

SEXUAL VIOLENCE RESEARCH INITIATIVE

**PRIMARY-LEVEL MENTAL HEALTH CARE  
FOR COMMON MENTAL DISORDER IN  
RESOURCE-POOR SETTINGS:  
MODELS & PRACTICE**

**A LITERATURE REVIEW**

Ray Lazarus and Melvyn Freeman

**FORD FOUNDATION**



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## ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Treatment
ARV	Antiretroviral (drugs or medication)
CMD	Common Mental Disorder (principally depression and anxiety)
CODs	Co-Occurring Disorders
HAART	Highly Active Antiretroviral Treatment
HIV	Human Immunodeficiency Virus
IDUs	Injecting Drug Users
IMAI	Integrated Management of Adolescent and Adult Illness
MSM	Men who have sex with men
NGO	Nongovernmental Organisation
PLHA	People/Person Living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
QOL	Quality of Life
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
USA	United States of America
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation
WLHA	Woman/Women Living with HIV/AIDS

## EXECUTIVE SUMMARY

Approximately 450 million people worldwide suffer from mental and neurological disorders. Lifetime prevalence ranges from 12.2–48.6% and 12-month prevalence between 8.4 and 29.1%. Fourteen percent of the global burden of disease can be attributed to neuropsychiatric disorder – three quarters of which occurs in developing countries. This already high proportion is rising and projections suggest that by 2030 unipolar depressive disorder alone will be the second highest cause of all DALYs (Disability Adjusted Life Years) lost globally.

Mental health care services in resource-poor countries are underdeveloped and largely restricted to urban areas, to hospital-based care and to people with severe mental disorders. Common mental disorders (CMD) such as depression and anxiety, which account for by far the highest proportion of the prevalence and burden of mental disorders, receive little, if any, attention in health care. Human resources for mental health care are generally minimal. Moreover, there is a general lack of awareness amongst frontline health workers of mental health and emotional problems, and how to detect such problems and intervene at that level.

The decentralisation of mental health services to primary and community level has been advocated to narrow the gap between the prevalence of mental disorders and the care available. The need to integrate mental health care into general health care has received particularly strong support. However, the extent to which such models have been implemented, their impact evaluated and scaling up of good practice has occurred is limited.

This report summarises the literature (both published and grey) on mental health care for common mental disorder (mental health and emotional problems) at primary and community level (and where indicated, secondary level) in resource poor settings. Examples of *good practice* or in some cases *emerging* or *promising* practice are described.

The report covers good practice in mental health care for primary health care patients and uses the example of mental health for People Living with HIV/AIDS as an example of a group at high risk for common mental disorder.

### Models of primary mental health care

Four common ways that mental health care is delivered at primary care level are:

- *Mental health in primary care.* Mental health is fully integrated with primary level general health care services with staffing by generalist health workers (e.g. doctors or nurses) as part of their routine function or as part of other health programmes operating at the primary care level.
- *Mental health at primary health care.* Mental health care is located on-site at (but not integrated with) primary level general health care services, with staffing by specialist mental health practitioners (whether professional or auxiliary workers).
- *Mental health community outreach.* Mental health care is provided in community settings by staff such as community/village health workers based in the community, or operating on outreach from a health service.
- *Mental health care provided through other sectors.* Statutory and non-statutory services in areas other than health may provide mental health care. Staffing may be generalist staff (e.g. social workers, police officers), volunteer counsellors, or on-site or on-call mental health professionals.

## Good practice in the health sector

The package of mental health care provided within primary health care will vary depending on which model of care is chosen. *Screening* for common mental disorder is an important first step in every model. Routine screening of all patients has been advocated; however, screening patients in various 'at risk' groups may be a more feasible option. Various screening tools are available. *Assessment* leading to diagnosis and judgement of severity and level of impairment/disability should follow directly from screening.

Various *interventions* have been found to be effective to varying degrees in treating common mental disorder, depending on the presenting problem, skills available within primary care, cultural acceptability and so on. These interventions include psychotropic medication; counselling (including informal counselling and psycho-educational counselling) and psychotherapeutic interventions (including cognitive behaviour therapy and interpersonal therapy).

Whether psychotherapy provided by generalists as opposed to specialists is as effective has not been fully tested; however, a review of psychosocial interventions by general practitioners found only limited evidence of successful intervention. In addition, there have been only a limited number of studies specifically assessing efficacy and effectiveness in developing countries with somewhat contradictory findings.

*How services* are organised is as important as clinical effectiveness. *Referral* involves the transfer of responsibility for all or part of a patient's care. In primary care mental health, this will usually involve referral to a mental health specialist or to services in other sectors, for example social or employment services, for the assistance necessary to support recovery.

*Case management* involves assigning responsibility for overseeing and coordinating the care of a patient to a particular member of the health care team. It includes systematic monitoring of adherence to treatment and indicators of progress or relapse; follow up in case of treatment default; and liaison with other team members. Case management has been found to be effective and cost-effective in a number of studies.

*Stepped care* has been found to provide effective and cost-effective management and allocation of scarce resources. It involves the provision of low intensity interventions to a significant proportion of patients and more intensive interventions for patients who have more severe disorder, or who fail to improve.

*Collaborative care* is directed at the efficient use of resources and effective care for patients. It includes case management and closer liaison between primary care generalist health workers and mental health specialists, as well as improved collaboration between staff working at the primary care level.

Critical elements of organising services are *staffing, training and supervision*.

The *staffing* resource implications of integrated primary mental health care are seldom addressed in the literature, the assumption being that primary care workers will take on the additional tasks necessary. The use of new categories of auxiliary workers to undertake some aspects of primary mental health care has been recommended and piloted in some settings. Adding additional general staff has also been suggested.

The key ingredients of effective *training* are that it should be systematic, participatory, tailored to the needs of the learners and should combine two or more strategies, for example, educational workshops and follow-up consultation visits. Implementation of training very often requires system changes (e.g. with regard to time per consultation, or privacy) to accommodate new practices. Supervision is central in promoting the implementation of training and changes in health worker practice, as well as identifying systemic barriers to implementation and finding ways to address them. Consultation-liaison is another means of providing support for front-line workers in order to implement training.

There are also numerous *systemic and organisational challenges* to the introduction of primary mental health care. These include the low ranking of mental health as a public health priority; the complexity of and resistance to the decentralisation of mental health services by policy-makers, managers, mental health specialists and primary health care workers and the insufficient numbers of specialist mental health workers in developing countries to provide effective training and supervision of primary care workers.

### *Good practice examples*

Examples of good practice in primary level mental health care from six developing countries (Uganda, Brazil, Chile, India, Belize and Pakistan) are described. These illustrate different ways of using psychotropic medicines, various counselling and psychotherapeutic methods and the organisation of services. Most examples make use of general health workers, usually with substantial support from mental health specialists in support roles. Use of new categories of mental health worker offers a promising, but as yet not widely tested, alternative. Important lessons derived from these examples are outlined in the conclusion.

### **Mental health care and treatment of people living with HIV/AIDS (PLHA)**

There is an interdependence and "vicious circularity" between mental health and HIV/AIDS. Mental health programmes are needed because of the vulnerability of people with mental disorders and substance abuse to contracting HIV; because mental ill-health is an important health outcome of being infected with HIV and because mental health status impacts on the course of the disease in various ways.

Studies in both more and less developed countries show that just under half of all PLHA have a diagnosable mental disorder and in some instances a threefold higher rate of mental disorder. Even with the greater availability of antiretroviral therapy, PLHA still often experience high levels of psychological distress and mental disorder. Difficulties include problems and decisions concerning relationships, having children, the side-effects of medication and dealing with stigma.

Where mental illness and HIV co-occur, there is increasing evidence that the progression of the virus is greater. Mental disorder also affects adherence to medication. Access to mental health services has been shown to decrease AIDS progression and mortality.

Despite the above, very few examples of mental health interventions for PLHA have been documented in developing countries. Available examples of counselling and psychosocial interventions provide little detail as to what these interventions entail. Few of the interventions have been subject to evaluation. Notwithstanding, there is emerging good practice that can assist in the development of mental health care for PLHA.

As a group at risk for mental disorder, it has been recommended that screening for CMD be done routinely. This should be followed by a full assessment for those who screen positive.

With regard to *interventions*, a range of studies has shown ART to significantly improve mental health, implying that access to ART is itself a key mental health intervention. However, for a number of people this is inadequate and more focused mental health interventions are needed.

PLHA with CMD can benefit from the use of psychotropic medication but dosages need to be adjusted. Though forms of counselling are often provided for PLHA, neither the extent nor the efficacy of most of these interventions is clear. Pre- and post-HIV-test counselling, even in the case of people testing positive, is usually brief and limited to a once-off session, with priority given to medical investigation and information rather than helping the person deal with the implications of the test result. Psycho-education (of up to four sessions) may assist in overcoming the difficulty that many clients have in absorbing relevant information in the immediate post-test situation.

Couple HIV counselling and testing has been promoted as a means to address a number of problems commonly arising in individual counselling of sexual partners, including the reluctance to disclose the PLHA's positive status to sexual partners. The model promotes support between partners to deal with other implications of the outcome. However, uptake has generally been low and the model not widely promoted.

Adherence counselling is commonly included in ART protocols and includes both preparatory counselling, as well as regular sessions, once the patient has started ART. Despite the important role of psychosocial factors in adherence, attention to psychosocial factors appears to take second place to biomedical factors.

Psychosocial support groups are widely seen as a cost-effective means of providing emotional and social support for PLHA, especially women. Some studies have found that participation in support groups was significantly associated with reduced rates of mental disorder.

Cognitive behavioural therapy (CBT) has been widely advocated for use with PLHA, and short-term psychodynamic psychotherapy (STPP) may also be an effective treatment, but evidence regarding the effectiveness of these therapies is not conclusive. Post-traumatic growth (PTG) in the course of HIV/AIDS, that is, positive changes following diagnosis and thereafter, has been reported in a number of studies.

A number of novel techniques have been introduced to address psychosocial issues affecting PLHA. These include using drawing, painting, collage and writing, together with discussion (usually in groups), to explore and work through experiences of PLHA. Three innovative techniques which appear to hold promise include the health journey, body mapping and memory work.

All the issues regarding the *organisation of care* pertinent to general mental health are also important with regard to mental health in PLHA. For example, case management appears to hold promise as regards improving mortality, uptake of ART and other health-related outcomes. *Collaborative* care that emphasises managing HIV simultaneously with mental disorders (and substance abuse) seems essential.

In many developing countries NGOs are playing a leading role in providing care, including psychosocial support, for PLHA. The development of linkages and closer collaboration between the various role-players requires recognition, negotiation and adaptation of the different cultures' characteristic of health care and these organisations.

Issues of *staffing, training and supervision* for dealing with mental health in PLHA as well as organisational issues such as low prioritisation of mental health and a lack of mental health professionals, largely mirror the needs and the difficulties of mental health services generally. However, the "double stigma" of mental health and HIV makes it even more difficult to involve staff.

For a complex variety of reasons, women are more vulnerable than men to HIV infection. Moreover, women usually suffer from more depression than men. This makes a focus on the mental health of women particularly important. Another group deserving of special attention are PLHA who abuse substances.

### ***Promising practice examples***

Though there are not many examples of good practice of mental health intervention for PLHA, promising examples from Uganda, South Africa and India suggest that with innovation, progress can be made. Though specific mental health symptoms or mental disorders are seldom directly addressed, it is likely that some interventions provide relief for PLHA experiencing mental distress.

### **Conclusions and recommendations**

Difficulties associated with primary mental health care and examples of good practice identified in this review underline the importance of the ten principles for the integration of mental health care developed by the World Health Organization and the World Organization of Family Doctors. The ten principles are:

- Policy and plans need to incorporate primary care for mental health.
- Advocacy is required to shift attitudes and behaviour.
- Adequate training of primary care workers is required.
- Primary care tasks must be limited and doable.
- Specialist mental health professionals and facilities must be available to support primary care.
- Patients must have access to essential psychotropic medication in primary care.
- Integration is a process, not an event.

- A mental health service coordinator is crucial.
- Collaboration with other sectors and stakeholders is required.
- Financial and human resources are needed.

With regard to the organisation of mental health services this review suggests in addition that:

- Routine or selective screening is necessary to identify cases.
- Positive screening needs to be followed up by more in-depth assessment to confirm or rule out false positives.
- In some cases of CMD, psychotropic medication is indicated and must therefore be available at primary care.
- Various counselling, psychosocial support and psychotherapeutic interventions need to be further incorporated into primary level interventions.
- Clear guidelines and procedures for referral are needed.
- Case management, stepped care and various forms of collaborative care may offer effective alternatives to referral of all mental health cases.
- Effective training and supervision of generalist primary health care workers needs to occur regularly.

