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Putting the community back
into community mental health

Putting the Community Back into Community Mental Health:

The Role of the Community Worker

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Introduction

Community mental health has become equated in the minds of many with primary health care. Against the backdrop of long-term institutionalisation, which has been the mainstay of mental health services in some countries for decades, primary care treatment seems the panacea. In many developed countries, community care came to the forefront in the 1970s in tandem with a push towards deinstitutionalisation, spearheaded in Italy by Franco Basaglia. In much of the developing world, however, the move towards community care is a recent development, which is to be celebrated. There is more, however, to community mental health than the primary clinic.

The World Health Organisation (WHO) has been a driver of the community mental health agenda, forming the Global Forum for Community Mental Health in 2007 and publishing a number of reports promoting community care. BasicNeeds is a founding member of the Global Forum for Community Mental Health and has ten years of practical experience delivering mental health in the community. As of December 2008, BasicNeeds has helped 67,995 people with mental illness or epilepsy in 9 countries to live and work in their communities. BasicNeeds currently operates in four African countries (Ghana, Kenya, Tanzania, Uganda) and four Asian countries (India, Sri Lanka, Lao PDR and Nepal). The organisation was established in 1999 by Chris Underhill (co-author of this chapter) and uses an intervention, called the Model for Mental Health and Development, which can be easily replicated so as to reach large volumes of people in need. The BasicNeeds Model adopts a participatory rights-based approach to mental health, which it delivers in five interwoven modules: capacity building; community mental health; sustainable livelihoods; research; and management. Through the community mental health module, rather than provide services directly, BasicNeeds mobilises psychiatric clinicians from the public sector and health volunteers from the community to coordinate weekly or monthly mental health clinics in outpatient primary health centres and follow-up care in people's homes and neighborhoods.

In 2008, BasicNeeds conducted a review of the community mental health module of its Model, which offers learning from ten years implementing mental health in developing world communities. The qualitative study, *Practice of Community Mental Health: Seven Essential Features for Scaling Up in Low and Middle Income Countries* assembles data from 19 focus group discussions, 22 key informant interviews and 16 observational sessions in six countries – Sri Lanka, Kenya, Lao PDR, Uganda, Tanzania and Ghana – in search of the key components to a successful community mental health intervention. One of the main conclusions of the study's principle investigator, Shoba Raja, is that a key and under-recognised component to successful community care for mental health is the community worker. "*Community based workers fulfil a crucial role in delivering community mental health services. Their role needs to be further defined, including through legislation, to ensure they are earning appropriate salaries and receiving requisite training for their work.*"

Despite the growing global popularity of community-based models for mental health, the role of the community in community mental health remains ill-defined. In the experience of BasicNeeds, many

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

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

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

Who are community workers?
Community workers in the BasicNeeds programmes are members of the community without formal training in health. They are sometimes called "community volunteers" or "community health workers" or even "village workers." The job of a community worker is not confined to the health sector. Indeed, they are often involved in poverty reduction programmes and other areas relating to determinants of health rather than specific health interventions. Community workers are usually recruited from large government programmes or from other NGOs and work on a per diem basis.

Community workers can be men or women and encompass a broad range of ages with basic levels of literacy. In the BasicNeeds Asian programmes in Lao PDR and Sri Lanka, community workers are predominantly women (86% and 83% respectively), whereas in the African programmes, they are predominantly men (in Ghana), or are equally divided between men and women (in Kenya). The average age of community workers is 30-50 in Ghana, and ranges from 20-45 years in Tanzania, whereas in Sri Lanka 80% are under the age of 25. In the Sri Lanka and Tanzania programmes, recovered service users form a significant contingent (20% and 5% respectively) of the community workforce. Users are often happy to do this work, having benefitted from it themselves.

What do community workers do?

There is a broad range of activities conducted by community workers, including many key functions on the continuum of mental health treatment. It is these workers who do the active case-finding of people with mental illness or epilepsy in their communities and refer them to the clinic. They also help set-up the clinic, ensuring that the venue is in order and supplies are on hand. The more literate community workers register service users and take down their family history. Following clinic visits, community workers conduct home-visits, during which they discuss the role of medication with users and carers and they check on the individual's overall progress, both in terms of health, livelihood and social integration.

The BasicNeeds programme in Ghana credits community workers with high rates of medication adherence (see text box). During home visits, community workers also perform a service comparable to that of counselling, by listening to people's concerns, identifying a problem and helping them to arrive at their own goals and solutions.

In addition, community workers play a crucial role outside of health-specific interventions. They facilitate the operation and documentation of self-help group meetings in Ghana, Kenya and Tanzania. They also support the horticultural projects of programme participants in Ghana and Sri Lanka. And in some instances, such as Sri Lanka (see text box), socialising with community volunteers has had recognised benefits on the wellbeing of service users. Indeed, although livelihoods and socialising are not health-specific interventions, they have a powerful impact on the mental health of programme participants.

