)* | | |
| **14. The following questions are about socio-economic and cultural factors that play a role in mental health.** | | | |
| **a.** | What portion of the centre/clinic budget is dedicated to mental health? | | |
| **b.** | How well do you manage on the current mental health budget? What would you hope to achieve if more resources were available? | | |
| **c.** | Are there any vacant posts for PHC mental health staff in this centre/clinic? If yes, what are the reasons for them not being filled? | | |
| **d.** | Is there a need for more posts for certain positions? | | |
| **e.** | Is there sufficient psychotropic medication and psychometric tests to cater for the centre/clinic's needs? | | |
| **f.** | Do you think that there are any links between poverty and poor mental health? If yes, describe these links. | | |
| **g.** | If yes, what is being done to eradicate these links? | | |
| **h.** | Do you think that there are any links between gender and poor mental health? If yes, describe these links. | | |
| **i.** | If yes, what is being done to deal with these links? | | |
| **j.** | What do you think are the main reasons people develop mental health problems? *(probe for bio-medical, cultural beliefs, stress)* | | |

| | QUESTION | *Notes/Key words* | |
|---|---|---|---|
| **k.** | What explanations do most users have for mental health problems? *(probe for bio-medical, cultural beliefs)* | | |
| **l.** | What do traditional healers have to offer in caring for people with mental health problems? | | |
| **m.** | How are language barriers dealt with for intervening with people with mental health problems? | | |
| **15. The following questions are about your knowledge of existing Mental Health Care legislation (Policies and plans).** *This must be tailored for each country* | | | |
| **a.** | What do you know about the new Mental Health Treatment Act of 1964? | | |
| **b.** | Did you have any input into the Act? *(If yes, what input. If no, do you feel you should have been consulted?)* | | |
| **c.** | Have you and other staff in your district received training in the provisions of the Act? | | |
| **d.** | What impact do you feel the Act has had on the provision of mental health services at district level? | | |
| **e.** | What impact do you feel that the Act has had on your job? | | |
| **f.** | What impact do you feel that the Act has had on the lives of people with mental health problems? | | |
| **g.** | Are there any changes needed to the Act? | | |
| **h.** | How easy is it to implement the Act at district level? | | |
| **i.** | Do all clinics and community health centres adhere to the norms and standards of mental health in the Primary Health Care Package? | | |
| **j.** | Do you think government policy and action ensures that people with mental health problems enjoy the same respect, treatment and opportunities as other people? (*Probe for details: How are rights protected, violated? What still needs to be done?*) | | |
| **k.** | Do you think that people with mental health problems can participate in developing government policies, plans and actions that affect their mental health? (*If yes, how? Are there limits, and why? If no, why not?)* | | |
| **l.** | Do you think it is necessary for people with mental health problems to be supported so that they can influence mental health policies and plans? (*If no, why not, if yes, what are they doing already? What should happen?)* | | |
| **16. General** | | | |
| **a.** | Are there any other comments you would like to make regarding mental health in your district? | | |

**The Mental Health and Poverty Project**

Semi-Structured Interview (B3): PHC Doctors

| | QUESTION | *Notes/Key words* |
|---|---|---|
| **17. Background** | | |
| **yyy** | How do you view mental illness? | |
| **zzz** | What role do you play in caring for people with mental health problems? | |
| **aaa** | What type of facility is this? | |
| **bb** | What kinds of users does this facility care for? (probe for age, gender, specific mental issues, serious/common) | |
| **cccc.** | What services are available for people with mental health problems within this facility? | |
| **dddd** | What human resources are available within this facility for people with mental health problems? | |
| **eeee.** | What other resources are available for people with mental health problems and their families in this facility? *(probe for psychosocial support groups, education, community care)* | |
| **fff** | If there are support groups, what are these and how are they run? | |
| **ggg** | If there is vocational rehabilitation, what form does this take and how is it run? | |
| **hh** | Do you have links with any mental health programmes that are currently being run in the district? | |
| **iiii** | Are you currently running any awareness, educational or training programmes in the field of mental health within your district/community? | |
| 18. **The following questions are about the care, treatment and rehabilitation of adults with more common mental health problems which don't require hospitalization, such as anxiety and depressive disorders.** | | |
| **a.** | Do you feel that you have sufficient training to identify, counsel and refer adults with common mental health problems? *(If yes, describe the training in terms of frequency and comprehensiveness. If limited or none, what training needs do you still have?)* | |
| **b.** | What support mechanisms are in place currently to assist you in working with common adult mental health problems? Describe these. *(If limited or none, what other support do you need?)* | |
| **c.** | What training do you receive in dealing with mental health issues which affect women, such as rape and gender violence? | |
| **d.** | Are there any specific support groups/shelters for people with common mental health problems e.g. support groups and shelters for abused women, support groups for people with substance abuse problems. *(Probe for number, what they do and who runs these)* | |
| **e.** | Are there any programmes for the prevention of specific problems e.g. sexual violence, substance abuse? *(Probe for number, what they do and who runs these)* | |
| **19. The following questions are about the care, treatment and rehabilitation of adults with serious mental health problems requiring hospitalization and follow-up medication.** | | |
| **jj.** | Do you feel that you have sufficient training to identify, counsel and refer adults with serious mental health problems? *(If yes, describe the training in terms of frequency and comprehensiveness. If limited or none, what training needs do you still have?)* | |

| | QUESTION | *Notes/Key words* |
|---|---|---|
| **a.** | What support mechanisms are in place currently to assist you in working with serious adult mental health problems? Describe these. *(If limited or none, what other support do you need?)* | |
| **b.** | If relevant, is there a system of supervision and/or ongoing support from specialist psychiatric staff to other mental health staff*? (If yes, what is the nature of this support?)* | |
| **kk** | Where are people identified as having serious mental health problems in the district referred to? Please describe the referral pathway *(Probe for referrals to district, regional hospitals or psychiatric hospital)* | |
| **ll.** | Do you have a back referral system in place so that health care providers at the district level are provided with information on the patient needs when discharged back into the community from regional and psychiatric hospitals or tertiary units? What information is included in the referral forms? How well does this system operate? | |
| **mm** | Do you have treatment guidelines that are adhered to for both in-patient and out-patient care? If so what are these? | |
| **20.** | **The following questions are about the care, treatment and rehabilitation of children and adolescents with mental and behavioural problems.** | |
| **r.** | If relevant, do you feel that you have sufficient training to identify, counsel and refer children/adolescents with mental and behavioural problems? *(If yes, describe the training in terms of frequency and comprehensiveness. If limited or none, what training needs do you still have?)* | |
| **s.** | What support mechanisms are in place currently to assist you in working with children/adolescents with mental and behavioural problems? Describe these. *(If limited or none, what other support do you need?)* | |
| **t.** | Where do carers such as PHC nurses and teachers refer children and adolescents who need specialist psychological help? | |
| **u.** | Are there any special facilities in the district or region for children and adolescents to be referred to e.g. Child and Adolescent Mental Health Unit? | |
| **v.** | Are there any specific support programmes for problems commonly experienced by children e.g. for children who are sexually abused, children with learning difficulties, substance abuse problems? *(Probe for number, what they do and who runs these programmes)* | |
| **w.** | Are there any programmes for the prevention of specific problems for children e.g., sexual violence, substance abuse, other high risk behaviours? *(Probe for number, what they do and who runs these programmes)* | |
| **x.** | Are there any special facilities within the criminal justice system to cater for sexually abused children e.g. private and child friendly assessment rooms? | |
| **21.** | **The following questions are about socio-economic and cultural factors that play a role in mental health.** | |
| **a.** | Do you feel that the care you provide is constrained by a limited mental health budget? (If yes, what would be some things that could be achieved with more resources? What are some of these needs?) | |
| **b.** | If relevant, do you have sufficient psychotropic medication and psychometric tests to cater for your needs? | |
| **c.** | Do you think that there are any links between poverty and poor mental health? (If yes, describe these links. What could be done to eradicate these links? | |

| | QUESTION | *Notes/Key words* |
|---|---|---|
| **d.** | Do you think that there are any links between gender and poor mental health? If yes, describe these links. What could be done to deal with these links?) | |
| **e.** | What do you think are the main reasons people develop mental health problems? *(probe for bio-medical, cultural beliefs, stress)* | |
| **f.** | What explanations do most users have for mental health problems? *(probe for bio-medical, cultural beliefs)* | |
| **g.** | How are language barriers dealt with for intervening with people with mental health problems | |
| **22. The following questions are about your knowledge of existing Mental Health Care legislation (Policies and plans).** *This must be tailored for each country* | | |
| **c.** | What do you know about the new Mental Health Care Treatment Act? | |
| **d.** | Have you received training in the provisions of the Act? | |
| **e.** | What impact do you feel that the Act has had on your job? | |
| **f.** | What impact do you feel that the Act has had on the lives of people with mental health problems? | |
| **g.** | Are there any changes needed to the Act? | |
| **h.** | Do you think government policy and action ensures that people with mental health problems enjoy the same respect, treatment and opportunities as other people? (*Probe for details: How are rights protected, violated? What still needs to be done?*) | |
| **i.** | Do you think that people with mental health problems can participate in developing government policies, plans and actions that affect their mental health? (*If yes, how? Are there limits, and why? If no, why not?)* | |
| **j.** | Do you think it is necessary for people with mental health problems to be supported so that they can influence mental health policies and plans? (*If no, why not, if yes, what are they doing already? What should still be done?)* | |
| **23. General** | | |
| **a.** | Are there any other comments you would like to make regarding mental health in your facility? | |