Advocacy is essential to bring home to planners and managers the importance of mental health care. Organisational development approaches are necessary to challenge the traditional structure and culture of general health care so as to accommodate new ways of working and, possibly, new categories of workers. Partnership with NGOs can help to address gaps and assist in developing new ways of working.

## Scaling up

Factors that can facilitate scaling up include the following:

- ensuring the involvement of and good relationships with all relevant stakeholders;
- sensitivity to local social, religious and cultural values and practices in development and scaling up;
- timing plans for scaling up appropriately;
- good communication about the project;
- ensuring sufficient resources and commitment from local and donor role-players; and
- building human resource capacity.

The following questions may be of assistance when comparing different mental health models that might be introduced in a particular setting:

- *To what extent do national, regional and local policy and plans facilitate the introduction of one rather than another model of primary mental health care?*
- *What sort of collaboration is possible between government health and non-health sectors, nongovernmental organisations, village and community health workers, and volunteers?*
- *Has there been sufficient advocacy to shift attitudes amongst all stakeholders (especially at management and staffing levels) concerning the provision of primary mental health care in general and in relation to a specific model?*
- *What mental health functions are envisaged for primary care workers? In the case of generalist workers, have they been identified in consultation with these workers? Are the functions limited and doable? What referral resources are available?*

- *What are the training implications? Are the necessary resources available for continued support and supervision?*
- *How could essential psychotropic medication be provided?*
- *What are the infrastructural, human resource and financial implications of one rather than another model?*
- *What steps would be necessary in the process of introducing the model? What are the time frames? What organisational change process would be required? Is there someone of sufficient seniority available to take on the task of coordination to drive and oversee the change process?*

### **Research priorities**

- To what extent have the ten principles for successful integration been followed and with what results?
- What is the quality of voluntary counselling and testing (VCT) and what models are most effective?
- Which (organisational) primary level mental health models are most effective and why?
- Which components of interventions are critical for success and how do they operate?
- Which clinical interventions are most effective (e.g. individual or groups; psycho-pharmacology or counselling)?
- What do people identify as pressing needs and how do they experience the interventions?
- To what extent are models replicable across situations and cultures?
- Evaluations of primary mental health care must be conducted beyond the introductory stage.

# 1. INTRODUCTION

## 1.1 Background

In most developing countries mental health care services have been and remain underdeveloped. Mental health care is often confined largely to urban areas and then restricted to hospital-based care for people with severe mental disorders. Where community-based services are provided, these are directed primarily at severe psychiatric disorder and take the form of repeat medical prescriptions. So-called common mental disorders (such as depression and anxiety), where disruptions to the individual's functioning may not be obvious, or can be contained within a family, have tended to receive little, if any, attention within the health care system. This is despite evidence showing a high prevalence and burden of disease resulting from these conditions. Where mental health or emotional problems are associated with an urgent health care need such as in the case of HIV infection, the former have tended to be overlooked in favour of ensuring appropriate medical care. Lack of sensitivity to mental health and emotional issues in allied systems (such as police, justice, or welfare) has often exacerbated these problems through a process of secondary victimisation.

These tendencies have been bolstered by a lack of training of frontline health and allied workers to create awareness of mental health and emotional problems and of appropriate responses (including, in the case of health workers, how to detect such problems and intervene at that level). Furthermore, when such problems have been picked up, effective responses have often been blocked by entrenched practices and systems that carry no expectation of care at that level (or within that system) and, at best, promote referral to specialist mental health services.

In an effort to promote more equitable and accessible mental health care, the decentralisation of mental health services has been advocated. Diverse models of mental health care have been developed and adapted to the particular circumstances of different countries and their health and allied systems. There has been particularly strong advocacy for the integration of mental health care into general health care, especially at primary level. The World Health Organization (WHO) has strongly endorsed this position, often referred to as integrated primary mental health care. Other models have attempted to increase the accessibility of mental health care by integrating services into allied systems such as the welfare or justice systems. The extent to which such models have been implemented (particularly with respect to common mental health and emotional problems rather than severe psychiatric disorders), their impact evaluated, and the scaling up of good practice has occurred is variable.

## 1.2 Primary mental health care: models and good practice

This report summarises a review of the literature (both published and grey literature) on mental health care for common mental disorder (mental health and emotional problems) at primary level (and, where indicated, secondary level) in resource-poor settings. Owing to time constraints, we drew extensively on published reviews and guidelines, particularly in respect of primary mental health care in the health sector. We also searched\* a range of electronic databases, selected journals and websites for relevant materials, especially with regard to mental health care for people living with HIV/AIDS.

\* Databases searched included Pubmed and Medline. Google and Google Scholar were also searched to identify grey literature. Key words used included: primary care, (primary) mental health care (and variants), (common) mental disorder, psychiatric disorder, depression, anxiety, counselling, psychotherapy, psychosocial support; linked to HIV/AIDS for that section of the report. Additional searches added country references based on the good practice examples of primary mental health care identified in the literature, on the assumption that these might yield an extension to the field of HIV. The websites of selected organisations prominent in the field, specifically those producing support materials or providing support for organisations in developing countries (WHO, SAMHSA, FHI, Horizons, Mailman School of Public Health) were also searched. Promising references from articles and resource lists were also tracked.

We have avoided using the terminology of “best practice”, in part because many examples are not sufficiently well documented or evaluated to allow such a judgement, but, in any case, because no single practice is equally well suited to all settings. We have preferred to refer to *good practice*, or, in some cases, to *emerging or promising practice*, particularly where documentation is more limited.

The review focuses on literature describing elements of good practice, as well as descriptions of specific examples of good or promising practice. The review is a selective one in the following respects:

- The review was restricted to practice directed at adults, rather than children or the elderly.
- In order to enhance applicability to similar settings, the focus was primarily on examples from resource-poor settings in the developing world. However, we have also referred to practices from the developed world where these might have wider application.
- Where available, we have referred to findings or conclusions of other recent reviews rather than repeating the work of those reviews. This applies particularly in the case of examples of good practice in the health sector, where we have drawn extensively on a recent report by the WHO and the World Organisation of Family Doctors (WHO/Wonca, 2008).
- Despite extensive searches, lack of sufficiently detailed descriptions or any evaluation resulted in our omitting a number of projects which might, given more adequate information, have merited inclusion as good practice examples.
- For reasons of time, we did not consider examples of traditional health care practice or systems as possible good practice.

The primary focus has been on good practice in integrated mental health care in the health care system. However, where identified, we have also described good practice within other systems. We have, where possible, referred to evaluations of these practices and to challenges of implementation and scaling up. However, in most cases, there was limited information in this regard.

The report covers good practice in mental health care for the general population of primary health care patients\* and, in addition, specific reference to promising examples of primary mental health care for people living with HIV. Where possible, we have identified examples that deserve closer attention with a view to wider replication, or because of the particular lessons they convey.

The structure of the report is as follows:

In section 2 we provide an overview of the prevalence and burden, as well as the resources available for mental health care, and then look more closely at common mental disorder.

In section 3 we outline concepts of primary health care and primary mental health care, before outlining generic models of the latter as a background to a review of good practice in primary mental health care.

In section 4 we look at good practice in primary mental health care for CMD in the health sector specifically, while in section 5 we examine applications of primary mental health care for people living with HIV/AIDS.

In section 6 we end the report with some conclusions and recommendations, including research priorities based on gaps identified in the review.

In this section we provide information on the prevalence and burden of mental disorders and resources for mental health care. We then examine common mental disorders and issues related to their identification and end by offering a working definition of common mental disorders for the purposes of this report.

\* We generally use the term “patient” when referring to people using the formal health care system or interacting with medical or nursing health care workers, while “client” is generally used for people using services outside the health care system or interacting with non-medical professional or auxiliary mental health workers.

## 2. MENTAL DISORDER AND MENTAL HEALTH CARE

### 2.1 Prevalence, burden and resources

Mental disorders globally have a high prevalence in and place a great burden on society, but there are minimal resources available (human and financial) to care and treat those needing assistance. In many countries the limited resources dedicated to mental health are utilised in large depersonalised institutions rather than within communities and as part of general health care. This occurs despite the facts that very significant numbers of people with mental disorder present in primary care settings and that institutional care has repeatedly been shown to violate human rights. Mental health care within primary care is limited globally especially in developing countries.

#### 2.1.1 Prevalence of mental disorders

The WHO estimates that about 450 million people worldwide suffer from neuropsychiatric conditions (WHO, 2001). Mental and behavioural disorders are found in all countries, in women and men at all stages of life, among the rich and poor and among rural and urban people. Worldwide it is now estimated that lifetime prevalence ranges from 12.2–48.6% and 12-month prevalence between 8.4 and 29.1% (mhGap, 2008). A recent study in South Africa found the overall prevalence of mental disorder to be 16.5% (Williams, Herman, Stein, Heeringa, Jackson, Moomal, et al, 2008). This prevalence is comparable to those found in Colombia and Lebanon but far higher than in a number of other countries that participated in the World Health Survey such as China, Japan, Nigeria, Germany, Italy and Spain using the same measuring instrument.

Most studies have found the overall prevalence of mental disorder to be almost the same for men and women. However, almost all studies show a higher prevalence of depression among women than men with a ratio of between 1.5:1 and 2:1. Women also have higher rates of most anxiety and eating disorders. Men have higher rates of attention deficit hyperactivity disorder, autism and substance abuse disorders (Hyman, Chisholm, Kessler, Patel & Whiteford, 2006).

The most common mental disorders are anxiety and depression (with a high level of co-morbidity). Psychotic disorders such as schizophrenia and bipolar disorder are estimated to affect between 1–3% of populations. There are no significant differences between urban, rural and mixed sites; however, prevalence in lower income countries is usually higher than in high-income countries, suggesting a strong correlation between mental health and poverty (Patel & Kleinman, 2003).

Mental disorders are associated with relatively low mortality rates; however, mental disorders, particularly depression and substance abuse, are associated with more than 90% of all cases of suicide (Bertolote, Fleischmann, De Leo & Wasserman, 2004). Globally, more than 1 million people die from suicide annually and suicide is among the three leading causes of death among 15–45 year olds (men and women). Moreover, non-suicide-related mortality is higher in people with mental disorder than in the general population (Heilä, Haukka, Suvisaari & Lönnqvist, 2005) as people with mental disorder are less likely to receive medical checks and to be provided with evidence-based health care for physical conditions (Disability Rights Commission, 2006). While this data comes from a high income country (the United Kingdom), it is unlikely that the trend would be more favourable towards people with mental disability in a low- or medium-income country and may in fact be even less favourable.

### 2.1.2 Burden of disease

Fourteen percent of the global burden of disease can be attributed to mental and neurological disorder. Nearly three quarters of the global burden of neuropsychiatric disorders are in low- and middle-income countries (WHO, 2001). The relative burden of mental disorder is rising and projections suggest that it will rise even further (see Table 1). The highest mental health cause of disability-adjusted life years (DALYs) lost is unipolar depressive disorder, which has been projected to be the second highest cause of all DALYs lost globally by 2030 – second only to HIV/AIDS. In high income countries depression is projected to become the single highest cause of DALYs lost. Even now, the burden from depression is higher than diseases such as diarrhoeal diseases, ischaemic heart disease, cerebrovascular disease, road traffic accidents, malaria and tuberculosis.

**Table 1: Changes in global ranking of leading causes of DALYs lost**

Disease or injury	2002 rank	2030 rank	Change in rank
Perinatal conditions	1	5	-4
Lower respiratory infections	2	8	-6
HIV/AIDS	3	1	+2
Unipolar depressive disorder	4	2	+2
Diarrhoeal disease	5	12	-7
Ischaemic heart disease	6	3	+3
Cerebrovascular disease	7	6	+1
Road traffic accidents	8	4	+4
Malaria	9	15	-6
Tuberculosis	10	25	-15
Chronic Obstructive Pulmonary Disease (COPD)	11	7	+4
Congenital abnormalities	12	20	-8
Hearing loss, adult onset	13	9	+4
Cataracts	14	10	+4
Violence	15	13	+2
Self-inflicted violence	17	14	+3

*Adapted from Mathers & Loncar (2006)*

### 2.1.3 Resources for mental health care

A multi-country study (Kohn, Saxena, Levav & Saraceno, 2004) supported by the WHO showed that 35–50% of people with serious mental disorder in developed countries and 76–85% in less-developed countries had received no treatment in the preceding 12 months. Treatment for common mental disorder is even less common.