What training do they have?

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

Role of Community Workers in BasicNeeds

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

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

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

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

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

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

At least two important resources exist and are available online for those interested in training community workers in mental health. The most recent of these is a training of trainers manual *An Introduction to Mental Health: Facilitator's Manual for Training Community Health Workers in India,*

produced by researchers from the Nossal Institute for Global Health at the University of Melbourne in conjunction with BasicNeeds. The Nossal-BasicNeeds manual provides training in mental health first aid for all major mental disorders (common and severe), as well as basic counselling skills, and was pilot-tested in Maharashtra, India. Another very useful document is a training tool called *Barefoot Counselling,* designed by researchers at the Sangath Clinic for child and family mental health in Goa, India. *Barefoot Counselling* is written in simple English and provides training in counselling for depression and anxiety.
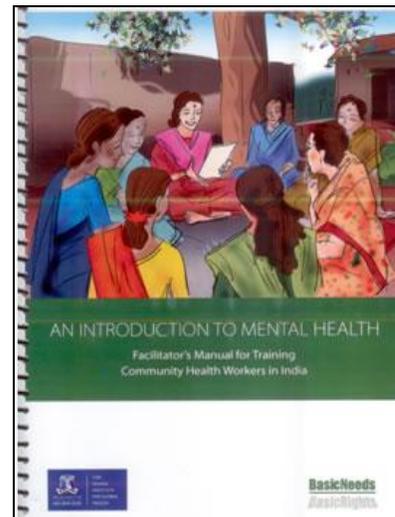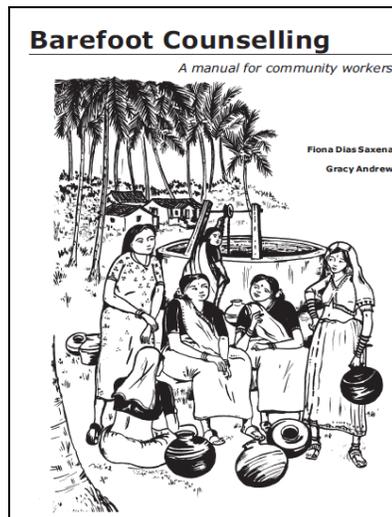
How many are there?

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

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

Table 1: Number of Community Workers in BasicNeeds Programmes

June 2009	Service Users	Community workers	Ratio
Lao PDR	538	148	4
Sri Lanka	3,246	1,912	2
Ghana	17,462	138	127
Uganda	2,576	0	NA
Kenya	2,298	514	4
Tanzania	4,290	216	20
Total	**30,410**	**2,928**	**31**

How are community workers funded?

Appropriate funding is fundamental to the success and sustainability of any community worker programme. Although they are often referred to as "volunteers," ideally community workers should not be volunteers in the sense of unpaid workers. BasicNeeds recompenses community workers differently from country to country, however in general they provide a per diem stipend of £1-£5 (see table 1). Community workers complement their BasicNeeds per diem with contributions from other government and NGO programmes. Governments typically pay with in-kind contributions, called "tokens," which include t-shirts, bags, lunches and, occasionally a bicycle. There is no fixed rate for NGO stipends, which creates what one BasicNeeds employee qualified "a situation of competition between NGOs" for the best community workers. Such competition, or free-market, is arguably beneficial to the quality and recognition of community workers.

Table 2: Community Worker Wages

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

The Asian programmes differ from Africa in their practice of compensation. BasicNeeds Lao PDR and Sri Lanka offer no financial remuneration for most community workers. BasicNeeds Sri Lanka has two categories of community worker, the lay volunteer (all 1,912 listed above fall into this category) and the more trained animator, of which there are 33 at the time of writing. Community animators organise village consultation meetings, set up mental health clinics and support users with livelihoods projects,

and they are paid £5/day. Volunteers, however, are unpaid. The BasicNeeds Programme Manager in Sri Lanka, Vanee Surendranatha, speculates that motivation for the work comes from a combination of factors:

> "At the beginning, they are motivated for new knowledge. Mental illness is something very curious for them to know. The recognition and being respected may be what keeps them going. They become so powerful because they have this knowledge and are making dialogue with these recognised people – psychiatrists, doctors, occupational therapists. At a DFID meeting once, a volunteer challenged a psychiatrist. He was saying it wasn't possible to manage the mentally ill person in the community, and she said to him, "You show me a mentally ill person and I will tell you how to treat her!"

Despite the benefits of knowledge and recognition to these volunteer community workers, there is a high turn-over. Approximately half of those trained move out of the village, largely because they marry young men in neighbouring areas.

What are the challenges?