**The Mental Health and Poverty Project**

**Semi-Structured Interview** (C): Hospital Manager (or equivalent)

| | QUESTION | *Notes/Key words* |
|---|---|---|
| **24.** | **Background** | |
| **jjj** | Can you briefly introduce yourself; tell me your background and your role in mental health? (*Probe for policy development, policy implementation, ensuring service delivery)* | |
| **kkkl** | Where does mental health stand in relation to the many other health issues within your hospital? Is it a priority? | |
| **llll.** | Is there a mental health plan in place at the district level? (*separate plan or integrated into the district plan?*) | |
| **25.** | **The following questions are about existing management frameworks and intersectoral links to support the delivery of mental health care in the district** | |
| **a.** | Do you have a multisectoral forum to ensure a multidisciplinary approach to mental heath care in the district? *(If yes, how does it operate and who is represented on this forum?)* | |
| **b.** | Who do you report back to on mental health? How often does this occur and in what way? | |
| **c.** | What kinds of things do you report on? | |
| **d.** | Do managers responsible for mental health care in the district have a need for additional knowledge and competencies that could be addressed through tailored training programmes? | |
| **e.** | What kind of regional support is there for district managers managing mental health care at the district level? How could this support be improved? | |
| **26.** | **The following questions are about the care, treatment and rehabilitation of adults with serious mental health problems requiring hospitalization and follow-up medication.** | |
| **dd** | Are all of the mental health staff full-time members of staff or are they only available at certain times? | |
| **ee.** | If no, what personnel requires more training (e.g. psychiatric nurses, medical doctors)? What are their training needs with regard to identifying, treating, counseling and referring mental health problems? | |
| **ff.** | What support mechanisms are in place currently to assist personnel in work with mental health problems? Describe these.<br>*(If limited or none, what would be the most effective way to support them?)* | |
| **gg** | How well is this system working and what are the problems with this system? | |
| **hh** | Are there any specific support groups/ shelters for people with mental health problems e.g. support groups and shelters for abused women, support groups for people with substance abuse problems? *(Probe for number, what they do and who runs these)* | |
| **ii.** | Are there any programmes for the prevention of specific problems e.g. sexual violence, substance abuse? *(Probe for number, what they do and who runs these)* | |

| | QUESTION | *Notes/Key words* |
|---|---|---|
| **jj.** | Does this hospital have dedicated beds for psychiatric patients? If so, how many dedicated beds are there? | |
| **kk** | Who refers people with mental health problems to this hospital *(probe for PHC clinics, psychologists, courts)* | |
| **ll.** | Is there a referral system in place for mental health and what information is included on the referral forms? | |
| **mm** | If there are no available psychiatric beds, what other options exist for patients? (probe for casualty admission, referral to other hospitals, possibility of admitting patient into non-psychiatric bed) | |
| **nn** | How long may patients be admitted for? | |
| **oo** | Please describe in detail the procedure for mental health assessment, treatment and follow-up care? | |
| **pp** | How well does this procedure work? Should anything be changed? | |
| **qq** | What is the procedure for this referral? How well does this procedure work? Should anything be changed? | |
| **rr.** | What is the procedure for involuntary admission and treatment in this hospital? How well does this procedure work? Should anything be changed? | |
| **ss.** | What is the procedure for seclusion or restraint in this hospital? How well does this procedure work? Should anything be changed? | |
| **tt.** | Who provides follow-up medication and treatment for outpatient psychiatric patients e.g. psychiatric nurses, doctors? Is that done on these premises or are they referred to another facility? | |
| **uu** | If the follow-up service is not available at this hospital, how accessible is it, e.g. is it provided at the nearest clinic point for patients or is it only provided at community health centres? What is the furthest distance which patients have to travel to collect their medication? | |
| **vv** | Do you have a back referral system in place so that health care providers at PHC level are given information on the patient needs when they are discharged back into the community? What information is included in the referral forms? | |
| **27.** | **The following questions are about the care, treatment and rehabilitation of children and adolescents with mental and behavioural problems.** | |
| **y.** | Have all mental health staff been trained to identify, counsel and refer children with mental health problems? *(If yes, describe the training in terms of frequency and comprehensiveness. If limited or none, what are their training needs?)* | |
| **z.** | What support mechanisms are in place currently to assist personnel in working with children and adolescents with mental health problems? Describe these. *(If limited or none, what would be the most effective way to support them?)* | |
| **aa** | Where are children and adolescents who need specialist psychological help referred to? Are there any special facilities in the district or region for children and adolescents to be referred to e.g. Child and Adolescent Mental Health Unit? | |
| **bb** | Is there a referral system in place and what is included on the referral forms? | |
| **cc.** | Are there any specific support programmes for problems commonly experienced by children e.g. for children who are sexually abused, children with learning difficulties, substance abuse problems? *(Probe for number, what they do and who runs these programmes)* | |

| | QUESTION | *Notes/Key words* |
|---|---|---|
| **dd** | Are there any programmes for the prevention of specific problems for children e.g., sexual violence, substance abuse, other high risk behaviours? *(Probe for number, what they do and who runs these programmes)* | |
| **28.** | **The following questions are about socio-economic and cultural factors that play a role in mental health.** | |
| **a.** | What portion of the hospital's budget is dedicated to mental health? | |
| **b.** | How well do you manage on the current mental health budget? What would you hope to achieve if more resources were available? | |
| **c.** | Are there any vacant posts for mental health staff in this hospital? If yes, what are the reasons for them not being filled? | |
| **d.** | Is there a need for more posts for certain positions? | |
| **e.** | Is there sufficient psychotropic medication and psychometric tests to cater for the hospital's needs? | |
| **f.** | Do you think that there are any links between poverty and poor mental health? If yes, describe these links. | |
| **g.** | If yes, what is being done to eradicate these links? | |
| **h.** | Do you think that there are any links between gender and poor mental health? If yes, describe these links. | |
| **i.** | If yes, what is being done to deal with these links? | |
| **j.** | What do you think are the main reasons people develop mental health problems? *(probe for bio-medical, cultural beliefs, stress)* | |
| **k.** | What explanations do most users have for mental health problems? *(probe for bio-medical, cultural beliefs)* | |
| **l.** | What do traditional healers have to offer in caring for people with mental health problems? | |
| **m.** | How are language barriers dealt with for intervening with people with mental health problems? | |
| **29.** | **The following questions are about your knowledge of existing Mental Health Care legislation (Policies and plans).** *This must be tailored for each country* | |
| **a.** | What do you know about the Mental Health Treatment Act of 1964? | |
| **b.** | Did you have any input into the Act? *(If yes, what input. If no, do you feel you should have been consulted?)* | |
| **c.** | Have you and other staff in your hospital received training in the provisions of the Act? | |
| **d.** | What impact do you feel the Act has had on the provision of mental health services at district level? | |
| **e.** | What impact do you feel that the Act has had on your job? | |
| **f.** | What impact do you feel that the Act has had on the lives of people with mental health problems? | |
| **g.** | What do you think should be changed in the Act? | |
| **h.** | How easy is it to implement the Act at district level? | |
| **i.** | Do all PHC clinics and community health centres adhere to the norms and standards of mental health within the Primary Health Care Package? | |

| | QUESTION | *Notes/Key words* |
|---|---|---|
| **j.** | Do you think government policy and action ensures that people with mental health problems enjoy the same respect, treatment and opportunities as other people? (*Probe for details: How are rights protected, violated? What still needs to be done?*) | |
| **k.** | Do you think that people with mental health problems can participate in developing government policies, plans and actions that affect their mental health? (*If yes, how? Are there limits, and why? If no, why not?)* | |
| **l.** | Do you think it is necessary for people with mental health problems to be supported so that they can influence mental health policies and plans? (*If no, why not, if yes, what are they doing already? What should still be done?)* | |
| **30. General** | | |
| | Are there any other comments you would like to make regarding mental health in your district? | |

**The Mental Health and Poverty Project**

**Semi-Structured Interview** (F): District Education Manager

1- How do you view mental illness?
2- What role do you play in caring for learners with mental health or behavioural problems?
3- What are the biggest mental health challenges faced by learners? (probe for behavioural problems, sexual abuse, learning disabilities).
4- Do schools in the district have school counsellors?
5- Who would be likely to identify that a learner has a mental/behavioural issue? (*probe for teacher, counsellor).*
6- Would that person have training for dealing with the mental/behavioural issues of children/adolescents?
7- Have teachers been trained to identify, counsel and refer children/adolescents with mental and behavioural problems? *(If yes, describe the training in terms of frequency and comprehensiveness. If limited or none, what training needs do you still have?)*
8- What support mechanisms are in place currently to assist teachers in working with children and adolescents with mental health problems? Describe these. *(If limited or none, what other support do you need?)*
9- Where do teachers/counsellors refer children and adolescents who need specialist psychological help? Are there any special facilities in the district or region for children and adolescents to be referred to e.g. Child and Adolescent Mental Health Unit?
10- Are there any programmes for the prevention of specific problems for children e.g., sexual violence, substance abuse, other high risk behaviours? *(Probe number, what they do and who runs these)*

11- Are there any specific support programmes for problems commonly experienced by children e.g. for children who are sexually abused, children with learning difficulties, substance abuse problems? *(Probe number, what they do and who runs these)*
12- Are you currently running any awareness, educational or training programmes in the field of mental health within your district/community?
13- If a child/adolescent with mental health problems remains in the school system, what steps are taken to make this easier for the learner, for other learners and for teachers?
14- Do you think that there are any links between poverty and poor mental health? (*If yes, describe these links. What could be done to eradicate these links?)*
15- Do you think that there are any links between gender and poor mental health? *(If yes, describe these links. What could be done to deal with these links?)*
16- What do you think are the main reasons people develop mental health problems? *(probe for bio-medical, cultural beliefs, stress)*
17- Do you have links with mental health service providers or service providers who may come into contact with mentally ill children/adolescents in the district?
18- Do you have links with any other mental health programmes for children/ adolescents that are currently being run in the district?
19- Does the education sector attend any multisectoral forums where child/adolescent mental health is discussed by a multidisciplinary team?
20- Who do you report back to on mental health issues? How often does this occur and in what way? What kinds of things do you report on?
21- What do you know about the Mental Health Treatment Act of 1964?
22- Have you received training in the provisions of the Act?
23- What impact do you feel that the Act has had on your job?
24- What impact do you feel that the Act has had on the lives of people with mental health problems?
25- Are there any changes needed to the Act?
26- Do you think government policy and action ensures that people with mental health problems enjoy the same respect, treatment and opportunities as other people? (*Probe for details: How are rights protected, violated? What still needs to be done?*)
27- Do you think that people with mental health problems can participate in developing government policies, plans and actions that affect their mental health? (*If yes, how? Are there limits, and why? If no, why not?)*
28- Do you think it is necessary for people with mental health problems to be supported so that they can influence mental health policies and plans? (*If no, why not, if yes, what are they doing already? What should still be done?)*
29- Are there any other comments you would like to make regarding mental health care?

**The Mental Health and Poverty Project**

**Semi-Structured Interview** (F): District Police Commissioner

Thank you for agreeing to take part in this interview. The aim of the interview is for us to develop an understanding of how the mental health needs of members of the public and offenders are met within the policing sector. With your permission, this interview will be recorded.

## 1. Support and Training

**Members of the public:**

The following questions are about police contact with members of the public who have mental health problems.