Inadequate professional resources for mental health care in developing countries are a major reason for the large gap between the prevalence of mental disorder and the provision of services. For example, in Africa there are 0.04 psychiatrists, 0.20 psychiatric nurses and 0.05 psychologists per 100 000 population compared with far more acceptable rates of 9.8, 24.8 and 3.1 respectively in Europe (WHO, 2005). Alongside the common occurrence of mental disorder in primary care, these figures provide another reason why mental health care should be provided in primary care.

Allocation of financial resources for mental health in developing countries is another obstacle to providing mental health care. It has been estimated that the cost per capita of providing a basic package of care for four priority conditions, schizophrenia, bipolar disorder, depression and hazardous alcohol use, would be around \$1.85 in low-income countries and up to \$6.25 in lower-middle-income countries (Chisholm, Lund & Saxena, 2007). This is up to 13 times higher than current expenditure in some low-income countries (such as Ethiopia). However, the global benefit of this package would be an annual reduction of 2000–3000

DALYs per million population at a cost of US\$3–9 million per million population (i.e. US\$3–4 per capita in sub-Saharan Africa and South Asia and US\$7–9 per capita in Latin America and the Caribbean). This means that for every US\$1 million invested in such a mental health package, 350 to 700 healthy years of life would be gained over no intervention (Hyman et al, 2006).

## 2.2 Common mental disorders (CMD)

### 2.2.1 Understanding CMD and their effects

Common mental disorder (CMD) is a term used to describe a group of mental disorders that frequently occur in primary care patients. They include depression, anxiety and somatisation (medically unexplained somatic symptoms such as headaches and backache), the latter often indicated by repeated visits to health care practitioners without resolution of the problem (Tomson & Shiers, 2003; Prince, Patel, Saxena, Maj, Maselko, Phillips, et al, 2007; Patel, Araya, Chowdhary, King, Kirkwood, Nayak, et al, 2008). Anxiety and anxiety disorders have tended to receive less attention than depression and somatisation, but this appears to be changing (Roy-Byrne, Davidson, Kessler, Asmundson, Goodwin, Kubzansky, et al, 2008).

As regards the prevalence of common mental disorders, a 1995 study conducted in 15 countries found a wide range (see Table 2). The reasons for the variation are not clear, but the average figures indicate that depression and anxiety in particular affect significant numbers of people. Somatisation, while less common, is significant for its potential to increase the burden on health services.

Table 2: Prevalence of common mental disorders

Country	Depression	Generalised anxiety	Somatisation disorder
Santiago	29.5	18.7	17.7
Rio de Janeiro	15.8	22.6	8.5
Paris	13.7	11.9	1.7
Manchester	16.9	7.1	0.4
Groningen	15.9	6.4	2.8
Mainz	11.2	7.9	3.0
Bangalore	9.1	8.5	1.8
Athens	6.4	14.9	1.3
Berlin	6.1	9.0	1.3
Ankara	11.6	0.9	1.9
Seattle	6.3	2.1	1.7
Verona	4.7	3.7	0.1
Ibadan	4.2	2.9	0.4
Nagasaki	2.6	5.0	0.1
Shanghai	4.0	1.9	1.5
<b>Total</b>	<b>10.4</b>	<b>7.9</b>	<b>2.9</b>

Source: Ustun & Sartorius (1995)

As regards severity, CMD refers to non-psychotic (Patel et al, 2008) and, generally, mild to moderate rather than severe manifestations, with relatively low risk of suicide (National Institute for Mental Health in England (NIMHE), n.d.). Nevertheless, CMDs, which are often chronic, frequently result in significant dysfunction and disability (Ustun & Sartorius, 1995). Thus, persons with mental disorders often exhibit occupational role dysfunction, physical disability not explained by physical health status and interpersonal difficulties. Failure to address CMD thus causes major social and financial burdens for families, friends and employers. It also consumes scarce health resources (Tomson & Shiers, 2003). For example, patients return to the primary care facility frequently, thereby taking additional time of primary care practitioners; and patients are sent for unnecessary investigations, wasting both time and money.

CMDs are often associated with physical health conditions, particularly those that are chronic, with the co-morbidity of depression and chronic diseases dramatically increasing the risk of poor health outcomes (Chatterji, Verdes, Tandon, Patel & Ustun, 2007; Egede, 2007; Löwe, Spitzer, Williams, Mussell, Schellberg & Kroenke, 2008). CMD is also often associated with stress related to family, work, social isolation, chronic physical illness, substance abuse and lifestyle pressures (Tomson & Shiers, 2003), emphasising the important role of context for the development and understanding of disorder (Kleinman, 2007). Both chronic disease and psychosocial problems are circumstances where some level of distress might well be expected and which may sometimes act as a trigger for CMD (Prince et al, 2007).

With regard to HIV infection, there has been fairly consistent evidence of an association with poor mental health in developed countries (see section 5). Prince and colleagues (2007) suggest that likely mechanisms underlying the association include “the acute trauma of the diagnosis; the difficulty of living with the illness; the long-term threat of decline and shortened life expectancy; necessary lifestyle changes; complicated therapeutic regimens; aversive symptoms such as pain; and stigma, which can lead to guilt, loss of social support, or breakdown of key relationships” (p. 864), all of which are typical of HIV infection. Evidence from low- and middle-income countries regarding an association between mental ill-health and HIV infection has been more equivocal. A systematic review (Collins, Holman, Freeman & Patel, 2006) found that the reported prevalence of mental disorders in HIV-positive people varied widely. However, there was some evidence of higher rates of depressive disorder and depressive symptoms in symptomatic HIV-positive people compared with non-symptomatic HIV-positive or sero-negative people. In non-symptomatic HIV-positive people, depressive symptoms may be more common immediately after learning their HIV status, declining over a period.

Poverty, low education, unemployment and gender all tend to be associated with higher rates of CMD and may be seen as risk factors for the development of CMD (Patel, Araya, de Lima, Ludermit & Todd C, 1999; Pothen, Kuruvilla, Philip, Joseph & Jacob, 2003; Saxena, Thornicroft, Knapp & Whiteford, 2007). In the case of women (especially poor women), there is evidence of increased risks for depressive disorder or symptoms, anxiety and post-traumatic stress disorder following experiences of gender violence (in particular, when perpetrated by an intimate partner) (Fischbach & Herbert, 1997; Krug, Dahlberg, Mercy, Zwi & Lozano, 2002; Wang & Rowley, 2007). Repeated exposure to physical or sexual violence appears to increase the risks for mental disorder (Pico-Alfonso, 2005; Kimerling, Alvarez, Pavao, Kaminski & Baumrind, 2007).

However, to focus narrowly on CMD in these cases poses a risk of medicalisation and individualisation of social and economic problems when a broader psychosocial perspective may more adequately capture their complexity (Pereira, Andrew, Pednekar, Pai, Pelto & Patel, 2007). If not addressed, the socioeconomic factors may undermine the effectiveness of any treatment provided.

### 2.2.2 Identification of CMD

CMDs present in complex ways, making recognition and diagnosis difficult. They frequently but not invariably occur together and often show a *shifting combination of symptoms* over time, making differentiation and classification difficult (Patel, Araya, Chatterjee, Chisholm, Cohen, De Silva, et al, 2007; Prince et al, 2007). Symptoms also frequently *fluctuate in severity* over time, complicating assessment of whether they reach the threshold for diagnosis of a mental disorder. This assessment may be further complicated because sub-threshold psychosocial symptoms are common in primary care and, despite not being sufficient for formal diagnosis, may cause significant impairment and disability and affect health outcomes (Gask, Klinkman, Fortes & Dowrick, 2008).

Presentations of CMD may vary culturally, “shaped by cultural idioms of distress which can make them appear to be very different in different settings” (Cohen, 2001, p. 12) and complicate identification and diagnosis (Bass, Bolton & Murray, 2007). This applies not only when culture is seen as referring to differences between major national or international groupings, but also within national groups, most obviously along local subcultural and socioeconomic cleavages (see, for example, Priya & Sathyamala, 2007).

In this regard, a key factor is the understandings and health-seeking behaviours of health care users. Value and belief systems that do not recognise emotional distress as warranting attention – or, at least, as requiring health care intervention, as opposed to other forms of assistance or support (Cooper, 2003; Dowrick, Kokanovic, Hegarty, Griffiths & Gunn, 2008; Walters, Buszewicz, Weich & King, 2008) – may obscure or distort what is presented (Saxena et al, 2007). Even when users do identify their own mental distress as such, stigma related to mental illness may make it difficult for them to report their concern to a health care provider (Cohen, 2001; Saxena et al, 2007). In these cases, identification of a mental health problem involves complex negotiation with the user to arrive at a diagnosis of a mental health rather than or in addition to a physical or other problem, or one not meriting attention of the health care worker. Language differences between health care users and health care providers may increase the difficulty of this negotiation.

The variability and complexity in presentation of CMD have implications for identification and assessment by healthcare providers (Tomson & Shiers, 2003; Gask et al, 2008). In both the developed and the developing world, despite increasing awareness, up to 50% or more of cases are missed (WHO/Wonca, 2008). In the developing world, health workers are typically correct in their diagnosis of cases that they do pick up, but miss a larger number of cases that – though usually less severe – do merit diagnosis (Cohen, 2001).

When cases of depression or anxiety are detected, this does not necessarily lead to treatment. In a study carried out in the UK, the likelihood of treatment being offered was found to be dependent on diagnosis (depression being more likely to be treated than anxiety), severity of symptoms and being male (Hyde, Evans, Sharp, Croudace, Harrison, Lewis et al, 2005). In addition, the question arises whether improved diagnostic sensitivity will lead to better outcomes (Cohen, 2001).

The typically mixed and fluctuating presentation of CMD does not in any case fit easily with the categorical diagnostic systems characteristic of specialist mental health (psychiatric) care and may contribute to the generally low rates of detection of CMD in the primary care referred to above. Nor do the specialist diagnostic systems make adequate provision for sub-threshold conditions, despite their association with impairment and disability. Varying cultural manifestations may also be misdiagnosed using specialist diagnostic systems developed mainly in Western countries. Alternative diagnostic systems developed for primary care (such as the ICD-10 PHC diagnostic and management guidelines for mental disorders (WHO, 1996) have not been shown to significantly improve diagnosis (Croudace, Evans, Harrison, Sharp, Wilkinson, McCann, et al, 2003), at least not without fairly intensive, hands-on training (Cooper, 2003). It is possible that low rates of detection of CMD are to some extent also a function of the health worker's conception of his/her role, the process of the patient–health worker consultation, as well as constraints on the time available for the consultation (Cooper, 2003).

### 2.2.3 A working definition of common mental disorder

The above speaks to a more flexible approach to defining CMD, one that focuses primarily on more formal definitions of depression, anxiety and somatisation, but acknowledges that presentations in primary care often do not conform fully to those definitions, whilst having the potential to cause significant impairment/disability. This approach also recognises that primary care practice to some extent already engages with the latter, primarily through non-medical interventions (Gask et al, 2008), such as informal counselling in the course of consultations, or assistance to access appropriate resources and also, sometimes through both appropriate and inappropriate use of medical interventions, such as medication (WHO/Wonca, 2008). The challenge then is not only to assist primary care health providers to identify diagnosable mental disorder more effectively, but also to promote the use of appropriate interventions when sub-threshold symptoms are presented, in order to limit impairment and disability and prevent progression to more severe forms of disorder.

This somewhat expanded formulation of mental health problems in primary care is also more appropriate when considering the needs of specific groups such as those infected and affected by HIV. When presenting in primary care settings, these categories of user may not have a diagnosable mental disorder, but rather present with fluctuating or sub-threshold symptoms and need intervention primarily to prevent impairment and the development of more severe disorder.

A focus primarily on formal CMD, but with some flexibility to accommodate sub-threshold symptom presentations, takes account of the severe resource constraints in developing countries and reduces the likelihood of scarce resources being inappropriately directed, especially when conditions may be self-limiting (Kleinman, 2007). At the same time, it recognises that primary care resources are already being expended on mental health care and that what is required is to help primary care practitioners use those resources as effectively as possible (Tomson & Shiers, 2003).