Managing a cadre of community workers is not without challenge. Foremost of these is the challenge of sustaining motivation in a context of limited remuneration. Joyce Kingori, BasicNeeds Programme Manager in Kenya notes that some community workers "*have expections beyond what the project can offer. They expect cash, in kind gifts, identification badges etc.*" Similarly, Vipula Dasanayake, Project Coordinator in Sri Lanka, notes that "*In tsunami affected areas, lots of NGOs had been working with big projects that paid money for volunteers. With that practice, some volunteers became money-oriented in those areas.*" Indeed, the cash and in-kind contributions are a primary incentive for many people to take on the role. The in-kind gifts of branded goods contribute to community recognition, which serve as a counter-point to the low-wages of the job.

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

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

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

The challenge arising from budget constraints in Uganda had an unexpected positive effect, however, in eliciting user-led activism. Self-help groups in the Sembabule district stepped up to fill the service gap. The *Bulamu Kwejjanjaba* Mental Health Association (BUKA) appointed a 'village mobiliser' in each village to monitor and follow up with members who missed clinic visits, counsel new participants and support carers. The role of the community worker was thus replaced by users acting in combination with

radio announcements to inform people about clinics. The example from Uganda echoes the success of BasicNeeds in Sri Lanka and Tanzania in employing service users to perform the functions of community workers. More work is needed to determine the best procedure for involving recovered service users so that it can be adopted as a wide-spread practice.

Where do community workers fit into our understanding of global mental health?
The idea of using community workers to promote community health and empower individuals is not novel within the field of health, but it is innovative within global mental health. The field of HIV has long embraced community workers as an essential part of the treatment network. Indeed, the *World Health Report 2004,* which focused on HIV, devoted part of a chapter to the role of community workers. It argues that "community health workers have functioned successfully in small-scale nongovernmental programmes, as well as in large-scale national programmes integrated into the public health system" (chapter 3). The concept of using community workers for treatment has more recently been referred to as task-shifting, referring to the shifting of certain responsibilities from health professional to lay-workers. In 2008, PEPFAR, UNAIDS and the WHO jointly published a set of guidelines on task-shifting for HIV: *Treat, Train, Retain – Task-Shifting: Global Recommendations and Guidelines.* The primary driver behind the move towards task shifting is the desire to scale-up services in a context of limited resources.

There is no reason that mental health cannot benefit from the same practices as HIV and also promote wide-spread use of community workers. Indeed, the WHO suggests as much. In 2001 the WHO produced a seminal World Health Report, *Mental Health: New Understanding New Hope* in which they put forth a "new paradigm" for mental health based in the community. The Report contains ten recommendations, including to "give care in the community" (recommendation 3). The Report also mentions in passing the need for community workers, which it calls "health workers," saying that the "shift towards community care requires health workers and rehabilitation services to be available at community level, along with the provision of crisis support, protected housing, and sheltered employment."

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

On a global scale, a further document was recently released by the WHO and WONCA, *Integrating Mental Health into Primary Care,* which gives a number of useful case studies on the interaction of the community in the delivery of primary health care. We note, however, that the WHO-WONCA report defines the community sector as one outside the formal system of healthcare, and thus outside of primary care. "*Informal community care comprises services provided in the community that are not part of the formal health and welfare system. Examples include traditional healers, professionals in other*

sectors such as teachers, police, and village health workers, services provided by nongovernmental organizations, user and family associations, and lay people." By contrast, primary care is said to encompass all the basic components of formal treatment, such as diagnosis, prescription and follow-up. In short, according to this report, treatment starts in primary care; and treatment in the community is treatment in the primary care clinic. At BasicNeeds, we see the community worker as integral to both the formal and informal treatment and recovery of the person with mental illness. The BasicNeeds community worker contributes to formal treatment through case finding, organisation of clinics, and follow-up supervision of medication adherence. Informally, community workers support carers and families to understand and communicate with the service user, and they play a key role in economic aspects of recovery, by facilitating livelihoods activities.

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

Although the impetus for task-shifting from health professionals to less formally skilled members of the community is largely resource-driven, community workers should not be seen as a cheap way out. Indeed, community workers are not less skilled workers, they are differently skilled workers. Their skill is as activists whose main role is to mobilise vulnerable members of their community. This point was made forcefully by the *World Health Report 2004* with regards to community workers for HIV and it pertains equally to mental health:
> "*Community health workers should not be viewed simply as local helpers who can temporarily take on tasks the formal health care delivery system lacks the resources to perform. They are not primarily a cheap way to deal with human resource constraints. Rather, community health worker programmes can and should be seen as part of a broader strategy to empower communities, enable them to achieve greater control over their health and improve the health of their members.*"

In the long-term, cash rewards must replace in-kind contributions in order for community workers to sustain their work. The benefit of the community worker is that they can mobilise people better than a health worker, not simply that they can mobilise at lower cost.

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

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