1.1. Under what circumstances would police personnel be likely to come into contact with members of the public who have mental health problems (not offenders)?
1.2. Are all police personnel aware of how to identify and deal with such persons?
1.3. What level of training do police personnel receive in identifying and dealing with people with mental health problems? Describe the training in terms of frequency and comprehensiveness.
1.4. If limited or none, what are their training needs with regard to identifying and dealing with persons with mental health problems?
1.5. What support mechanisms are in place currently to assist police personnel in work with persons with mental health problems? Describe these.
1.6. If limited or none, what would be the most effective way to support police personnel?
1.7. Are there strict guidelines in place for how police personnel must deal with such persons? If so, what are these?
1.8. What is the procedure when the police are asked to escort a person with mental illness to a facility for involuntary admission/treatment?
1.9. Who would ask for this service and where would the person be escorted to?
1.10. What is the procedure when police personnel come into contact with a person with mental health problems in a public setting?
1.11. What is the procedure when a member of the public calls to request that the police deal with a person with mental health problems?

**Offenders:**
The following questions are about police contact with offenders who have mental health problems.

1.12. Under what circumstances would police personnel be likely to come into contact with offenders who have mental health problems?
1.13. Are all police personnel aware of how to identify and deal with such persons?
1.14. What level of training do police personnel receive in dealing with offenders with mental health problems?
1.15. Describe the training in terms of frequency and comprehensiveness.
1.16. If limited or none, what are their training needs with regard to identifying and dealing with offenders with mental health problems?
1.17. What support mechanisms are in place currently to assist police personnel in work with offenders with mental health problems? Describe these.

1.18. If limited or none, what would be the most effective way to support police personnel?
1.19. Are there strict guidelines in place for how police personnel must deal with such persons? If so, what are these?

**Victims & Witnesses**

The following questions are about the mental health needs of victims and witnesses.

1.20. What level of training do police personnel receive in dealing with the mental health needs of victims and witnesses e.g. of sexual abuse, violence, murder?
1.21. Describe the training in terms of frequency and comprehensiveness
1.22. If limited or none, what are their training needs with regard to identifying, counseling and referring victims and witnesses?
1.23. What support mechanisms are in place currently to assist police personnel in working with victims and witnesses? Describe these.
1.24. If limited or none, what would be the most effective way to support police personnel?
1.25. Are there strict guidelines in place for how police personnel must deal with such persons? If so, what are these?
1.26. What is the procedure if police personnel suspect that a victim or witness is experiencing mental health problems?

**Children and Adolescents**

The following questions are about children and adolescents with mental and behavioural problems.

1.27. What level of training do police personnel receive in dealing with children and adolescents with mental health problems?
1.28. What level of training do police personnel receive in dealing with children and adolescents with mental health problems who commit crimes?
1.29. What level of training do police personnel receive in the mental health needs of children and adolescents who have been the victim or witness of a crime?
1.30. Describe the training in terms of frequency and comprehensiveness
1.31. If limited or none, what are their training needs with regard to identifying and dealing with children and adolescents with mental health problems?
1.32. What support mechanisms are in place currently to assist police personnel in working with children and adolescents with mental health problems? Describe these.
1.33. If limited or none, what would be the most effective way to support police personnel in working with children and adolescent mental health problems?
1.34. Are there strict guidelines in place for how police personnel must deal with such persons? If so, what are these?
1.35. What is the procedure if police personnel suspect that a child or adolescent has mental health problems?

## 2. Socio-Economic and Cultural Factors

The following questions are about socio-economic and cultural factors that play a role in mental health.

2.1. Do you feel that the care the police sector provides for persons with mental health problems is constrained by a limited budget? What could be achieved with more resources?

2.2. Do you think that there are any links between poverty and poor mental health? If yes, describe these links.
2.3. Do you think that there are any links between gender and poor mental health? If yes, describe these links.
2.4. What do you think are the main reasons people develop mental health problems? *(probe for bio-medical, cultural beliefs, stigmatizing views, stress)*
2.5. What explanations do most police personnel have for mental illness? *(probe for bio-medical, cultural beliefs)*

**3. Management frameworks and intersectoral links to support the delivery of mental health care**

The following questions are about existing management frameworks and intersectoral links to support the delivery of mental health care in the district

3.1. Do you have links with mental health service providers or service providers who may come into contact with mentally ill persons in the district?
3.2. Do you have links with any other mental health programmes that are currently being run in the district?
3.3. Does the policing sector attend any multisectoral forums where mental health is discussed by a multidisciplinary team?
3.4. Who do you report back to on mental health issues? How often does this occur and in what way? What kinds of things do you report on?

## The Mental Health and Poverty Project

**Semi-Structured Interview** (G4): District Magistrate

| | QUESTION | *Notes/Key words* |
|---|---|---|
| **31. Background** | | |
| **ww** | How do you view mental illness? | |
| **xx.** | What role do you play in caring for people with mental health or behavioural problems? | |
| **32. The following questions are about existing management frameworks and intersectoral links to support the delivery of mental health care in the district** | | |
| **a.** | Do you have links with any other mental health programmes that are currently being run in the district? | |
| **b.** | Does the legal sector attend any multisectoral forums where mental health is discussed by a multidisciplinary team? | |
| **c.** | Who do you report back to on mental health issues? How often does this occur and in what way? What kinds of things do you report on? | |
| **33. The following questions are about your training and support needs when dealing with people who have mental health problems.** | | |

| | QUESTION | *Notes/Key words* | |
|---|---|---|---|
| **a.** | Under what circumstances would you be likely to come into contact with adults with mental health problems? | | |
| **b.** | Have you been trained to identify and deal with adults with mental health problems? (If yes, describe the training in terms of frequency and comprehensiveness. If limited or none, what training needs do you still have?) | | |
| **c.** | Are there strict guidelines in place for how you must deal with such persons? If so, what are these? | | |
| **d.** | Where are adults with mental health problems who remain within the legal system referred to? | | |
| **e.** | What training do you receive in dealing with mental health issues which affect women, such as rape and gender violence? | | |
| **f.** | Under what circumstances would you be likely to come into contact with children or adolescents with mental health problems? | | |
| **g.** | Have you been trained to identify and deal with children/adolescents with mental and behavioural problems? *(If yes, describe the training in terms of frequency and comprehensiveness. If limited or none, what training needs do you still have?)* | | |
| **h.** | What support mechanisms are in place currently to assist you in dealing with children/adolescents with mental health problems? Describe these. *(If limited or none, what other support do you need?)* | | |
| **i.** | Are there strict guidelines in place for how you must deal with such persons? If so, what are these? | | |
| **j.** | Are there any specific support programmes for problems commonly experienced by children e.g. for children who are sexually abused, children with learning difficulties, substance abuse problems? | | |
| **k.** | Where are children or adolescents with mental health problems who remain within the legal system referred to? | | |
| **l.** | What level of training have you received in dealing with the mental health needs of victims and witnesses e.g. of sexual abuse, violence, murder? Describe the training in terms of frequency and comprehensiveness | | |
| **34. The following questions are about socio-economic and cultural factors that play a role in mental health.** | | | |
| **h.** | Do you think that there are any links between poverty and poor mental health? (*If yes, describe these links. What could be done to eradicate these links?)* | | |
| **i.** | Do you think that there are any links between gender and poor mental health? *(If yes, describe these links. What could be done to deal with these links?)* | | |
| **j.** | What do you think are the main reasons people develop mental health problems? *(probe for bio-medical, cultural beliefs, stress)* | | |
| **35. The following questions are about your knowledge of existing Mental Health Care legislation (Policies and plans).** *This must be tailored for each country* | | | |
| **m.** | What do you know about the Mental Health Treatment Act of 1964? | | |
| **n.** | Have you received training in the provisions of the Act? | | |
| **o.** | What impact do you feel that the Act has had on your job? | | |
| **p.** | What impact do you feel that the Act has had on the lives of people with mental health problems? | | |
| **q.** | Are there any changes needed to the Act? | | |

| | QUESTION | *Notes/Key words* | |
|---|---|---|---|
| **r.** | Do you think government policy and action ensures that people with mental health problems enjoy the same respect, treatment and opportunities as other people? (*Probe for details: How are rights protected, violated? What still needs to be done?*) | | |
| **s.** | Do you think that people with mental health problems can participate in developing government policies, plans and actions that affect their mental health? (*If yes, how? Are there limits, and why? If no, why not?)* | | |
| **t.** | Do you think it is necessary for people with mental health problems to be supported so that they can influence mental health policies and plans? (*If no, why not, if yes, what are they doing already? What should still be done?)* | | |
| **36. General** | | | |
| **b.** | Are there any other comments you would like to make regarding mental health care? | | |

**The Mental Health and Poverty Project**

**Semi-Structured Interview** (G5): District Housing Manager

| | QUESTION | *Notes/Key words* | |
|---|---|---|---|
| **37. Background** | | | |
| **yy.** | How do you view mental illness? | | |
| **zz.** | What role do you play in caring for people with mental health or behavioural problems? | | |
| **aa.** | Where does housing for people with mental health stand in relation to the many other housing issues within your district? Is it a priority? | | |
| **38. The following questions are about existing management frameworks and intersectoral links to support the delivery of mental health care in the district** | | | |
| **bb** | Do you have links with any other mental health programmes that are currently being run in the district? | | |
| **cc** | Do you have links with any other mental health programmes for children/ adolescents that are currently being run in the district? | | |
| **dd** | Does the housing sector attend any multisectoral forums where mental health is discussed by a multidisciplinary team? | | |
| **ee** | Who do you report back to on mental health issues? How often does this occur and in what way? What kinds of things do you report on? | | |
| **39. The following questions are about housing for people with mental health problems** | | | |
| **a.** | What are the housing needs within the district for adults with mental health problems? | | |