CMD, as used in this review, therefore includes:

- anxiety, depression and somatisation, whether differentiated or mixed;
- severity generally mild to moderate (non-psychotic, low risk of suicide);
- significant (or indications of increasing levels of) impairment/disability;
- sub-threshold symptoms, particularly where these are associated with impairment/disability;
- co-morbidity with chronic health conditions;
- co-morbidity with substance abuse and other lifestyle-related conditions;
- psychosocial problems (such as the psychosocial consequences of HIV infection) that potentially lead to significant stress or distress; and
- culturally (or subculturally) specific presentations of mental disorder/distress.

### 3. MODELS OF PRIMARY MENTAL HEALTH CARE

In this section, we start by reviewing the concepts of primary health care and primary mental health care before outlining generic models of the latter as a background to a review of good practice in primary mental health care.

#### 3.1 The many meanings of primary health care

Before discussing in detail good practice in primary mental health care, it is worth recalling the definition of primary health care in the Alma-Ata declaration (WHO, 1978). This encompasses a broad vision of health care, extending beyond the health services as such. In a recent commemorative series, Bhutto, and colleagues (2008) refer to primary health care as encompassing interventions that take place in *community settings*, involving families and communities (including through outreach services such as those provided by community health workers) and those offered at *first-level health facilities*, together with mechanisms to improve *continuity of care* at this level. *Links with other levels of healthcare* and *with other systems of care* (such as social services and religious organisations) are also an essential rather than merely supplementary part of primary care (Ekman, Pathmanathan & Liljestrand, 2008). In other words, the Alma-Ata declaration did not limit the nature of services, where services are provided or who provides the services to the health care setting alone.

Nevertheless, in many contexts, the focus of primary care has tended to remain on (or revert to) the health care setting. However, even within the health care system, integration has not proven to be easy – and not only for mental health care. For example, in HIV and reproductive health services, international consensus appears to have shifted from an emphasis on *integration* aimed at creating a comprehensive service capable of meeting several needs simultaneously, towards promoting *linkages*, that is, developing or improving links between existing services (or service packages) (Glion Call to Action, 2004; WHO/IPPF/UNFPA/UNAIDS, 2005; WHO/UNFPA, 2006). Rather than just a matter of semantics, the latter seems to reflect a pragmatic attempt to overcome the difficulties of effective integration in the face of system constraints, including continuing vertical programming, separate funding streams and pressure on resources (including infrastructure, staffing, training, drugs and technologies) (Epstein, Whelan, van de Wijgert, Mane & Mehta, 2002; WHO/UNFPA, 2006). The same difficulties have confronted efforts to integrate mental health care into primary health care.

As regards services at the primary care level, resource constraints have tended to encourage a focus on more restricted “core packages of services” for vulnerable target groups (or specific target conditions), often delivered primarily within first-level health services (e.g. a limited number of cost-effective maternal and child health (MCH) services). This is often justified as an initial, pragmatic step, with expansion of areas and coverage to follow at a later stage. In this process, mental health has often not made the cut for first-line implementation, perhaps because of inaccurate assumptions regarding the low burden of disease and lack of effective interventions (WHO, 2001).

#### 3.2 Primary mental health care

As previously indicated (section 1.1), there has been strong advocacy for the provision of mental health care at primary level, with the means to achieve this end generally described as involving integration of mental health into primary care. However, the term, “integration”, is often used loosely, without clear definition of what is meant (England & Lester, 2005). Generally, what is implied is the horizontal integration of mental health care within general primary health care, more specifically, through integration into the

activities of the general health workers who operate at that level. Vertical integration – leading to improved linkages, alignment, communication and collaboration between different levels of care and particularly at their interface – is often implied (e.g. by reference to improved referral pathways or consultation-liaison), but generally seen as an adjunct, rather than a key aspect of integration.

A central motivation for integration is to provide holistic and continuous patient care within and between levels of care. More pragmatic reasons for promoting the integration of mental health into general health care are to improve recognition and treatment of CMD at this level and to alleviate the widespread shortage of more skilled mental health professionals, especially in developing countries (Goldberg, 2003).

How integration should operate is less clear. There is a range of options as regards the package of care (what specific services are provided), the *location* of services (as part of first-line, formal services or through outreach into the community) and *staffing* (whether generalist, professional mental health or new categories of auxiliary worker).

The different options translate into a range of models of primary mental health care within the health care system. There are, in addition, models of integration into or linkages with sectors other than the health care sector, as well as some that operate as stand-alone services, but as an integral or closely related part of a larger system for which they provide specific aspects of care on an agency or subcontracted basis. This reflects the fact that “primary [health] care is ... only one of several places where a user may go for help” (Tylee, 2003, p.2), more so where the need for care is precipitated by social factors such as criminal or political violence or stigmatisation (in the case of mental disorder or HIV/AIDS). Alternative resources include police, social services and, in many cases, nongovernmental organisations (NGOs). Integration or partnership between these services and with the health services is essential for the delivery of effective primary mental health care (NIMHE, n.d.).

It is important to note that across sectors and systems many projects remain at the level of pilots or with only limited scaling up. In relatively few cases has there been careful, well-designed impact evaluation (Cohen, 2001). This is not surprising given that such projects constitute complex interventions, taking place within a complex context, and that determining effectiveness is consequently equally complex and difficult (Campbell, Murray, Darbyshire, Emery, Farmer, Griffiths, et al, 2008). However, this does emphasise the importance of using the extent of evaluation as one element in assessing the potential utility of a particular example.

### 3.3 Typical models of primary mental health care

As indicated, there is a range of different models, differing in terms of the package of care offered, staffing and the location of services. Differences tend to reflect the context in which they have been developed and operate and any particular project may reflect a mix of models. However, it is possible to identify a number of relatively distinct models, which are described below.

#### 3.3.1 Mental health in primary care

This model is characterised by its location at and full integration with primary level general health care services with staffing by generalist health workers as part of their routine function. This in turn affects the nature of the package of care provided.

Primary mental health care forms part of primary health care generalist services, including a general medical practitioner practice, typically reported for developed countries, but increasingly seen as a possibility in developing countries (Patel & Cohen, 2003). Alternatively, a mental health component may be offered as part of other health programmes operating at the primary care level, such as services for maternal and child health, TB, HIV or chronic diseases. In the latter case, the mental health component may not be identified as such, but instead described as an initiative to improve the core service.

*Staffing* for mental health care is provided by generalist staff (doctor or nurse). Staff receive training and supervision in mental health from mental health professionals based at a secondary or tertiary level. Models for support can be varied, ranging from telephone or radio supervision through to specialists sitting in on primary care consultations together with the primary care practitioner.

The *package* of care generally includes identification, assessment (generally including diagnosis and some determination of severity and impairment) and treatment of CMD, and prescription of psychotropic medication where appropriate. The use of formal screening instruments, used routinely, to assist in identification has been promoted in some settings (see *Screening for CMD*). Various counselling and psychotherapeutic interventions are increasingly being incorporated into the care package and the potential value of case management has also been highlighted. Where necessary, referral for specialist care or other services following standard referral pathways and procedures may be arranged. In some instances medical treatment started by a practitioner operating at a secondary level may be continued by a primary care health worker.

### 3.3.2 Mental health at primary health care

*This model differs from the previous model in that it is located on-site at (but not integrated with) primary level general health care services, with staffing by specialist mental health practitioners (whether professional or auxiliary workers). This again affects the nature of the package of care provided.*

Mental health care is provided at the site of first-line health care (a clinic or health post), but by staff who deal specifically with the mental health care of patients referred by generalist health workers. These may be mental health professionals, usually nurses with mental health training or psychiatric specialisation, but sometimes psychologists. Auxiliary staff such as mental health aides, counsellors or lay health workers may also be used to assist professional mental health staff or to take on fairly narrowly defined mental health care tasks within the health centre. Mental health practitioners operating at the primary care level are sometimes considered part of the primary care team and sometimes as part of secondary level rather than primary level team. In either case, close liaison between the mental health practitioners (mental health professionals or auxiliary workers) and the primary care team is necessary to ensure continuity of care.

In some instances, the mental health practitioners may work exclusively at one particular health point, but may equally (and more usually) have responsibility for a number of different clinics/health points in a district. In the latter case, patients needing mental health care would be referred to or return to see the mental health practitioner on visits to the particular clinic/health post. In some cases, however, the practitioner may be available to attend to a patient at the clinic at other times, or the patient could be referred to a more central venue.

Identification and initial assessment of mental disorder would usually be undertaken by a generalist health worker with the patient referred for confirmation of diagnosis and treatment to the mental health practitioner. In some instances, where patients self-identify a mental health problem, they may be permitted to see the mental health practitioner directly, rather than seeing a generalist first. The nature of treatment offered by the mental health practitioner varies depending on level of worker, professional background and mental health training, but may include informal or more formal counselling or psychotherapeutic interventions (individual, family or in a group), prescription or dispensing of psychotropic medication and case management. Where necessary, referrals to secondary or tertiary level care are arranged.

### 3.3.3 Mental health community outreach

In this model, mental health care is provided in community settings by staff based in the community or operating on outreach from a health service. The care offered tends to be restricted to a narrow range dependent on the level of mental health expertise of the staff providing the service.

Community/village health workers or other health workers based within the community can play an important role in identifying, supporting and referring people for more specialised mental health care. Workers at this level usually have a very good understanding of the culture and health-seeking behaviours of community members and, because they are also familiar with the families, they are often able to pick up where things may be going wrong. With some mental health training, they can assist in dealing with life crises where people need some outside support and understand when someone needs referral to a health practitioner working within the "formal" sector – as opposed, for example, to a traditional practitioner. Workers based in the community can also visit patients that have defaulted or not attended the clinic/health post for mental health care as expected. This can be extremely useful in reducing patient relapse.

In some models, practitioners working within the primary care clinic/health post (including generalist workers and specialised mental health practitioners) may also visit people in their communities for mental health care as part of an outreach programme or where the need arises. However, the extent of outreach may be limited by transport and time constraints, in turn reflecting staffing, financial and budgetary constraints.

### 3.3.4 Mental health care provided through other sectors

As indicated above, related statutory and non-statutory services may act not just as agencies for referral to health services or resources for specialised care (e.g. in the case of natural disaster or rape trauma), but also directly provide some aspects of primary mental health care, if not a full package. In this regard, they show many of the same characteristics with respect to location and staffing. That is, services may be delivered as part of the core service, or by an on-site referral service or one that is easily accessible to the site. Staffing may be generalist staff (social workers, police officers with or without sensitisation training), or on-site or on-call (sometimes volunteer) counsellors, or on-site or on-call mental health professionals. Stand-alone services for specific groups, such as victims of violence, may be an integral part of such systems even when operated by another agency.

### 3.3.5 Matrix of models of primary mental health care

The models outlined above may be summarised in a matrix.

Table 3: Matrix of models of primary mental health care

Location	Staffing	Package of care
Mental health <u>in</u> primary care	- Generalist HWs	- Screening (formal, routine) - Identification (during routine health consultation) - Assessment (diagnosis, severity, impairment) - Psychotropic medication - Informal/formal counselling - Psychotherapeutic interventions
Mental health <u>at</u> primary care	- Auxiliary HWs	- Screening (formal, routine)
	- Specialist mental health workers (MHWs) (direct patient care)	- Assessment (diagnosis, severity, impairment) - Psychotropic medication - Formal counselling - Psychotherapeutic intervention
Mental health community outreach	- Community/village HWs	- Identification (during routine activities) - Informal counselling/support
	- Generalist HWs/ specialist MHWs	- Psychotropic medication - Formal counselling - Psychotherapeutic intervention
Mental health in other sectors	- Generalist staff - Auxiliary staff	- Screening (formal, routine) - Identification - Assessment (diagnosis, severity, impairment) - Informal counselling/support
	- Specialist MHWs (direct client care)	- Psychotropic medication - Formal counselling - Psychotherapeutic intervention

## 4. GOOD PRACTICE IN THE HEALTH SECTOR

In this section, we look at good practice in primary mental health care for CMD in the health sector. We start with a general overview of relevant literature structured around the package of care outlined above and the way that care is organised. We then look at issues that pose particular challenges or require special attention in primary mental health care (special categories of need). We also look at critical challenges related to staffing and broader systemic and organisational issues. We then describe a number of specific examples of good practice and end with some conclusions.

### 4.1 Package of care

#### 4.1.1 Screening for CMD

As previously discussed (2.2.2 *Identification of CMD*), rates of identification of CMD by generalist health workers are generally poor and efforts to improve detection through training have not generally led to a significant improvement. Yet without identification there can be no treatment. In a systematic meta-analytic review of collaborative care, Bower and colleagues (2006) found that the identification of patients through systematic screening was one of only three variables that predicted improvement in depressive symptoms.