| | QUESTION | *Notes/Key words* | |
|---|---|---|---|
| **b.** | What governmental housing is available in this district for adults with mental health problems? (*probe for residential facilities, halfway houses, group homes)* | | |
| **c.** | What are the housing needs within the district for children and adolescents with mental health problems? | | |
| **d.** | What governmental housing is available for children and adolescents with mental health problems? (*probe for residential facilities, halfway houses, and group homes).* | | |
| **e.** | In terms of RDP housing projects, what efforts are being made to include housing for people with mental health problems? | | |
| **f.** | Are there any plans to provide more housing of this kind in the future? | | |
| **g.** | What support mechanisms are in place currently to assist you in supporting persons with mental health problems? Describe these. If limited or none, what other support do you need? | | |
| **h.** | Are there strict guidelines in place for how you must deal with such persons? If so, what are these? | | |
| **i.** | What support mechanisms are in place currently to assist you in supporting children/adolescents with mental and behavioural problems? If limited or none, what other support do you need? | | |
| **j.** | Are there strict guidelines in place for how you must deal with such persons? If so, what are these? | | |
| **k.** | What problems exist in providing housing to people with mental health problems? | | |
| **40. The following questions are about socio-economic and cultural factors that play a role in mental health.** | | | |
| **k.** | Do you feel constrained in terms of what you can do to help by a limited budget? What would you hope to achieve with more resources? | | |
| **l.** | Do you think that there are any links between poverty and poor mental health? (*If yes, describe these links. What could be done to eradicate these links?)* | | |
| **m.** | Do you think that there are any links between gender and poor mental health? *(If yes, describe these links. What could be done to deal with these links?)* | | |
| **n.** | What do you think are the main reasons people develop mental health problems? *(probe for bio-medical, cultural beliefs, stress)* | | |
| **41. The following questions are about your knowledge of existing Mental Health Care legislation (Policies and plans).** *This must be tailored for each country* | | | |
| **a.** | What do you know about the new Mental Health Treatment Act of 1964? | | |
| **b.** | Have you received training in the provisions of the Act? | | |
| **c.** | What impact do you feel that the Act has had on your job? | | |
| **d.** | What impact do you feel that the Act has had on the lives of people with mental health problems? | | |
| **e.** | Are there any changes needed to the Act? | | |
| **f.** | Do you think government policy and action ensures that people with mental health problems enjoy the same respect, treatment and opportunities as other people? (*Probe for details: How are rights protected, violated? What still needs to be done?*) | | |

| | QUESTION | *Notes/Key words* | |
|---|---|---|---|
| **g.** | Do you think that people with mental health problems can participate in developing government policies, plans and actions that affect their mental health? (*If yes, how? Are there limits, and why? If no, why not?)* | | |
| **h.** | Do you think it is necessary for people with mental health problems to be supported so that they can influence mental health policies and plans? (*If no, why not, if yes, what are they doing already? What should still be done?)* | | |
| **42. General** | | | |
| **c.** | Are there any other comments you would like to make regarding mental health care? | | |

## The Mental Health and Poverty Project

Semi-Structured Interview (G6): Social worker

| | QUESTION | *Notes/Key words* | |
|---|---|---|---|
| **43. Background** | | | |
| **mm** | Can you briefly introduce yourself, your background and describe the setting in which you offer social work services? (*health , education, social services, NGO, etc*) | | |
| **nn** | What are the key social service issues you deal with and where does mental health stand in relation to these issues within your district? Is it a priority? | | |
| **oo** | How do people in your district view mental illness (Prompt: *Are there any differences between different groups, e.g. rural farmers vs urban workers. )* How do you view mental illness? | | |
| **pp** | Is there a need for initiatives to address stigma and discrimination toward people with mental health problems in this district? If yes, what?<br>(Prompt: *E.g., anti-stigma campaigns, support for user advocacy/organisation, inclusion in government activities, etc)* | | |
| **qq** | Please describe what mental health related roles and services you offer? (*ensuring service access, accessing grants, community work)* | | |
| **rrr** | How is social work services you offer integrated into health and mental health programmes at the district level e.g. maternal and child health, HIV/AIDS? | | |
| **sss** | Where are you based in the district? *(clinic, social welfare office, NGO)* | | |
| **ttt** | How far might people have to travel to see you? | | |
| **uu** | What size population are you looking after? | | |
| **vv** | How many cases do you deal with per month? What proportion of these have mental health related problems? Such as? | | |
| **ww** | How many other social workers are in your area and to what extent do you feel mental health is part of their workload? Please elaborate.? | | |

| | QUESTION | *Notes/Key words* | |
|---|---|---|---|
| **xxxx** | Do you feel that you are coping with your workload overall? And the mental health aspects of your workload? *(If no, why not? What could be done to help you cope?)* | | |
| **yyyy** | Is there a shortage of social work services in your district? *(If yes, why? Remuneration? Heavy caseload? Lack of posts? If yes, what would help and what could you achieve if your suggestion were implemented? )* | | |
| **44.** | **The following questions are about existing management frameworks and intersectoral links to support the delivery of mental health care in the district** | | |
| **g.** | Do you have a district management committee? If yes, what is the composition and what support do they provide? | | |
| **h.** | Do you have a multisectoral forum to ensure a multidisciplinary approach to mental heath care in the district? If yes, how does it operate and who is represented on this forum? | | |
| **i.** | To whom do you report back on mental health? What kinds of things do you report on? How often does this occur and in what way? | | |
| **j.** | What kind of regional support is there for social workers managing mental health care at the district level? How could this support be improved? | | |
| **45.** | **The following questions are about the care, treatment and rehabilitation of adults with more common mental health problems which don't require hospitalization, such as anxiety and depressive disorders.** | | |
| **fff.** | Have you been trained to identify, and refer adults with common mental health problems? others *(If yes, describe the training in terms of frequency and comprehensiveness. If limited or none, what training needs do you still have?)* | | |
| **ggg** | What support mechanisms are in place currently to assist you in working with common mental health problems? Describe these. *(If limited or none, what other support do you need?)* | | |
| **hh** | What training do you receive in dealing with mental health issues which affect women, such as rape and gender violence? *(Probe for frequency and comprehensiveness)* | | |
| **iii.** | How well is the district social service system working? | | |
| **jjj** | What are the problems with the district social service system? Are their any specific problems related to the mental health services you offer? | | |
| **kk** | How well do the health and social service system work for people requiring both mental health and social service supports? (*How can this be improved?)* | | |
| **lll.** | Is there a referral system in place for mental health? Please describe the referral pathway within the district. What information is included on the referral forms? | | |
| **mm** | Are there any specific support groups/shelters for people with common mental health problems e.g. support groups and shelters for abused women, support groups for people with substance abuse problems. *(Probe for number, what they do and who runs these)* | | |
| **nn** | Are there any programmes for the prevention of specific problems e.g. sexual violence, substance abuse? *(Probe for number, what they do and who runs these)* | | |
| **46.** | **The following questions are about the care, treatment and rehabilitation of adults with serious mental health problems requiring hospitalisation and follow-up medication.** | | |

| | QUESTION | *Notes/Key words* | |
|---|---|---|---|
| **nn** | Have you been trained to identify and refer adults with serious mental health problems? *(If yes, describe the training in terms of frequency and comprehensiveness. If limited or none, what training needs do you still have?)* | | |
| **oo.** | What support mechanisms are in place currently to assist you in working with people who have serious adult mental health problems? Describe these. *(If limited or none, what other support do you need?)* | | |
| **pp** | Where are people identified as having serious mental health problems in the district referred to? Please describe the referral pathway *(Probe for referrals to district, regional hospitals or psychiatric hospital)* | | |
| **qq** | Is there a back referral system in place so that you are provided with information on the patient needs when (s)he is discharged into the community from regional and tertiary hospitals? What information is included in the referral forms? How well does this system operate? What needs to be improved? | | |
| **rr.** | Is there a referral system between the different sectors involved in patient care at district level e.g. between the psychiatric social worker and psychiatric nurse? What information is included in the referral forms? | | |
| **ss.** | If a person cannot be cared for by their family, where can they be cared for? *(probe for community care, residential facilities)* | | |
| **tt.** | How are disability grants accessed and administered for people with mental illness? *(Probe for detail about assessment procedure, steps, length of time)* | | |
| **uu** | How well does this system operate? Are there any difficulties with accessing and maintaining grants for mental illness? | | |
| **vv.** | Do you feel that the R830 per month disability grant is enough money to live on? *(If no, what should be done to improve this?)* | | |
| **ww** | Is there enough help available for people with mental health problems? *(If no, what extra help should be made available?)* | | |
| **47.** | **The following questions are about the care, treatment and rehabilitation of children and adolescents with mental and behavioural problems.** | | |
| **ee.** | Have you been trained to identify and refer children/adolescents with mental and behavioural problems? *(If yes, describe the training in terms of frequency and comprehensiveness. If limited or none, what training needs do you still have?)* | | |
| **ff.** | What support mechanisms are in place currently to assist you in working with children and adolescents with mental health problems? Describe these. *(If limited or none, what other support do you need?)* | | |
| **gg.** | Are there any special facilities in the district or region for children and adolescents with mental health problems to be referred to e.g. Child and Adolescent Mental Health Unit?, Other social service funded units? | | |
| **hh** | Who provides care for mental health problems in children and adolescents? E.g. traditional healers, priests, psychologists in private practice, psychologists within the public health care system, nurses, teachers, social workers? What kind of care do they provide? | | |
| **ii.** | Is there a referral system in place for child/adolescent mental health and what is included on the referral forms? | | |

| | QUESTION | *Notes/Key words* | |
|---|---|---|---|
| **jj.** | Are there any specific support programmes for problems commonly experienced by children e.g. for children who are sexually abused, children with learning difficulties, substance abuse problems? *(Probe for number and who runs these programmes)* | | |
| **kk** | Are there any programmes for the prevention of specific problems for children e.g., sexual violence, substance abuse, other high risk behaviours? *(Probe for number, what they do and who runs these programmes)* | | |
| **ll.** | Is there enough help available for children/adolescents with mental health problems? *(If no, what extra help should be made available?)* | | |
| **48. The following questions are about socio-economic and cultural factors that play a role in mental health.** | | | |
| **n.** | Do you feel that the care you provide is constrained by a limited budget? *(If yes, what would be some things that could be achieved with more resources?)* | | |
| **o.** | Do you think that there are any links between poverty and poor mental health? (*If yes, describe these links. What is being done to eradicate these links?)* | | |
| **p.** | Do you think that there are any links between gender and poor mental health? *(If yes, describe these links. What is being done to deal with these links?)* | | |
| **q.** | What do you think are the main reasons people develop mental health problems? *(probe for bio-medical, cultural beliefs, stress)* | | |
| **r.** | What do traditional healers have to offer in caring for people with mental health problems? | | |
| **s.** | How are language barriers dealt with for intervening with people with mental health problems? | | |
| **49. The following questions are about your knowledge of existing Mental Health Care legislation (Policies and plans).** *This must be tailored for each country* | | | |
| **m.** | What do you know about the new Mental Health Treatment Act of 1964? | | |
| **n.** | Have you and other staff in your district received training in the provisions of the Act? | | |
| **o.** | What impact do you feel the Act has had on the provision of mental health services at district level? | | |
| **p.** | What impact do you feel that the Act has had on your work as a social worker? | | |
| **q.** | What impact do you feel that the Act has had on the lives of people with mental health problems? | | |
| **r.** | Are there any changes needed to the Act? | | |
| **s.** | How easy is it to implement the Act at district level? | | |
| **t.** | Please comment on other legislation which impacts on your work as a social worker working with people with mental heath related problems, such as the Child Care Act, and the Substance Abuse Dependency act? Are there any changes needed to these Acts? | | |
| **u.** | Do you think government policy and action ensures that people with mental health problems enjoy the same respect, treatment and opportunities as other people? (*Probe for details: How are rights protected, violated? What still needs to be done?*) | | |
| **v.** | Do you think that people with mental health problems can participate in developing government policies, plans and actions that affect their mental health? (*If yes, how? Are there limits, and why? If no, why not?)* | | |

| | QUESTION | *Notes/Key words* | |
|---|---|---|---|
| **w.** | Do you think it is necessary for people with mental health problems to be supported so that they can influence mental health policies and plans? (*If no, why not, if yes, what are they doing already? What should happen?)* | | |
| **50. General** | | | |
| **b.** | Are there any other comments you would like to make regarding mental health in your district? | | |


## The Mental Health and Poverty Project

**Semi-Structured Interview** (G4): Religious leaders/Faith healers

| | QUESTION | *Notes/Key words* | |
|---|---|---|---|
| **51. Background** | | | |
| **ooo.** | How do you view mental illness? | | |
| **ppp.** | What role do you play in caring for people with mental health problems? | | |
| 52. **The following questions are about what mental health services and resources are available from this organisation for people with mental health problems.** | | | |
| **qq** | What kind of organisation is this? *(Probe for details – What users does it provide for)?* | | |
| **rr** | What services are available for people with mental health problems within this organisation? | | |
| **sss** | What human resources are available within this organization for people with mental health problems? | | |
| **ttt** | If there are support groups, what are these and how are they run? | | |
| **uu** | If there is supported employment, what form does this take and how is it run? | | |
| **vv** | If home visits are conducted what are the main aims of these visits? | | |
| **ww** | How do people with mental health problems come to use this organisation *(probe family members, traditional healers, hospitals, welfare system)?* | | |
| **xx** | Do you have links with any mental health programmes that are currently being run in the district? | | |
| **yy** | Are you currently running any awareness, educational or training programmes within your district/community? | | |
| 53. **Support and Training** | | | |
| **u.** | Have you been trained to identify, counsel and refer adults with mental health problems? *(If yes, describe the training in terms of frequency and comprehensiveness. If limited or none, what training needs do you still have?)* | | |

| | QUESTION | *Notes/Key words* | |
|---|---|---|---|
| **v.** | What support mechanisms are in place currently to assist you in working with adult mental health problems? Describe these. *(If limited or none, what other support do you need?)* | | |
| **w.** | What training do you receive in dealing with mental health issues which affect women, such as rape and gender violence? | | |
| **x.** | Are there any programmes for the prevention of specific problems e.g. sexual violence, substance abuse? *(Probe for number, what they do and who runs these)* | | |
| **y.** | Are there strict guidelines in place for dealing with people with mental health problems? If so, what are these? | | |
| **z.** | If you feel that you cannot help a person with mental health problems, where are they referred to? | | |
| **aa.** | Are there any specific support groups/shelters for people with common mental health problems e.g. support groups and shelters for abused women, support groups for people with substance abuse problems? *(Probe for number, what they do and who runs these)?* | | |
| **bb.** | Have you been trained to identify, counsel and refer children/adolescents with mental and behavioural problems? *(If yes, describe the training in terms of frequency and comprehensiveness. If limited or none, what training needs do you still have?)* | | |
| **cc.** | What support mechanisms are in place currently to assist you in working with children and adolescents with mental health problems? Describe these. *(If limited or none, what other support do you need?)* | | |
| **dd.** | Where do you refer children and adolescents who need specialist psychological help?<br>Are there any special facilities in the district or region for children and adolescents to be referred to e.g. Child and Adolescent Mental Health Unit? | | |
| **ee.** | Are there any programmes for the prevention of specific problems for children e.g., sexual violence, substance abuse, other high risk behaviours? *(Probe number, what they do and who runs these)* | | |
| **ff.** | Are there any specific support programmes for problems commonly experienced by children e.g. for children who are sexually abused, children with learning difficulties, substance abuse problems? *(Probe number, what they do and who runs these)* | | |
| **gg.** | If relevant, is there a system of supervision and/or ongoing support from specialist psychiatric staff to other mental health staff*? (If yes, what is the nature of this support?)* | | |
| **54. The following questions are about socio-economic and cultural factors that play a role in mental health.** | | | |
| **o.** | Do you feel that the care you provide is constrained by a limited mental health budget? *(If yes, what would be some things that could be achieved with more resources?)* | | |
| **p.** | Do you think that there are any links between poverty and poor mental health? (*If yes, describe these links. What could be done to eradicate these links?)* | | |
| **q.** | Do you think that there are any links between gender and poor mental health? *(If yes, describe these links. What could be done to deal with these links?)* | | |
| **r.** | What do you think are the main reasons people develop mental health problems? *(probe for bio-medical, cultural beliefs, stress)* | | |

| | QUESTION | *Notes/Key words* | |
|---|---|---|---|
| **s.** | What explanations do most users have for mental health problems? *(probe for bio-medical, cultural beliefs)* | | |
| **t.** | How are language barriers dealt with for intervening with people with mental health problems? | | |
| **55. The following questions are about your knowledge of existing Mental Health Care legislation (Policies and plans).** *This must be tailored for each country* | | | |
| **hh.** | Do you know any things about the mental health legislation in Uganda? | | |
| **ii.** | What impact do you feel that the Act has had on the lives of people with mental health problems? | | |
| **jj.** | Do you know anything about the mental health policy in Uganda? | | |
| **kk.** | Do you think government policy and action ensures that people with mental health problems enjoy the same respect, treatment and opportunities as other people? (*Probe for details: How are rights protected, violated? What still needs to be done?*) | | |
| **ll.** | Do you think that people with mental health problems can participate in developing government policies, plans and actions that affect their mental health? (*If yes, how? Are there limits, and why? If no, why not?)* | | |
| **mm.** | Do you think it is necessary for people with mental health problems to be supported so that they can influence mental health policies and plans? (*If no, why not, if yes, what are they doing already? What should still be done?)* | | |
| **56. General** | | | |
| **d.** | Are there any other comments you would like to make regarding mental health care? | | |

**B2**
**Focus Group Discussion Guide (Primary Health Care Nurses)**

1- How do you people view mental illness?
2- What are the main reasons why people develop mental health problems?
3- What are the explanations most users have for mental health problems?
4- What roles do you play in caring for people with mental health problems?
5- What services are available for people with mental health problems in this facility?
6- What human resources are available for people with mental health problems and for their families in this facility?
7- What other resources are available for people with mental health problems and their families in this facility?
8- Are you currently running any mental health awareness, educational or training programmes in the district?
9- How would you go about categorizing mental health as being serious or mild? c.f neuroses Vs Psychoses
10- Do you feel you have sufficient training to identify and deal with adults having common mental health problems (less severe ones), that may not require hospitalization?
Probe: - What support mechanisms are in place to assist you in this?
11- Do you feel you have sufficient training to identify and deal with adults having serious mental health problems? Probe: - What support mechanisms are in place to assist you in this?
12- What training do you receive in dealing with gender-specific mental health issues?

Probe: Rape and gender violence in women

13- Are there any programmes for prevention of specific problems?
14- How is the system of supervision and/or support from specialist psychiatrists to other mental health staff?
15- How is the care, treatment and rehabilitation of children and adolescents with mental health problems handled in this country?
Probes: - Are there any special facilities for them?
- Do you feel you have sufficient training in dealing with this children and adolescents?
- What support mechanisms are in place to assist you in working with children and adolescents with mental health problems?
16- Are there any programmes for prevention of specific problems for children?
17- What are the socio-economic and cultural factors that play a role in mental health?
Probes: - Is care constrained by a limited mental health?
- Are there any links between poverty and poor mental health?
- Are there any links between gender and poor mental health?
18- How are language barriers dealt with in interventions with people with mental health problems?
19- Do you know about the Mental Health Treatment Act in this country? Probe: What do you know about it?
20- What impact has this act had a) on your job?
b) on the lives of people with mental illness?
21- Are there any changes needed in this Act? If yes, which ones?
22- Do you think government policy and action ensures that people with mental health problems enjoy the same respect, treatment and opportunities as other people?
23- Do you think people with mental health problems can participate in developing government policies, plans and actions that affect their mental health?
24- Do you think it is necessary to support people with mental health problems so that they can influence mental health policies and plans?
25- Are there any general comments you would like to make concerning mental health policy development and implementation in this country?
26- Are there any general comments you would like to make regarding mental health in this facility and in this country at large?

**D1**

**FGD Guide: Mental Health Staff working in other facilities.**

1) How do you people view mental illness?
2) What are the main reasons why people develop mental health problems?
3) What are the explanations most users have for mental health problems?
4) What roles do you play in caring for people with mental health problems?
5) What kind of users does this facility care for? (Probes: age, gender, specific mental issues)
6) What services are available for people with mental health problems in this facility?
7) What human resources are available for people with mental health problems and for their families in this facility?
8) What other resources are available for people with mental health problems and their families in this facility?
9) Are you running any mental health awareness, educational or training programmes in the district?
10) How would you go about categorizing mental health as being serious or mild? c.f neuroses Vs Psychoses

11) Do you feel you have sufficient training to identify and deal with adults having common mental health problems (less severe ones), that may not require hospitalization?
12) Probe: - What support mechanisms are in place to assist you in this?
13) Do you feel you have sufficient training to identify and deal with adults having serious mental health problems? Probe: - What support mechanisms are in place to assist you in this?
14) What training do you receive in dealing with gender-specific mental health issues?
15) Probe: Rape and gender violence in women
16) Where does funding for this facility come from?
17) What are the socio-economic and cultural factors that play a role in mental health?
18) Probes: - Is care constrained by a limited mental health?
19) Are there any links between poverty and poor mental health?
20) Are there any links between gender and poor mental health?
21) How are language barriers dealt with in interventions with people with mental health problems?
22) Do you know about the Mental Health Treatment Act in this country? Probe: What do you know about it?
23) What impact has this act had a) on your job?
24) b) on the lives of people with mental illness?
25) Are there any changes needed in this Act? If yes, which ones?
26) Do you think government policy and action ensures that people with mental health problems enjoy the same respect, treatment and opportunities as other people?
27) Do you think people with mental health problems can participate in developing government policies, plans and actions that affect their mental health?
28) Do you think it is necessary to support people with mental health problems so that they can influence mental health policies and plans?
29) Are there any general comments you would like to make concerning mental health policy development and implementation in this country?
30) Are there any general comments you would like to make regarding mental health in this facility and in this country at large?