As a means to maximise the chances of identifying CMD (or other mental health problems), routine screening, where possible with more detailed assessment of those who screen positive, has been advocated (Tostes, Chalub & Botega, 2001; Patel et al, 2008). This may form the first step in what is referred to as stepped care (see section 4.2.2.2). However, a Cochrane review by Gilbody, House and Sheldon (2005), comparing screening all patients versus no patients, updated in 2007 (Gilbody, Sheldon & House, 2008), argues against screening all patients. Screening for depression in patients in different "at risk" groups is a more feasible option.

Various screening tools have been proposed. Patel and colleagues (2008) compared five widely used short screening questionnaires for CMD against a structured clinical interview for use by lay interviewers. Some of the questionnaires were slightly adapted to increase the feasibility of their use in PHC settings. The questionnaires each took on average three minutes to administer. All the questionnaires were found to show moderate to high discriminating ability, with little difference in their ability to identify cases accurately. However, when calibrated to reduce the number of false positives detected, the rate of missed positive cases increased. The authors concluded that the cut-off point selected for any of the questionnaires should be calibrated taking account of local conditions. To avoid misallocation of scarce resources, a higher cut-off point might be necessary in resource-limited primary-care settings. However, where resources permit routine second-stage assessment of screen positive cases by a medical practitioner (or, presumably, other suitably trained health workers), a lower cut-off point could be used to reduce the number of missed cases during screening, with false positives then eliminated in the second-stage assessment.

However, doubt has been expressed as to whether, outside the context of a research or pilot project, these tools will in fact be used routinely by generalist health practitioners because of the time (however limited) needed to administer the questionnaires (Arroll, Khin & Kerse, 2003). If self-administered, their reliance on patient literacy would be an obstacle in many developing countries. The MANAS project now being subject to randomised controlled trial in India (Chatterjee, Chowdhary, Pednekar, Cohen, Andrew, Araya et al, 2008; Patel et al, 2008) has addressed these problems by having the screening instrument administered by an auxiliary worker (health assistant) who refers only screen positives for further assessment or intervention by the next tier of health worker.

#### **MANAS Project, Goa, India (Chatterjee et al, 2008; Patel et al, 2008)**

The MANAS Project is a collaborative, stepped-care intervention developed to address CMD in primary care. The first step involves the administration (by a trained health assistant) of the 12-item General Health Questionnaire (GHQ). Choice of the GHQ to screen patients was based on an evaluation of five possible questionnaires that found that the GHQ was best able to discriminate both CMD as a broad clinical category and the narrower category of depressive episode. Patients who screen positive (score >5) are referred for one or more of a number of further steps in care, including psycho-education, interpersonal psychotherapy and prescription of psychotropic medication.

An alternative approach to screening for depression that has the merit of simplicity and brevity is the use of two questions\* only, asked directly by the practitioner. This approach has been shown to have high sensitivity and reasonable specificity in a primary care setting. In other words, the questions successfully detected most cases of depression and although they also misidentified a significant number of patients as depressed, these could readily be excluded on follow-up assessment (Arroll et al, 2003).

Another brief approach, the Anxiety & Depression Detector (ADD), makes use of five questions to detect various anxiety states as well as depression (Means-Christensen, Sherbourne, Roy-Byrne, Craske & Stein, 2008). Although there were a number of methodological limitations to the study reporting the development of the ADD, it does highlight the importance of screening for a wider range of conditions. The appropriateness of the particular questions and the form in which they are stated would, however, need to be verified before use in different cultures (Bass et al, 2007).

#### **4.1.2 Assessment**

Assessment leading to diagnosis and judgement of severity and level of impairment/disability should follow directly from screening when this is part of a general health consultation. Screening as a separate activity, undertaken by an auxiliary worker, requires referral to an appropriate member of the general health care team to confirm or disconfirm a diagnosis and to assess severity and level of impairment/disability. The MANAS project (see above) makes provision for attention at a higher level for both sub-threshold and more severe disorders where these are identified through screening. Whether diagnosis makes use of formal psychiatric diagnoses of the ICD-10 or DSM-IV type, or systems developed specifically for primary health care (see 2.2 *Common mental disorder*) is perhaps less important than the decisions on treatment flowing from the assessment.

#### **4.1.3 Psychotropic medication**

Patel et al (2007) conclude from a systematic review of various forms of treatment for a range of mental health disorders, including depression, that depression can be treated effectively with low cost antidepressants. The review found that, in low and middle income countries specifically, antidepressants alone or in combination with other treatments have been shown to be efficacious although effectiveness has not yet been demonstrated. Recent reviews suggest, however, that antidepressants are more effective than placebos in more severe forms of depression but not so in most people with mild forms of depression (Bauer, Bschor, Pfennig, Whybrow, Angst, Versiani, et al, 2007; Anderson, Ferrier, Baldwin, Cowen, Howard, Lewis, et al, 2008; Kirsch et al, 2008).

To be effective, psychotropic medication must be taken at adequate dose levels and for an adequate duration. For example, in a systematic review focused on the duration of treatment, Geddes and colleagues (2003) found that the chances of relapse were reduced when treatment for depression was continued for at least 12 months and possibly as long as 36 months. A study in India (Patel et al, 2003) found antidepressant treatment effective particularly in the short-term, but it appeared that poor adherence may have affected longer-term outcomes. However, the dual requirements of adequate dose and duration are often not met in primary care, in part related to prescribing practices.

\* The two questions were: During the past month have you often been bothered by feeling down, depressed, or hopeless? and, During the past month have you often been bothered by little interest or pleasure in doing things? (Arroll et al, 2003).

To improve prescribing practices, the use of evidence-based guidelines has sometimes been advocated. It is doubtful, however, whether prescribing guidelines are any more likely to be applied as a routine part of health consultations than has been found with regard to identification of mental disorders. Baldwin and Thompson (2003), in a review of antidepressant pharmacotherapy, cautioned that, despite widespread availability, in developed countries prescribing guidelines are seldom used in routine general practice. In developing countries, where patient loads are much higher, the chances seem even less. Hence reliance on prescribing guidelines alone is unlikely to significantly improve primary mental health care.

As alternatives, Baldwin and Thompson noted (but without elaboration) the value of some involvement of specialist mental health services. They also support the use of an assertive case management approach as a means of enhancing the outcomes of medication: "assuming responsibility for patient follow-up, assessing whether depressive symptoms are resolving, monitoring adherence to treatment, and taking action when patients depart from guideline-based treatment" (Baldwin & Thompson, 2003, p. 3).

Baldwin and Thompson also mention the unmentionable: that existing antidepressant drugs are not ideal. Typically, patients have to wait for about four weeks before they derive benefit and many do not experience significant relief of symptoms. Moreover, it is important to consider the effects of medication on social functioning. The tolerability of drugs should include not just the presence of adverse side-effects, but also other unacceptable effects on everyday life. They suggest that acceptability would include such factors as a once daily dosage, minimal adverse effects, minimal interference with everyday life and low or no interaction with food or drugs. These factors may be a long way from realisation in developing countries, where cost factors and availability play such a large role (see 4.4 *Systemic and organisational issues* below).

#### 4.1.4 Counselling

Counselling is used here to refer to non-medical interventions that are usually fairly limited in duration (generally not more than 6–8 sessions, but in some cases one session only) and scope (generally aimed at managing symptoms rather than more significant changes). It may be structured (e.g. with regard to content and number of sessions) and at times directive. It may be conducted by staff with limited or no mental health training and only limited if any training in counselling specifically.

##### 4.1.4.1 *Informal counselling*

Informal counselling refers to counselling that may occur in the context of a health consultation. Health consultations generally involve some communication between health worker and patient regarding health status and treatment (symptoms, duration, effect on functioning, expected or patient-reported effects of treatment, dosage, the importance of adherence) and related issues, for example life-style factors (diet, exercise, substance use, sources of stress and support). In the case of patients for whom psychotropic medication has been prescribed, this communication would presumably include (if only to establish the effect of the medication) some discussion of the patient's emotional state and work, family and social circumstances. Problems in these areas would in turn invite some more or less useful responses by health workers, which may include emotional support, limited problem-solving, advice-giving and referral to other resources.

It is likely that there is great variability in how purposeful, empathic and effective such communication is, ranging from empty reassurance and inappropriate advice-giving and exhortation through to what may amount to counselling that allows the patient an opportunity to articulate problems and express feelings so as to open the way to more effective problem-solving. A number of factors, such as limited staffing and hence limited time for consultations, lack of training and, not least, the predominance of a biomedical model, place limitations on the extent to which such informal counselling can contribute to primary mental health care. Nevertheless, it does occur and may provide limited assistance where there are no alternative resources. More effective training of health personnel to make appropriate use of informal counselling opportunities or, at least, to avoid inappropriate responses could improve its quality.

#### 4.1.4.2 *Psycho-educational counselling*

Psycho-educational counselling is defined here as counselling which focuses primarily on providing relevant information (for example, regarding symptoms, the role of related factors such as stress, coping strategies) and helping patients to apply the information in their own situation, for example, to recognise the onset of symptoms or stress factors and tailor stress management techniques to deal with these. It is usually time-limited in terms of the number of sessions and period over which they are offered. Where there are limited mental health professional resources, psycho-educational interventions may appear to have the merit that staff (social workers, general nurses, auxiliary workers) who are not necessarily mental health professionals could be trained to undertake them.

The MANAS intervention previously mentioned includes a structured psycho-educational component delivered by a counsellor as the first step of a multi-step intervention. In the pilot study of the intervention, patients described the psycho-educational component as useful; they could recall the content of the sessions and they reported that they were making use of some of the stress-reduction techniques recommended in the sessions (Chatterjee et al, 2008).

However, some cautions regarding psycho-educational interventions are suggested by Conradi and colleagues (2007), who conducted a three-year randomised controlled comparison of an individualised psycho-educational relapse prevention intervention. Similar to findings of other studies, they found that psycho-education provided no extra benefit over usual care on outcome measures including relapse, symptoms, presence and severity of disorder. Factors possibly responsible were considered to be the relatively low intensity of the intervention (three face-to-face sessions of 90 minutes each with follow-up at quarterly intervals) and the fact that those who undertook the intervention were not trained psychotherapists

Although this study was conducted in a developed country, it does raise the question whether psycho-education is necessarily an effective use of resources. It also highlights possible risks of what may otherwise seem to be a relatively low-intensity intervention and the need to assess carefully the elements of any psycho-educational intervention to avoid unintended negative outcomes such as heightened patient sensitivity to negative mental states.

#### 4.1.5 **Formal psychotherapeutic interventions**

We have reserved the term "psychotherapy" for psychological interventions that have an explicit theoretical base that (even in the case of brief forms of a therapy) tend to be longer in duration (number of sessions and time period) than counselling and that require specific training of practitioners in that model. We start this section with a general overview and then consider specific models of psychotherapy.

There have been a number of systematic reviews of the efficacy and effectiveness of psychotherapeutic interventions on their own or in combination with antidepressant medication. Churchill and colleagues (2001) conducted a very thorough systematic review and, where possible, a meta-analysis of 63 controlled trials of brief (20 sessions or less) psychotherapeutic interventions, including cognitive-behavioural therapy (CBT), interpersonal psychotherapy (IPT), brief psychodynamic therapy (PDT) and supportive therapy (ST) as compared with treatment as usual and each other. Findings were that any of these forms of psychotherapy resulted in significant improvement to a point where patients were no longer considered clinically depressed, had significantly fewer symptoms post-treatment and experienced greater symptom reduction as compared with baseline than was the case for treatment as usual. However, the improvement in signs of clinical depression was significantly greater for CBT. Comparing individual and group formats (CBT only, because of a lack of trials comparing individual and group formats in the other forms of therapy), the individual format appeared to result in significantly greater improvement. The findings were limited by a range of methodological problems in the original trials and with regard to generalisability (many of the studies were conducted in the USA or other developed countries), because of personal and socio-demographic characteristics (many studies used volunteer subjects, often with higher income and education levels), severity of disorder (ranging from sub-threshold to major depression) and therapy variables (such as the extent of therapist experience and adherence to the particular psycho-therapeutic model).