**C1**

**Focus Group Discussion Guide (Psychiatric Nurses in Hospitals)**

1) How do you people view mental illness?
2) What are the main reasons why people develop mental health problems?
3) What are the explanations most users have for mental health problems?
4) What roles do you play in caring for people with mental health problems?
5) What services are available for people with mental health problems in this facility?
6) What human resources are available for people with mental health problems and for their families in this facility?
7) How would you go about categorizing mental health as being serious or mild? c.f neuroses Vs Psychoses
8) Do you feel you have sufficient training to identify and deal with adults having common mental health problems (less severe ones), that may not require hospitalization?
9) Probe: - What support mechanisms are in place to assist you in this?
10) Do you feel you have sufficient training to identify and deal with adults having serious mental health problems? Probe: - What support mechanisms are in place to assist you in this?
11) What training do you receive in dealing with gender-specific mental health issues?
12) Probe: Rape and gender violence
13) Are there any programmes for prevention of specific problems?

14) How is the system of supervision and/or support from specialist psychiatrists to other mental health staff
15) How is the care, treatment and rehabilitation of children and adolescents with mental health problems handled in this country?
16) Probes: - Are there any special facilities for them?
17) Do you feel you have sufficient training in dealing with this children and adolescents?
    i. - What support mechanisms are in place to assist you in working with children and adolescents with mental health problems?
18) What are the socio-economic and cultural factors that play a role in mental health?
19) Probes: - Budget limitations
20) Links between poverty and mental health
21) Links between gender and poor mental health

22) How are language barriers dealt with in interventions with people with mental health problems?
23) Do you know about the Mental Health Treatment Act in this country? Probe: what do you know about it?
24) What impact has this act had a) on your job?
    b) on the lives of people with mental illness?
25) Are there any changes needed in this Act?
26) Do you think government policy and action ensures that people with mental health problems enjoy the same respect, treatment and opportunities as other people?
27) Do you think people with mental health problems can participate in developing government policies, plans and actions that affect their mental health?
28) Do you think it is necessary to support people with mental health problems so that they can influence mental health policies and plans?
29) Are there any general comments you would like to make concerning mental health policy development and implementation in this country?
30) Are there any general comments you would like to make regarding mental health in this facility and in this country at large?

**The Mental Health and Poverty Project**

Focus Group Discussion E1: Teachers

1- How do you view mental illness?
2- What role do you play for learners with health or behavioural problems?
3- For how long have you been teaching?
4- What level do you teach at? (age/grade)
5- Have any of you had an experience of teaching a learner with mental or behavioural issues? These can range from learning difficulties, being the victim of abuse, substance abuse, anorexia, depression, anxiety.
6- What was that experience like for you? What was the hardest part of that experience? Did you feel able to cope with the learner? Please be honest, we are trying to find out if teachers need training and support for these situations.
7- What did you do? (probe for counseling, referral, reporting, calling in parents, or just ignoring the problem)

8- What do you feel are the biggest mental health challenges faced by learners? *(probe for behavioural problems, sexual abuse, learning disabilities).*
9- Have you been trained to identify, counsel and refer children/adolescents with mental and behavioural problems? *(If yes, describe the training in terms of frequency and comprehensiveness. If limited or none, what training needs do you still have?)*
10- What support mechanisms are in place currently to assist you in working with children and adolescents with mental health problems? Describe these. *(If limited or none, what other support do you need?)*
11- Where do you refer children and adolescents who need specialist psychological help? Are there any special facilities in the district or region for children and adolescents to be referred to e.g. Child and Adolescent Mental Health Unit?
12- Are there any programmes for the prevention of specific problems for children e.g., sexual violence, substance abuse, other high risk behaviours? *(Probe number, what they do and who runs these)*
13- Are there any specific support programmes for problems commonly experienced by children e.g. for children who are sexually abused, children with learning difficulties, substance abuse problems? *(Probe number, what they do and who runs these)*
14- Do you have links with any mental health programmes that are currently being run in the district? Or are you currently running any awareness, educational or training programmes within your district/community?
15- If a child/adolescent with mental health problems remains in the school system, what steps are taken to make this easier for the learner, for other learners and for teachers?

**The following questions are about socio-economic and cultural factors that play a role in mental health.**

16- Do you think that there are any links between poverty and poor mental health? (*If yes, describe these links. What could be done to eradicate these links?)*
17- Do you think that there are any links between gender and poor mental health? *(If yes, describe these links. What could be done to deal with these links?)*
18- What do you think are the main reasons people develop mental health problems? *(probe for bio-medical, cultural beliefs, stress)*
19- What do you know about the Mental Health Treatment Act of 1964?
20- Have you received training in the provisions of the Act?
21- What impact do you feel that the Act has had on your job?
22- What impact do you feel that the Act has had on the lives of people with mental health problems?
23- Are there any changes needed to the Act?
24- Do you think government policy and action ensures that people with mental health problems enjoy the same respect, treatment and opportunities as other people? (*Probe for details: How are rights protected, violated? What still needs to be done?*)
25- Do you think that people with mental health problems can participate in developing government policies, plans and actions that affect their mental health? (*If yes, how? Are there limits, and why? If no, why not?)*
26- Do you think it is necessary for people with mental health problems to be supported so that they can influence mental health policies and plans? (*If no, why not, if yes, what are they doing already? What should still be done?)*
27- Are there any other comments you would like to make regarding mental health care?

**G2 (a)**

**SSI/FGD guide for Traditional Healers**

| | QUESTION | *Notes/Key words* | |
|---|---|---|---|
| **57. Background** | | | |
| **zzz** | How did you become traditional healers? What training did you receive? *(probe for length, who it was with, what they learnt)* | | |
| **aaa** | Did you receive any training specifically for mental problems? (If yes, what kind of training. If no, would you like training?) | | |
| **bbb** | If someone comes to you for help how do you diagnose what problem they have? (*probe for techniques used and system/categories of diagnosis*) | | |
| **ccc** | Are there specific diagnoses for mental problems? *(If so, what are these?)* | | |
| **ddd** | What are the reasons that someone would suffer from mental problems? (*probe for different explanatory models of illness)* | | |
| **eee** | Are there special treatments for mental problems? *(If so, what are these? Probe for herbal medicine, rituals, other treatments and support)* | | |
| **58. The following questions are about the care of people with mental health problems.** | | | |
| **a.** | How many people do you see a month who have mental problems? | | |
| **b.** | How do people with mental problems come to use your services *(own choice, family members, referrals from other traditional healers, PHC clinics)* | | |
| **c.** | If you could not help them, where might you refer them to? *(Probe for what problems they feel they cannot treat and where they refer them e.g., other traditional healer, PHC clinic, hospital, community health worker)* | | |
| **d.** | What support mechanisms are in place currently to assist you in caring for people with mental health problems? Describe these. *(If limited or none, what other support do you need?)* | | |
| **e.** | If people have been through hard times such as rape or the death of a loved one, would they come to traditional healers for help? *(If yes, what help or support would you provide?)* | | |
| **f.** | Do any of you belong to the Traditional Healers Organisation or any other organisations? *(If yes, do these organisations ever discuss mental issues?)* | | |
| **g.** | How often do you interact with medical practitioners such as a primary health care or psychiatric nurse? *(What form does this interaction take? How happy are you with this interaction? Can this be improved?)* | | |
| **h.** | Are you aware of what can happen if a person uses both herbal medicine and medicine from a doctor at the same time? *(If yes, probe for knowledge of effects of drug interactions?)* | | |
| **i.** | Do you think that traditional medicine and the medical system can work together? *(If yes, how can this be achieved? Probe for how they think the formal health system could support them in their work)* | | |

| | QUESTION | *Notes/Key words* | |
|---|---|---|---|
| **j.** | Aside from your training as traditional healers, have you ever had any other health training? *(If yes, what kind of training, if no, would you like any training?)* | | |
| **k.** | Do you have any formal links to the health system e.g., referral networks? (*If yes, what kind of links, if no, would you like to have some kind of link*?) | | |
| **l.** | Do you think that there are any links between poverty and mental problems? (*If yes, describe these links. What could be done to eradicate these links?)* | | |
| **m.** | Do you think that there are any links between gender and mental problems? *(If yes, describe these links. What could be done to deal with these links?)* | | |
| 59. **The following questions are about the care of children and adolescents with mental problems.** | | | |
| **a.** | Do you see children or adolescents who need help with mental problems? | | |
| **b.** | If yes, do they have the same problems as adults or different ones? | | |
| **c.** | If yes, would they have the same treatments as adults or different ones? | | |
| **d.** | If yes, if you could not help a child or adolescent with their mental problems where would you refer them to? *(Probe for what problems they feel they cannot treat and where they refer them e.g., other traditional healer, PHC clinic, hospital, community health worker)* | | |
| **60. The following questions are about your knowledge of existing Mental Health Care legislation (Policies and plans).** *This must be tailored for each country* | | | |
| **nn** | Have you heard about the Mental Health Treatment Act of 1964? (If yes, have you received any training in the provisions of the Act? What are your feelings about the Act) | | |
| **oo.** | Have you heard about the mental health policy? | | |
| **61. General** | | | |
| **e.** | Are there any other comments you would like to make regarding mental health care? | | |

**G2(b)**

**SSI/FGD guide: Traditional Healers**

1- Mwafuuka mutya abasawo be'a okinaansi? Mwafuna kutendekebwa kwangeri ki?
2- Mwali mufunyeyo okutendekebwa kwonna okukwatagana n'ebyobulamu bw'emitwe?
3- Omulwadde bwajja gyemuli, muzuula mutya ekimutawanya?
4- Waliwo endwadde ezenjawulo ezimanyikiddwa nga zo zamitwe? Ndwadde ki ezo?
5- Nsonga ki ezitera okuletera abantu obulwadde bw'omutwe?
6- Waliwo enzijanjaba ezenjawulo ezimanyikiddwa nga zabalwadde bamitwe?
7- Abalwadde b'emitwe bameka bolaba omwezi? Yebo batuuka batya okugya gyemuli?
8- Bwemuba temuusobole kubayamba mubasindika wa?
9- Abantu abayiseeko mukaseera akazibu abakyala okukwatibwa, okufiirwa nebirala nabo bagya gyemuli?
10- Mulina ebibiina byemulimu nga bamemba?
11- Mutera okulabagana/okwetabamu nabasawo bekizungu? Buli di? Mungeri ki?