Weissman and Markowitz (2003), in a review of the then current practice in psychotherapies for mood disorder, concluded that CBT and IPT were the major forms of therapy available with a strong evidence base for efficacy and effectiveness, but that more research was needed to explore their active ingredients and ideal "dosage". They noted that, in the USA, psychotherapy has become increasingly available and has been found to be efficacious for a variety of ethnic and social groups; thus, while sensitivity to cultural differences is essential, such differences need not pose insurmountable barriers to adaptation.

A recent meta-analytic review (Bortolotti, Menchetti, Bellini, Montaguti & Berardi, 2008) of randomised controlled trials of the effectiveness of psychotherapy for depression as compared with usual GP care and antidepressants supported the relative effectiveness of psychotherapy as compared with usual care, but found no difference from antidepressant medication. The review did not distinguish between different approaches to therapy, which may have decreased its ability to detect any difference as compared with antidepressant medication.

The question of the relative effectiveness of psychotherapy provided by generalists as opposed to specialists is particularly pertinent for resource-constrained settings. A review by Cuijpers and colleagues (2008) found that though brief psychological therapies have a strong evidence base when provided by specialists, evidence for their effectiveness when provided by non-specialist workers within primary care has not been tested. A Cochrane review on "psychosocial interventions by general practitioners" (Huibers, Beurskens, Bleijenberg & van Schayck, 2007) found only limited evidence of successful intervention by general practitioners. They identified problem-solving therapy (PST) for depression as promising.

Despite the fact that the above reviews are based almost exclusively on research in developed countries, the thoroughness of the reviews lends weight to their conclusions. What they convey is that brief psychotherapeutic interventions are a potentially important component of mental health care and appear amenable to adaptation for different cultural and ethnic groups.

That these interventions are suitable for primary mental health care in developing countries does not necessarily follow. There has been only a limited number of studies specifically assessing efficacy and effectiveness, in developing countries (e.g. Araya, Rojas, Fritsch, Gaete, Simon & Peters, 2003; Bolton, Bass, Neugebauer, Verdelli, Clougherty, Wickramaratne, et al, 2003; Patel, Araya & Bolton, 2004) with somewhat contradictory findings.

#### *4.1.5.1 Interventions using cognitive behaviour therapy (CBT)*

Cognitive-behavioural therapies (CBT) are based on psychological models such as learning theory and information processing models that describe the relationship between thoughts, emotions and behaviour. Cognitive-behavioural therapy employs a range of therapeutic techniques to attempt to change thoughts, beliefs and/or behaviour that are understood to underlie distressing emotions such as depression and anxiety (National Institute for Clinical Health & Excellence, 2007).

There has been extensive research supporting CBT's efficacy and effectiveness over many years (Churchill et al, 2001). However, much of the research has been conducted in research centre trials and outcomes are generally less satisfactory in routine clinical care (White, 2008). Moreover, in developed countries, formal CBT is usually conducted by mental health professionals, specifically psychologists. However, in most developing countries, psychologists are in short supply and often not present at all in primary care. Some of the good practice examples below provide a perspective on the use of CBT in these circumstances.

#### *4.1.5.2 Interpersonal psychotherapy (IPT)*

Interpersonal psychotherapy is a structured, present-focused and time-limited treatment that starts from the position that mood changes are associated with a disturbing change in the patient's interpersonal environment and then further compromise the patient's interpersonal functioning. Examples include complicated bereavement following death of a loved one, role disputes involving a significant other, or role transitions such as a change in career, the beginning or ending of a relationship, or developing a physical illness. The therapist's task is to assist patients to deal with the disturbing life event(s), build social skills and re-organise their lives (Markowitz & Weissman, 2004).

IPT has been used as both an acute and maintenance treatment and, although developed as an individual intervention, has been used in a group format. It has been shown to be efficacious and effective in a series of clinical trials for a number of mood and anxiety disorders, as well as some other conditions such as eating disorders. Originally developed for use by mental health professionals, a modified, manual-based version focusing on sub-threshold mood and anxiety symptoms has since been developed for use by non-mental health professionals. Further study of its use by less experienced therapists has been recommended to assure a balance between reduced personnel costs versus the quality and efficacy of the intervention (Weissman & Markowitz, 2003; Markowitz & Weissman, 2004). These points are relevant when considering the use of this approach in one of the good practice examples in Uganda.

## 4.2 Organisation of care

### 4.2.1 Referral

Referral involves the transfer of responsibility for all or part of the care of a patient (Bower & Gilbody, 2005b). Although it may occur within a primary care team, it usually involves referral to a specialist “at” primary care level or, where necessary, secondary or tertiary levels of care. Typical examples of referral within the health services would be referral to a psychologist for brief psychotherapy or to an in-patient unit at a district hospital. Referral may also be made to services in other sectors, for example social or employment services, for assistance necessary to support recovery. In each of these examples, responsibility for some aspect of care may be retained by the referring service or health worker, for example, for monitoring adherence and response to psychotropic medication.

Referral is often mentioned only in passing in reviews of primary mental health care. Yet it is an essential component of care that requires resources at the primary care level such as knowledge of resources to which referral can be made and their varied referral procedures, as well as, particularly, staff time. The importance of formal and informal communication networks should also not be underestimated as a means of smoothing the pathways that patients may need to follow.

Referral obviously assumes the existence of resources for referral and these may be in short supply in many developing countries. Paradoxically, this may increase the need for effective use of the limited resources that do exist.

### 4.2.2 Case management, stepped care and collaborative care

These three overlapping and interlinked approaches to the organisation of care – for a range of illnesses and not only mental disorder – have been the subject of increasing interest and study in recent years. Increasingly, all the components are integrated; then often referred to as stepped collaborative care (which includes also the component of case management) (Gilbody, Whitty, Grimshaw & Thomas, 2003). In developing countries, these approaches may offer innovative alternatives where there are limited or no referral resources.

#### 4.2.2.1 Case management

Case management (sometimes also referred to as care management) involves assigning responsibility for overseeing and coordinating the care of a patient to a particular member of the health care team. This is often someone who is responsible for providing a major aspect of the patient's care beyond the acute stage, for example, monitoring response to medication, or providing counselling or psychotherapy. Case management involves structured and systematic monitoring of adherence to treatment and indicators of progress or relapse; follow up in case of treatment default; and liaison with other team members regarding treatment. The case manager may also facilitate access to resources such as health care for physical conditions if this is necessary, or support from other sectors, such as employment opportunities, grants or other material assistance. Case management is generally a central part of stepped care and collaborative care.

Katon and colleagues (2001), in a review examining changes in the traditional roles of primary care and specialist health workers, reported that case management had been found to be effective and cost-effective in a number of studies. However, they emphasised the importance of supervision of case management to

ensure that patients with more refractory conditions receive the higher-level care they need. Telephone consultation (increasingly possible worldwide with cellphone technology) has been found to offer an acceptable alternative in some settings, especially when it builds on prior more direct face-to-face joint consultation (Hilty, Yellowlees & Nesbitt, 2006).

#### 4.2.2.2 *Stepped care*

Stepped care has developed as an approach to effective and cost-effective management and allocation of scarce resources. Needham (n.d.) has described stepped care as involving provision of low intensity interventions to a significant proportion of patients who nevertheless derive significant benefit from these interventions; more intensive interventions (including referral for specialist care) are then restricted to patients who have more severe disorder or who fail to improve. Successful stepped care is assumed to provide a filter that encourages appropriate care at the level of intensity required, with shorter waiting lists and easier access to more advanced care for those who really need these services.

Stepped care may include the range of components usually included in primary mental health care (and discussed above). Screening and identification of disorder should be seen as an essential first step (Patel et al, 2008). Post assessment for sub-threshold conditions, "watchful waiting" (delaying intervention pending further assessment, usually within 2 weeks) may sometimes be the most appropriate option (National Institute for Clinical Excellence, 2007). Non-medical interventions may successively include self-help materials (used by patients on their own or under the guidance of a member of the health care team), group therapy, brief individual therapy and longer-term individual therapy. Different models of therapy may be used for different steps, with different health care team members responsible for delivery (Bower & Gilbody, 2005a). In the case of psychotropic medication, patients with mild-moderate disorder would generally not receive medication as a first step, but rather as a further step in cases of persistent depression despite a fair trial of other interventions.

Although stepped care generally starts with a less resource-intensive treatment, this is not invariably so (Bower & Gilbody, 2005a). For example, in more severe depression, relatively more resource-intensive psychotropic medication may be provided without a prior trial of psycho-education or brief psychotherapy. It is also important that stepped care does not obstruct appropriate and timely referral of patients for specialist care if they fail to respond to interventions (Katon et al, 2001).

Monitoring and the related decision-making are fundamental to stepped care and a central function of health workers and the health care team. Initial assessment and routine regular monitoring of patient outcomes are critical in determining the level of intervention to be provided, or that "stepped up" care is necessary (Bower & Gilbody, 2005a) – or, indeed, stepped-down care, or termination of treatment, though this is seldom mentioned. Hence, case management can be seen as essential for effective stepped care.

Stepped care has common-sense logic in circumstances of limited resources and there is some evidence that it may improve patient outcomes. Bower and Gilbody (2005a; b) caution, however, that more evidence is necessary in order to assess its value. For example, ranking of interventions in terms of their resource intensity is often based on assumptions, whereas evidence may indicate that a more limited intervention by a less skilled worker is neither as effective nor as cost-effective as a more intensive intervention.

#### 4.2.2.3 *Collaborative care*

Collaborative care is a way of organising care that is directed at more efficient use of resources and more effective care for patients. Bower and colleagues (2006) describe it as a multifaceted, multicomponent intervention, including in particular case management and closer liaison between primary care generalist health workers and mental health specialists, but also improved collaboration between staff working at the primary care level. It may also involve a stepped care approach in the use of interventions of different resource intensity, or the addition of new categories of mental health worker to supplement more traditional categories. Collaborative care has been shown to have some positive effects on outcomes such as depressive symptoms, medication adherence and patient satisfaction (Bower & Gilbody, 2005b).

The component of liaison with mental health specialists in collaborative care differs from traditional consultation-liaison, in which specialist mental health personnel advise primary care generalist health workers on the management of patients who present some difficulty – a practice that has been found to have limited and inconsistent effects on the practices of generalist health workers and no effect on patient outcomes (Bower & Gilbody, 2005b). Although collaborative care may involve some elements of consultation-liaison, there are some key differences. Firstly, collaborative care consultation involves the generalist and specialist in joint direct consultation with patients. Secondly, interaction between specialist and generalist staff is intended to be more egalitarian: specialists contribute mental health expertise, while generalists contribute their expertise on general health and issues related to the local context to reach joint decisions for which they assume shared responsibility. This shift is captured in the term “shared care” (WHO/Wonca, 2008).

Based on their meta-analytic review of collaborative care for depression, Bower et al (2006) conclude that critical success factors in collaborative care are the use of case managers with a mental health (rather than general health) background, together with regular specialist supervision of case managers. Their findings suggest that mental health expertise is important, although it is not clear in what way – whether due to specific technical skills, non-specific patient-related or team-work skills. They note, however, that, because expertise is costly and in some settings in short supply, a trade-off between effectiveness and cost may have to be considered, especially in routine implementation.

Bower and Gilbody (2005b) earlier noted that collaborative care interventions have most often been in respect of psychotropic medication and tested on patients with more severe disorders, who are more at risk of relapse and recurrence. Findings of studies showing positive effects may be less relevant for patients with milder disorders.

### 4.3 Special categories of need

#### 4.3.1 Women

As previously indicated (2.1.1 *Prevalence of mental disorders*), women are more at risk of developing CMDs than men. This calls for increased vigilance in primary health care settings for possible underlying mental disorder in women.

Patel et al (2006) recommend that primary health care and reproductive health services should include assessment of the mental health and social circumstances of women who present with gynaecological symptoms or chronic illness in order to detect and treat CMD and that women with sub-threshold symptoms should as a minimum be followed up to facilitate early detection and management of diagnosable disorder. An expert meeting convened by WHO/UNFPA (2008) recommended screening for mental health problems for all women who are pregnant or have recently given birth, together with a range of simple and affordable interventions at a primary care level to assist women with mental health problems. Collaborative care has been proposed to increase synergies between reproductive health and HIV/AIDS care for women (see 5.4.3.1); the extension of this notion to include mental health care would benefit women using these services.

In view of the documented risks for women's mental health (Pico-Alfonso, 2005; Vos, Astbury, Piers, Magnus, Heenan, et al, 2006; Mechanic, Weaver & Resick, 2008), health services need to be particularly alert to mental health needs where intimate partner violence is suspected or detected. With regard to rape survivors, Campbell (2001) has, however, highlighted that mental health interventions may actually have a negative impact, with research indicating that rape survivors (particularly in the case of date rape) may feel blamed, not believed and re-traumatised by the “help” they receive from mental health care providers (Campbell & Raja, 1999; Campbell, Sefl, Barnes, Ahrens, Wasco & Zaragoza-Diesfeld, 1999). In order to guard against destructive interventions, Campbell (2001) recommends further training for counsellors regarding the risk of secondary victimisation. In addition, ongoing supervision may aid in preventing harmful counselling practices. As for mental health care for women in general, effective interventions with regard to mental health and gender violence require that all stakeholders work collaboratively in the best interests of survivors (Tavara, 2006).

Achieving the various changes in the health services mentioned above necessitates a broader organisational approach that reviews and redesigns programmes and systems through a gender-sensitive lens.\*

#### 4.3.2 Suicide

Suicide and attempted suicide are major problems in developing countries (see 2.1.1 *Prevalence of mental disorders*). Although a smaller proportion of people who die by suicide in developing countries have a diagnosable mental disorder than is the case in developed countries, mental disorder remains a key factor in many suicides. Social stressors such as poverty and relationship problems are a contributory factor in many cases. There appears to be a particularly close relationship between suicidal ideation in women and domestic violence (Vijayakumar, 2004). Awareness of and screening for these trigger factors, identification of at-risk individuals and provision of mental health care in primary care can contribute to reduction in suicide (WHO, 2000; Phillips, 2004). Active case management (see also 4.2.2.1 *Case management*) is usually necessary in order to access appropriate support and/or referral resources.

Working with at-risk or suicidal patients is anxiety provoking, not only because of concern for the patient, but also because of the additional responsibility attached to decisions on management; a system for shared responsibility can help to alleviate some of this burden (Kaliniecka & Shawe-Taylor, 2008). In this regard, collaborative care (see also 4.2.2.3 *Collaborative care*) in which specialist mental health personnel are available to assist in assessing and managing identified risk offers one option.

### 4.4 Staffing, training and supervision

#### 4.4.1 Staffing

The range of staff involved directly or more peripherally in primary mental health care as reflected in the literature ranges from auxiliary workers working in the community or in a clinic setting, through to traditional primary health care workers such as doctors and nurses, non-medical workers such as social workers, and specialist mental health professionals such as psychiatrists, psychiatric nurses and psychologists. The extreme scarcity of specialist mental health professionals in resource-poor settings (Saxena et al, 2007; Alem, Jacobsson & Hanlon, 2008) may in fact be as much a motivation for the development of primary mental health care as is the fact that mental disorder is so prevalent at this level.

The staffing resource implications at primary care level have, however, seldom been addressed. Instead the assumption seems to have been that primary care workers will – somehow – despite their already high workloads and the limitations of time this imposes, take on the additional tasks required to undertake effective primary care. The alternative of using new categories of auxiliary workers to undertake some aspects of primary mental health care has been recommended by respondents to a recent survey of African mental health professionals, mainly psychiatrists (Alem et al, 2008), and has been implemented in some settings generally on a pilot basis (see the example of Pakistan 4.7 *Good practice examples*).

An early attempt (Lazarus, Freeman & Rispel, 1995) to address the question of staffing resources involved the development of a model for estimating numbers of staff required to provide mental health care for various target proportions of the primary care patient population. Mental health care was assumed to involve screening, a limited number of follow-up sessions for screen positives and, if necessary, counselling (decreasing proportions of provision assumed for each of the interventions). The model allowed adaptation for different categories of patients (e.g. those attending general medical, antenatal or child services). The model also provided for estimation of training, supervision and consultation resources. It was clear that even at low target levels and with very limited interventions the resource requirements (in terms of time converted to full-time staff equivalents) were not negligible. An incremental approach was therefore recommended, with the proviso that there could be no compromise on the supervision and consultation resources that are essential to effective care at this level. This stress fits well with more recent findings mentioned above that continue to highlight the importance of supervision for effective case management and stepped care.

\* Gender-inclusive or mainstreaming approaches have received particular attention in relation to HIV/AIDS and are addressed in more detail (section 5.4.3.1).

#### 4.4.2 Training and supervision

There can be no effective primary mental health care without training and supervision (Alem et al, 2008). Training is used here to refer to a wide range of approaches which are intended to affect health worker practices at the primary care level so as to facilitate primary mental health care. The question is: Which training approaches are effective?

The key ingredients of effective training are that it should be systematic, participatory, tailored to the needs of the learners and combine two or more strategies, for example educational workshops and follow-up consultation visits (Chilvers, Harrison, Sapos & Barley, 2003). In particular, useful outcomes of training generally involve trainees in activities directly related to their daily practice, such as interviewing patients (Cooper, 2003).

Training in primary mental health care more commonly involves short, one-off courses of at most a few days, often in training venues with little in common with day-to-day primary care. Following such training, there is generally a lack of systematic follow up and, in particular, supervision in the workplace. While these courses may provide a break from routine and hence motivation for trainees, the extent to which learning on these courses is put into practice is open to question (personal observation). Reasons may include lack of competence and confidence following a short course and reversion to habitual practice once back in a familiar setting.

Courses such as the above may be backed up by guidelines (sometimes including tools such as diagnostic and treatment algorithms). However, on their own, guidelines have been shown to be ineffective in changing practice in primary care (Croudace et al, 2003; Gilbody et al, 2003) – hence they may not add substantially to any training that has taken place.

Beyond training itself, implementation of training very often requires system changes (e.g. with regard to time per consultation or privacy) to accommodate new practices. Without such changes, any incipient changes will not be sustained (Chilvers et al, 2003).

Many of the above observations on effective training relate particularly to training of medical practitioners in general practice in the United Kingdom. However, there is little doubt that they are equally relevant in other settings and for other categories of health worker.

The importance of supervision to assure appropriate decision-making in either case management or stepped care has been mentioned above. However, it is also centrally important in promoting implementation of training and change in health worker practice (Da Rocha-Kustner, 2009). It does so, firstly, by providing health workers with the opportunity to consolidate learning, clarify principles, discuss problem cases, explore treatment options and share the feelings that inevitably arise in working with patients with mental disorders.

A second function of supervision is to identify systemic barriers to implementation and to find ways to address them. It is usually particularly difficult for health workers of lower or more junior status to take up such issues and the help of a supervisor, ideally a more senior health worker, but alternatively a group of colleagues sharing supervision, may be necessary to do so.

Consultation-liaison could be seen as a means of providing support to front-line workers to implement what they have learned in training. However, as previously indicated (see 4.2.2.4 *Collaborative care*), consultation-liaison does not appear to effect significant change in health worker practices. On the other hand, collaborative care does seem effective, presumably because it requires the active engagement of the health worker in relevant activities (such as interviewing, considering diagnoses, developing a treatment plan), but with specialist support and guidance, which can be tailored to the level of experience and confidence of the health worker.

## 4.5 Systemic and organisational issues

Systemic and organisational challenges to the introduction of primary mental health care are numerous. These were well illustrated in a report on a survey of international mental health experts and leaders (Saraceno, van Ommeren, Batniji, Cohen, Gureje, Mahoney, et al, 2007). Amongst the challenges mentioned were:

- the low ranking of mental health as a public health priority, despite well-publicised evidence of its relative burden of disease and the consequent low priority for funding;
- the complexity of and resistance to the decentralisation of mental health services by policy makers, managers, mental health specialists and primary health care workers; and
- insufficient specialist mental health workers in developing countries to provide effective training and supervision of primary care workers.

Despite evidence showing that there are effective mental health interventions that can be used in resource-poor settings (Patel et al, 2007), implementation has been limited. One obstacle may be the lack of consistently rigorous research to identify the organisational requirements for effective intervention (e.g. using one or another category of health worker; supervision requirements); hence the apparent failure of an intervention may be ascribed to the intervention rather than the organisational context.

Another obstacle is the complexity of costing primary mental health care, which makes it difficult to assess and hence make a case for cost-effectiveness. Cost-effectiveness research conducted in developed countries cannot simply be extrapolated to developing countries because of significant differences in infrastructure, resources, cost-structures, income levels and inequality (Mcdaid, Knapp & Raja, 2008). Economic modelling may be used to adapt evidence to take account of these differences, but this can only provide a general guide, which will need testing to determine the extent of applicability in local circumstances. Common macroeconomic risk factors such as poverty, poor living conditions, low levels of education, gender and rapid economic transition may act both to increase vulnerability to mental ill-health and as barriers to the effectiveness of otherwise useful treatments.

One of the few studies to investigate the cost and cost-effectiveness of various mental health interventions in a developing country was that of Patel et al (2003). Findings indicated that antidepressant medication has been associated with significantly improved clinical and economic outcomes, especially in the short term. Contrary to a number of studies in developed countries, no such advantage was found for psychotherapy by trained therapists. Further research is needed to clarify whether factors such as those mentioned above may be responsible for the failure to transfer successfully to new settings.

Cost and budget factors are also implicated in poor continuity in drug supply which detracts from effective treatment in primary mental health care. Other factors include the availability of local manufacturers and suppliers as opposed to reliance on imports, the length and reliability of supply lines, restrictions on stocking, and prescribing or dispensing psychotropic medication at primary care level.

With regard to the issue of decentralisation, primary mental health care requires changes in the way health workers interact with patients (at the most basic level in the amount of time spent with patients) and with each other (often with a less rigid demarcation of roles between different professions). This poses challenges to traditional organisational culture and practices (often characterised by rigidity and lack of flexibility in the health care sector) and to traditional boundaries between different professions and between generalist and specialist health workers. The roles of new categories of worker, specifically auxiliary workers, and their lines of accountability may not be well defined or understood, resulting in their not being used effectively.

These kinds of systemic and organisational challenges persist, despite strong international and national efforts to move towards primary mental health care. Policy pronouncements alone are clearly not enough to bring about change (Alem et al, 2008).

## 4.6 Examples of good practice

In this section, we describe selected examples of good practice in primary mental health care for CMD offered as part of the health sector. As mentioned in the Introduction (1.2), we have drawn heavily on the WHO/Wonca report (2008), but have in a number of instances supplemented the report by referring to information or practices not included in the report. We have also identified one additional example of good practice. (Good practice in primary mental health care for people infected or affected by HIV and AIDS is dealt with later.)

The examples reflect a range of contexts and alternatives, providing a sense of the variety of ways in which primary mental health care can be implemented. All the examples are from developing countries. They include a wide range of country contexts with regard to population size, economic development and levels of education and health, and standards of living. In most of the countries, there are wide disparities in socioeconomic circumstances, often emphasised along rural/urban or urban/suburban divides. Most of the examples are located in less well-resourced urban or rural areas in these countries.

Some examples illustrate national-level initiatives on primary mental health care, while others are limited to a specific province or district, or are pilot projects. Most of the examples are a mix of the model-types previously identified. Some lean more towards full integration into primary care, usually with strong support from specialist mental health staff or levels of care. Others rely more strongly on specialist mental health care provided at the primary care level. An example of outreach using auxiliary workers is included.

Descriptions are inevitably highly summarised\*. Important as it is, we have not described the process of implementation followed in the examples (the main lessons of which are encapsulated in the ten principles previously outlined). Rather, to meet the brief of this project, we have focused primarily on aspects which could affect replicability in other settings. Thus, for each example, we have described the health service context; where primary mental health care is located (e.g. within generic primary health care, or specific health programmes); the case mix addressed (specifically the extent to which CMD is a focus); the mental health care package provided; staffing at service delivery level and specialist support; and selected findings from any evaluation.

The examples are presented roughly following the order of the summary matrix shown before (3.3.5 *Matrix of models of care*), starting with examples that place greater emphasis on care within primary care.

### *Example 1: Uganda*

#### *District health services and group interpersonal psychotherapy in Uganda: Mental health in primary care supported by community outreach*

Sources: WHO/Wonca, 2008; Bolton et al, 2003; Verdeli, Clougherty, Bolton, Speelman, Ndogoni, Bass, et al, 2003.

Uganda's national health strategy places strong emphasis on primary health care, which is offered at services at parish, sub-county and county level. The WHO/Wonca report focuses on the Sembabule District. Primary health care services are provided by general nurses, midwives and clinical officers, supplemented by nursing assistants at parish level and medical doctors at county level. The primary health care services are supported by district general and regional and national referral hospitals (including a psychiatric hospital). However, at least half of all Ugandans do not have easy access to primary health care and many centres do not offer the full range of services expected at that level.