12- Mumanyi ekiyinza okuva mumuntu okukozesa eddagala lyekinnansi ate nezungu mukiseera kyekimu?
13- Mulowooza enzijanjaba yekinnansi neyekizungu ziyinza okukwatagana?
14- Nga ojeeko okutendekebwa nga'basawo bekinnansi, mwali mufunyeyo okutendekebwa okulala kwonna mubyobulamu?
15- Mulowooza waliwo engeri obwavu, n'obulwadde bw'emitwe gyebikwataganamu?
16- Ate waliwo engeri obulwadde bw'emitwe nenkula zabantu gyebikwataganamu?
17- Mukola nekubaana abalina obuzibu bw'obulwadde bw'emitwe?
18- Nabo baba nebizibu byebimu ng'abakulu? Enzijanjaba betaaga yemu?
19- Bwemuba temusobole kuyamba baana nabavubuka, mubasindikawa?
20- Mwali muwulidde kuteeka erifuga eby'obulamu bwemitwe erya 1964? Kiki kyemulilowoozako?
21- Ate enteekateeka ya gavumenti kubyobulamu bwemitwe?
22- Waliwo ekirala kyona kyemwandiyagadde okwogera kubyobulamu bwemitwe?

**Semi-structured interview schedule for adults with mental health problems (18 and older)**

***Please read Appendix: Notes for the interviewer (pg 13) before commencing interview***

*Interviewer says:*

Hello, my name is _____ from _____

Thank you for agreeing to take part in this interview. We would like to find out about your experience of mental illness, your views about mental health services and what you think should be included in a mental health policy for the country.

When we speak about mental health services during this interview, we include any person or organisation that offers care and or support to people with mental health problems. This service could include the diagnosis of a mental health problem, providing medication, counselling, as well as non-medical services, such as providing psychosocial supports and other services to improve the person's mental health. These services may be offered by community workers, community health workers and counsellors, traditional healers, other non medical healers, psychiatrists, psychologists, social workers, psychiatric nurses, primary health care doctors or nurses.

When we speak about a mental health policy, we refer to a document in which government states what it aims to achieve in the future to improve the mental health of all citizens and reduce the burden of ill-health for people living with mental health problems.

Speaking about your experiences may be difficult, but will help us with our research, which looks at what is needed to improve mental health services and what should go into a useful mental health policy for our country.

Although your answers are being recorded, your name will not be linked to this recording, so your views will be anonymous. It is up to you if you wish to answer any or all of my questions. The interview should take no longer than ___ minutes but can be stopped by you at any point.

*(Enquire if participant needs any further explanation of purpose of interview before proceeding. Complete consent form. Ask for agreement to tape the interview.*
*Note that if this is not Note that if this is not acceptable, the interview will continue, but not recorded and full notes will be taken.*

## Section 1 – Demographic Information

*Ask participant to provide the following basic details.*

| | |
|---|---|
| Age | How old are you? |
| Gender | *Observe and note in summary sheet* |
| Ethnic/Race group | Under what race group would you be classified? |
| Level of education | What education do you have |
| Urban or rural | *Observe and note in summary sheet* |
| Type of dwelling | Where do you live? What kind of home do you have? |
| Total number of occupants<br>Number of adults<br>Number of children | How many children and adults live with you? |
| Household Income | Could you estimate what income your household has available each month?<br>Who is the main breadwinner in your home?<br>What is his/her main source of income?<br>Does anyone receive any grants? Which ones?<br>*If not above breadwinner ask*: What is your own main source of income?<br>Does your household receive any other help with income. (*If yes ask:* Please describe the help you receive). |

## Section 2: Help seeking and Symptom Management/Treatment

*Interviewer says:* In this section I will ask you about your mental and physical health problems and what you think can be done to improve services for these problems.

### 2.1 Mental Health Problem

2.1.1 **Knowledge:** can you tell me what kind of mental health problem you have? *(Probe for traditional beliefs versus biomedical explanations)*

2.1.2 **Naming the problem**: If *not already given above* : Have you ever been given a name (diagnosis) for your mental health problem? *(Probe for traditional beliefs versus biomedical explanations)*

2.1.3 **Understanding the problem**: What do you think is the reason you have this problem? *(Probe for traditional beliefs, biomedical explanations, or stress-related reasons) )*

2.1.4. **Onset of Problem**: Can you tell me how old you were when your mental health problem started? (*Or approximation*)

2.1.5 **Help-seeking:** How old were you when you first came for help? (*Or approximation*)

2.1.6 **Help-seeking:** Who did you go to first for help? *(Probe for family member, traditional healer, doctor, priest, etc. Probe whether person has helped)*

2.1.7 **Help-seeking:** Who else have you gone to for help since then? *(Probe for family member, traditional healer, doctor, priest. etc Probe whether person has helped.)*

2.1.8 **Information:** Have you received information about your rights when coming for treatment? *(Explore if given in understandable form*)

2.1.9 **Policy:** What can the health services do to make it easier for you to get the help you need for your mental health problem?

**2.2 Physical Health**

2.2.1 .Do you have any physical health problems? (*Explore: What is the problem, how long has the problem been there? Has it affected their mental health problem –how?*)

2.2.2 Have you ever had problems getting help for your (*mention problem)* because of your mental health problem? (*if yes, that problems were experienced What helped overcome the problem?)*

2.2.3 **Policy:** What can the health department do to make it easier for you to get the help you need for your (*mention problem*)?

**2.3. Service access and satisfaction**

2.3.1 **Utilisation** What services have you used for your mental health problem? (*Guide: home visits, clinic, hospital, residential homes, support groups, clubs crisis care, traditional healers) )*

2.3.2 **Utilisation:** Are there services which you have not been able to use for any reason? (*Probe for barriers to using service)*

***Interviewer says***[i]: "Thank you. I now am going to ask you about some of the services you have received for your mental health problem. Please tell me what you feel about each of these questions. *Guide: Read each question, obtain response and allow/encourage participant to explain response they feel strongly about . At the end of each set of questions (access, safety and comfort, staff, information and self-determination/participation), you may also explore responses further, if necessary: Say, after each section, for example: I see you are mainly happy about your (e.g. access to services, staff), but have a problem with (name issue), Can you explain what makes you unhappy about this? How could this be improved to help you? Or: I see you are mainly unhappy about your (e.g. safety, participation in services). Please tell me what makes you unhappy about these issues? How could this be improved to help you?*

| **Access and affordability** | |
|---|---|
| 1 | Is your clinic/treatment centre close enough to travel there? |
| 2 | Is your clinic/ treatment centre open enough hours a week? |
| 3 | Is the amount of time you have to wait to be seen fine? |
| 4 | Is your medication always available? |
| 5 | Can you get emergency care when you need it? |
| 6 | Can you get hospital care in your community when you need it? |
| 7 | Can you get counselling and support when you need it (*If yes, probe:What?)* |
| 8 | Do you have the chance to meet with people who have similar concerns about their mental health problems? *Probe if wanted, useful/not useful and how*) |
| 9 | Can you always afford to come for treatment when you need to? (*Guide: travel costs, taking off work etc)* |
| *Probe responses as above, where necessary* | |
| **Service conditions and safety** | |
| 10 | Is your clinic clean and comfortable? |
| 11 | Is the hospital service clean and comfortable? |
| 12 | Do you feel safe from physical and emotional harm when getting treatment? |
| 13 | Have you ever been forced to take treatment you did not want or did not understand? |

*Probe responses as above ,where necessary*

**Staffing**

14 Do the staff at your clinic or hospital know how to give you proper treatment and support?

15 Do the staff speak a language you understand?

16 Do the staff treat you with respect and dignity at all times

17 Do the staff keep your personal and treatment information private?

*Probe responses as above ,where necessary*

**Information and Psychoeducation**

18 Have you been given enough information to understand your treatment and medication?

19 Does your family have enough information about your mental health problem and treatment to help and support you?.

*Probe responses as above ,where necessary*

**Service level participation**

20 Do you feel that your opinions about your treatment and services are given attention?

21 Do you know how to make a complaint about services if you need to? (*Explore: What and how. Guide: Complaints procedure, mental health review boards*

22 Have you ever been scared to make a complaint or give your ideas about services you need?

*Probe responses as above ,where necessary*

## Section 3 – Stigma and Discrimination

3.1 **Attitude:** What do people in your community think about people with mental health problems? (*Explore attitudes*) How have they behaved toward you?

3.2 **Attitude:** What do you think about people with mental health problems? *(Explore- what has influenced their attitude)*

3.3 **Respect and dignity:** Have others ever treated you without respect because of your mental health problem? *(Explore: what happened, with whom, in which setting (home, community, clinic, school work, police how did you deal with this?)*

3.4 **Exclusion:** Has anyone ever stopped you from doing things other people are allowed to do because of your mental health problem? *(Explore: what happened, with whom, in which setting (home life community life, education and work, how did you deal with this?)*

3.5 **Police/Legal contact:** Have you ever had any contact with the law (*police, courts*) as result of your mental illness? *If yes*, did they know you had a mental problem? How did they treat you?

3.6 **Protection from discrimination:** What do you think must be done so that people with mental health problems can get the same respect as other people? (*Probe for details- in the community, by government, etc*)

## Section 4: Advocacy and Policy level Participation

4.1 **Awareness:** Do you know of any activities in your district to make people aware of mental health and how to cope with mental health problems? *(If yes explore what. If no, are these needed, and what? Guide: educational material, petitions, awareness meetings, marches, campaigns, public announcements, TV, radio)*

4.2 **Exposure:** Do you know how to keep up to date with mental health policies which affect you? *(If not, is there interest in this? If yes, explore what is available. Guide: web, published directory, newsletter, newspapers, gazettes, organisational network, meetings, etc)*

4.3 **Participation: Opportunities**: What opportunities are there for you to have your say about mental health policies? (Guide: *Responses might include: service evaluations, serving on hospital boards or health committees, community or departmental meetings about (mental) health issues, support groups, lobby groups, education/information, skills training, funding, help to set up organisations, etc)*

4.4 **Participation: Organisation** : Are there any people, activities or organisations in your district to help you get your needs and ideas heard about services and policies? *Explore*: If not, are these needed? (*Why?) If yes* Who leads these organisations? How are people with mental health problems involved? Do they help you

4.5 **Participation: Interest:** Are you interested in having your ideas heard when government makes mental health policies which affect you? *(Explore why, to what extent Guide: See Table B*

4.6 **Participation: Barriers:** Are there things that hold you back from having your say about mental health policies? (*Probe for effect of illness on involvement, lack of confidence, lack of skills, stigma, lack of support)*

4.7 **Participation: Policy:** Is there anything that should be done so that you can have your say about mental health policies? (*Probe for details. Guide: See Table C: Examples of government support to user participation and organisation*

**Section 5: Basic Needs of People with mental health problems (Living, Learning, Working, Socialising)**

## 5.1 HOUSING NEEDS (LIVING)

5.1.1 **Housing:** Where and with whom do you live? (*Explore. Guide: own home, with relatives, friends, government-funded home, temporary accommodation, has basic amenities such as water, electricity, homeless? Probe whether living in: home of brick, iron, other)*

5.1.2 **Housing:** Are you receiving the right kind of help with housing? *If yes, explore-how? What ? If no,* what is needed (Probe. *Guide: family friends to share, pay for housing, subsidised housing from local services, other?) If managing on own, explore personal strengths*

## 5.2 EMPLOYMENT AND OCCUPATION NEEDS (WORK)

5.2.1 **Work:** Are you working at present? (*If not*, have you ever worked?) Could you describe what kind of work you do (did) and for whom you work (ed)? (*Guide: self-employed? formal job? Informal work, sheltered employmen*t)

5.2.2 **Work:** Have you ever had problems finding work because of your mental health problem? *(Probe for details)*

5.2.3 **Work:** Have you ever had a drop in your income because of your mental health problem? *(Probe for details- what happened? How did this affect your life?)*

5.2.4 **Work:** *Only ask people who have ever worked;* Have you ever lost your job because of your mental health problem? *(Probe for details)*

5.2.5 **Work:** Are you receiving the right kind of help with work? *If yes, explore-How? What? If no,* what kind of help do you think is needed (with work)? (*Guide: help to find paid work in open labour market? Sheltered employment? Daytime activities? Flexible work environment, Flexible work hours, supportive employer? etc*) *If managing on own, explore personal strengths*

## 5.3 EDUCATION AND SKILLS TRAINING NEEDS (ED/SKILLS)

*Note education refers to literacy, numeracy, academic skills, Skills training refers to practical training, technical skills. A "good job" should pay for basic needs, have activities which the person enjoys and be manageable with the person's mental health problem*

5.3.1. **Ed/Skills:** Have you had any problems with getting an education because of your mental health problem? *(Explore-what kind of problems? Does the person feel literate and numerate enough? What further education do they need?*).

5.3.2 **Ed/Skills:** Have you had any problems with learning job skills because of your mental health problem? (*Explore –access problems, ability to grasp skills?)*

5.3.3 **Ed/Skills:** Is your education and skills enough to get and keep a good job? (*Explore barriers*)

5.3.4 **Ed:** Did you get the right kind of help with education? *If yes, explore-How? What? If no,* what kind of help do (did) you need with education? (*Guide: finding education, on the job support, funds for study, etc*) *If managing on own, explore personal strengths*

5.3.5 **Skills:** Did you get the right kind of help with skills training? *If yes, explore-How? What? If no,* what kind of help do (did) you need with skills training? (*Guide: finding training, on the job training funds for training etc) If managing on own, explore personal strengths*

## 5.4 MATERIAL SUPPORTS

5.4.1 **Food:** Do you feel that you get enough to eat? (*Explore, if problems*).

5.4.2. **Food:** Do you receive the right kind of help to get enough food? *If yes, explore-How? What? If no,* what kind of help do you need to get enough food? (*Guide: food supply, help to prepare food, money for food, training to grow food, agricultural supplies, training, land etc*) *If managing on own, explore personal strengths*

5.4.3 **Benefits:** Are there any government (state) or work benefits due to you?

*Guide: South African benefits:*

| *Benefit type* | *Benefit type* |
|---|---|
| *Unemployment insurance* | *Care dependency grant* |
| *Medical boarding payment* | *Child support grant* |
| *Disability grant (DG)* | *Child maintenance* |
| *Old age pension* | *Other (Specify)* |

5.4.4 **Benefits**: Do you receive all the benefits you should get? (Explore: *Is the person aware of what benefits are available? Do they know which ones are due to them? Do they know how to access this benefit? For participants who have to pay child maintenance check for barriers to do so, Is anyone withholding/abusing the participants benefits?)*

5.4.5**. Benefits**: Do you receive the right kind of help with getting and keeping benefits? *If yes, explore-How? What? If no,* what kind of help do you need to get and keep benefits? (*from family, community, from local services?). If managing on own, explore personal strengths*

5.4.6. **Money:** Do you have enough money to pay your bills (*amenities, rent, clothes, household supplies, school fees, etc*) *Explore, if necessary. Guide: can pay all bills, selected bills, no money, cant manage money etc)*

5.4.7. **Money**: Do you receive the right kind of help with money? *If yes, explore-How? What? If no,* what kind of help do you need with money? (*Guide: funds to pay bills monitoring of payment of bills, protection from abuse of benefits by others etc). If managing on own, explore personal strengths*

## 5.5 HOME AND SELF CARE

5.5.1. **Self-care:** Are you able to take care of your self care needs (washing, grooming, changing clothes)?

5.5.2 **Self-care:** Do you receive the right kind of help with taking care of your daily self care routine? *If yes, explore-How? What? If no,* what kind of support is needed with self care? (*Explore. Guide: funds for supplies, skills training, reminders, day care support, regular supervision, etc?* ). *If managing on own, explore personal strengths*

5.5.3**. Household chores:** Are you able to take care of household chores at home? *Explore if necessary. Guide: manages on own or not coping, gets help, home-based care service or little assistance)*

5.5.4 **Household chores**: Do you receive the right kind of help with your chores at home (washing, cleaning, tidying, preparing meals, etc)? *If yes, explore-How? What? If no,* what kind of support do you need? (*Explore. Guide: someone to teach chores, reminders to clean, wash, tidy, day service, home-based carer, oversight/regular supervision with routine needed?*). *If managing on own, explore personal strengths*

## 5.6 TRANSPORT

5.6.1. **Transport:** Do you have any problems with transport, for example to work, your clinic appointment and social events? *Explore. Guide: own transport, public transport, lifts, walks long distances, etc*)

5.6.2 **Transport**: Do you receive the right kind of help with transport? *If yes, explore-How? What?* If no, what kind of help with transport do you need? (*Guide: money, lifts, government programme, subsidy, transport grant/card*). *If managing on own, explore personal strengths*

## 5.7 SOCIAL CONTACT

5.7.1 **Company:** Do you have enough contact with other people? *Explore, Guide: Able to organise enough social contact, has enough friends, attends a drop in centre, day centre, community centre/group for company, lonely, isolated, no opportunities for contact*

5.7.2 **Company:** Do you get the right kind of help to meet people/have company/make friends? *If yes, explore-How? What? If no,* what kind of help do you need to meet people/have company? *If managing on own, explore personal strengths*

5.7.3 **Intimate partner:** Do you have a partner? *(Or relationship, spouse, whichever is appropriate for the participant).* Is your current situation to your satisfaction or would you like it to change*? Explore if necessary*.

5.7.4 **Intimate partner:** Do (did) you get the right kind of help to start and keep a healthy relationship? *If yes, explore-How? What? If no,* what kind of help do (did) you need to start and keep a relationship? *Explore. Guide: introductions, support, social clubs, couple counselling, social skills training, dating line/club. If managing on own, explore personal strengths*

.5.7.5 **Childcare**: Do you take care of any children 18 years and under? Whose children are these? *Guide: biological, adopted, fostered child(ren), caring for child(ren) by agreement (neighbour, village council), providing day care for child(ren)*

5.7.6 **Childcare** Do you have any difficulty looking after them? *Explore (Guide: financial difficulties, poor access to grants, too ill etc)*

5.7.7 **Childcare:** Do you get the right kind of help with your their children *If yes, explore-How? What? If no,* what help is needed? *(Specify what and by whom ). If managing on own, explore personal strengths*

5.7.8 **Impact of mental health problem:** Has your mental health problem ever resulted in problems with making friends, getting a partner or caring for your children?

5.7.9. **Social activities**: Do you have sufficient rewarding things to do or places to go during the day? At night? *Explore if necessary, e.g. What kind of activities are you involved in, what kind of activities would you like to have available ?.*

5.7.10 **Social activities**: Do you think people with mental health problems get the right kind of help with social activities? *If yes, explore-How? What? If no,* what kind of help is needed with social activities? (*Guide: advice, inclusion, arrangements, state service development*). *If managing on own, explore personal strengths*

5.7.11 **Self harm** Have you ever been at risk to harm yourself as a result of your mental health problem? (*When and what helps?*)

5.7.12 **Self Harm**: *If has been at risk ask:* Do you receive the right kind of help when you are at risk to self harm? *If yes, explore-How? What? If no,* what help is needed? *(Explore. Guide: supporting counselling, reliable emergency contact available when at risk). If managing on own, explore personal strengths*

5.7.13 **Harm to Others:** Have you ever been at risk to harm others as a result of your mental health problem?

5.7.14 **Harm to others**: *If has been at risk ask* Do you receive the right kind of help when you are at risk to harm others? *If yes, explore-How? What? If no,* what help is needed? *(Explore). If managing on own, explore personal strengths.*

**6. General:**

6.1 From your experience, what do you think are the main things government should do to help people with mental health problems?

6.2 Do you have any other ideas for the new mental health policy?

**Section 6: Concluding questions**

6.1. Would you like to receive information about the results of this study? What would be the best way to get information to you about the results of this study?

6.2 Would you be prepared to take part in further research about mental health?

6.3 Finally, are there any documents or readings which you think we should use to have a better understanding of the issues we have discussed today?