Historically, people with severe mental disorder were treated by specialised psychiatric workers at referral hospitals, while those with CMD received no care at all. Complicating the picture, many people prefer to use religious leaders and, to a lesser extent, traditional practitioners rather than the formal health services for mental health problems such as depression. Mental health care is now offered at all levels of primary care. These services are supported by specialist care at regional or central referral hospitals.

\* More detailed accounts, particularly with respect to the setting up and development of each service, are available in the relevant source documents, namely the WHO/Wonca report and other documents specifically cited.

Estimates of prevalence of mental disorders are 20–30%. Rates of trauma-related disorder are presumed to be high, because of exposure to conflict or post-conflict situations in parts of the country and high rates of HIV and AIDS (7% of those aged 15–49 years).

Primary mental health care includes community-level identification and referral and follow-up of people with mental disorder. Within the various primary care services mentioned above are included identifying mental health problems, managing patients with uncomplicated CMDs or stable chronic mental disorders, managing emergencies and referring patients who need to have their medication reviewed or for admission to hospital. Psychotropic medication on the national Essential Drug List (EDL) is available at primary care level.

A promising innovation developed in Uganda that has had limited application in some districts (not including Sembabule) is group interpersonal psychotherapy (IPT) for depression. As the name implies, the focus of IPT is on depression in relation to interpersonal relationships, a focus that was considered congruent with Ugandan culture. Three specific aspects targeted in the Ugandan intervention were persistent grief following the death of a loved one, interpersonal conflict with significant others and life changes that disrupt close personal relationships. The Ugandan intervention was time-limited (16 weekly 90-minute sessions) and conducted according to a manual, which included detailed scripts in simplified language. Groups were made up of 8–10 individuals of the same sex. In each session, the group leader facilitated participants' reporting on and drawing links between depressive symptoms and experiences during the previous week. Group members were then encouraged to offer support and suggestions for change. The group IPT initiative was not part of formal primary mental health care and group leaders were non-clinician, tertiary-level educated employees of the sponsoring NGO, who, following selection, received two weeks of intensive training in the Ugandan version of group IPT and were supervised during implementation of the intervention.

Formal primary mental health care is provided by general health workers (including general doctors, nurses and midwives) who have received in-service training to provide effective mental health care (around 600 nationally to date). All general health workers who have received this training are allowed to prescribe EDL psychotropic medication. In the case of chronic patients, general health workers may prescribe and administer psychotropic medication only after the treatment has been initiated by a mental health professional and generally not in the case of injectable psychotropic or atypical antipsychotic medication. The work in the centres is complemented by community-level volunteer health teams, who have received basic training in mental health and attend monthly meetings where problems are discussed and training updated. In addition, hospital-based specialist mental health professionals, including psychiatric clinical officers and psychiatric nurses, make regular visits to primary care centres, initially to work alongside trained staff to build their competence and confidence and increasingly to provide ongoing consultation, mentoring and further training.

Limited recording of patient statistics in primary health care indicates that identification and management of mental disorder has improved and that patients are generally treated at a local or regional hospital rather than the central psychiatric hospital. Patients are generally satisfied with the service, especially that they can be treated close to home. In the case of the group IPT intervention, attendance at the sessions was good, drop-out rates very low and, in a cluster randomised controlled trial, outcomes were found to be significantly better for intervention than for control subjects (Bolton et al, 2003).

### *Comment*

This example indicates how primary mental health care can be introduced effectively even in contexts of very limited resources and in the face of initial resistance from general health workers. National commitment and the inclusion of mental health in the minimum health care package and in the health information system contributed greatly to gaining acceptance, as did the careful process of gaining the support of stakeholders at various levels. The availability of psychotropic medication at primary care level and the wide range of health workers permitted to prescribe significantly increased its accessibility. Work with volunteers and service users in the community also proved worthwhile. Barriers included the initially negative attitudes of general health workers, staff shortages, which added to the difficulties of arranging training, and lack of vehicles to facilitate outreach visits by the specialist mental health teams.

In the case of group IPT, the intervention is an interesting one but, as it was implemented as a pilot, it is not clear how well it would transfer to routine care. Its use of group leaders with a tertiary level of education, provided with substantial supervision by highly qualified supervisors, could also restrict its replicability, although in a primary care pilot in Goa, India (Chatterjee et al, 2008), trained and supervised auxiliary-level workers with a lower level of education were substituted with apparent success. The same pilot, however, found that group IPT was not feasible because of participant concerns about confidentiality and the number of sessions involved; whether individual IPT would prove feasible and efficacious has yet to be determined. In this regard, poor attendance at the series of IPT sessions, primarily related to financial factors, could be a barrier.

### *Example 2: Brazil*

#### *Family health teams in Brazil:*

##### *Mental health in and at primary care*

Sources: WHO/Wonca, 2008; Mateus, Mari, Delgado, Almeida-Filho, Barrett, Gerolin, et al, 2008.

Brazil has an extensive network of public health services, mainly primary care, across the country, including in rural areas. The WHO/Wonca report focused on the city of Sobral in north-eastern Brazil. The model of primary care for Brazil as a whole, including Sobral, involves the deployment of Family Health Teams (FHTs) who are responsible for primary and community-based health care in a defined geographic area. This includes diagnosis and treatment of most diseases, together with promotion and prevention activities.

Mental health care is now integral to the work of FHTs. Other mental health resources at community level include centres for psychosocial care (CAPS), which have been established in both urban and rural areas (although with some inequity between different regions of the country). These centres offer specialised mental health outpatient and, in some cases, day and limited in-patient care, as well as first-line emergency care. The CAPS, together with FHTs and mental health units in general hospitals, make up an interconnected Comprehensive Mental Health Network. In time, these networks are expected to lead to the closure of traditional psychiatric hospitals.

Mental disorders common at community level include anxiety and mood disorders, somatoform disorders and substance dependence. High levels of mental disorder or distress have been reported for primary care users.

Patients presenting in primary care have both their physical and mental health status assessed. Mental disorders that are identified (particularly CMD, but also other disorders) are as far as possible treated by primary care practitioners, including by the prescription of psychotropic medication (with the exception of a few municipalities in Brazil that do not authorise this function for primary care practitioners). If necessary, a specialist assessment is arranged (generally for more complex cases) usually as a joint consultation with the primary care practitioner and patient, leading to a joint decision on further treatment or referral. Therapy and support groups are available within primary care settings for patients with mild to moderate and chronic mental disorders.

FHTs, usually comprising a general practitioner and at least one nurse or nursing technician and a community health worker (health agent), are the core providers of primary mental health care. They are supported by Mental Health Support Teams (MHSTs) staffed by psychiatrists, psychiatric nurses, psychologists, social workers and occupational therapists drawn from the Mental Health Network. The joint consultation approach used in Sobral and elsewhere in Brazil is described as collaborative or shared mental health care. Rather than transferring care through up- and down-referral, collaborative care facilitates care remaining at primary care level, but with shared responsibility for decisions. This approach ensures good quality mental health care, while also building the competence and autonomy of primary care practitioners. Therapeutic groups are facilitated by mental health and primary care professionals, while community workers and lay participants run support groups.

In municipalities where formal evaluations have been conducted, collaborative care appears to have resulted in improved management of patients by FHTs and a reduced number of hospitalisations. There is qualitative evidence of improved diagnostic and treatment skills for depression and anxiety disorders, greater confidence in applying these skills and improved communication skills generally amongst primary care family physicians.

#### *Comment*

This example demonstrates the value of a number of interlocking strategies: a strong system of family-centred primary health care (particularly appropriate for mental health care), together with specialist mental health support delivered through collaborative care and a network of supporting mental health resources including both hospital and community. The approach has developed over time, growing organically from small, local initiatives. It is probably the combination of elements and their gradual elaboration that accounts for its success.

The approach was developed during a period of general health care reform in Brazil (and Sobral in particular) that provided a set of favourable circumstances that may not be present in other contexts. The failure of some municipalities to authorise prescribing rights for primary care practitioners suggests, however, that there has not been universal acceptance of the value of primary mental health care – whether by primary care practitioners themselves, or mental health specialists.

#### *Example 3: Chile*

##### *Family health care teams and stepped care in Chile:*

##### *Mental health in and at primary care with limited community outreach*

Sources: WHO/Wonca, 2008; Araya et al, 2003; Patel et al, 2004; Rojas, Fritsch, Solis, Jadresic, Castillo, González, et al, 2007.

Chile's public sector primary care consists of a network of services, including health posts with minimal staffing in isolated rural areas and health centres in larger rural or urban centres. Health centres are staffed by multidisciplinary teams (including general physicians, dentists, nurses, obstetric nurses, nurse aides, nutritionists, social workers and, increasingly, psychologists). General health centres use an individual approach. Family health centres (FHCs) use an approach that prioritises the family rather than the individual as the focus of health care; emphasises early detection, diagnosis and treatment; stresses health education and patient self-management; and includes rehabilitation and palliative care.

Primary mental health care is offered in both general and family health centres. However, the focus of the WHO/Wonca report was a particular FHC in the south-eastern sector of Santiago. The centre has four multidisciplinary health teams, each responsible for a quarter of the centre's registered population. Mental health care provided by the FHC is supplemented by ambulatory specialist care provided by a Mental Health Community Centre (MHCC), a day hospital and a short-term inpatient unit in a general hospital to which more complex cases are referred.

Depression and anxiety disorders (particularly the former, linked to high national prevalence and the existence of a national depression programme) are the disorders most commonly seen in primary care. Other problems commonly seen include alcohol and drug problems and domestic violence.

The FHC provides care primarily for mild-moderate disorder, referring more severe disorder to the referral resources mentioned above. Psychotropic medication is available if required, as well as individual, family and group psychosocial interventions. Clinical guidelines, treatment pathways and group intervention manuals are available to provide guidance on diagnosis and management of a number of conditions. Home visits are conducted when necessary to help for case identification and follow-up. Special programmes, including for depression and domestic violence, have been initiated.

Some health centres in Chile have adopted a stepped care approach to encourage more rational use of resources for patients with major depression. The approach has recently been piloted for women with postnatal depression and is reportedly being extended across Chile. The approach involves a sequential,

multi-component programme. The components comprise a structured nine-session psycho-educational group, systematic monitoring of clinical progress and a structured pharmacotherapy programme for women with severe or persistent depression. A case management component running across the other components and involving structured and systematic monitoring of clinical progress and follow up is also used. Topics covered in the psycho-educational programme include information on symptoms and causes of depression, available treatment options, scheduling positive activities, problem-solving techniques, and basic cognitive and relapse-prevention techniques. Patients with mild-moderate depression are assigned to the psycho-educational intervention and only receive psychotropic medication if monitoring indicates that their depression is persisting or has worsened. Patients with initially more severe depression receive both the psycho-educational intervention and psychotropic medication concurrently.

Improvement in the prescription of adequate dose levels and duration of treatment has been attributed to:

- the provision of structured prescribing guidelines for doctors;
- structured monitoring of and support for adherence;
- the use of case managers who also act as brokers between patients and doctors regarding symptoms and treatment;
- peer support; and
- patients taking a more active role in decisions about and monitoring of their treatment (consequent on their involvement in a psycho-educational intervention).

Regardless of the specific approach, all members of the FHC team are involved in identifying mental health problems as part of their routine function and may undertake home visits. However, responsibility for treatment lies primarily with the physician and the psychologist. The former is responsible for diagnosis and prescription of psychotropic medication if required, while the latter undertakes crisis intervention, if necessary, as well as individual, family and group psychosocial interventions. Where available, the stepped care psycho-educational component is run by social workers or nurses with special training. Part-time physicians, university students and community volunteers provide additional specialised assistance to the FHC team. Specialist support for the FHC team is provided on a monthly basis by staff of the MHCC, usually a psychiatrist and psychologist, who provide consultation on problem cases.

The number of new cases and the number receiving treatment through the specific FHC have increased significantly over the past few years. Levels of user satisfaction are high. In a randomised controlled trial, the stepped care programme showed improved outcomes for patients as compared with usual care (which includes access to antidepressant treatment, brief psychotherapeutic interventions and referral for specialist care) despite the fact that most patients did not attend all group sessions of the psycho-educational component of the programme (average number attended: 6.26 sessions).

### *Comment*

As in Brazil, the introduction of primary mental health care in Chile appears to have been facilitated by major health sector reform, as well as support from prominent champions. Like Brazil, the strong emphasis on family-centred care at the primary care level is favourable for mental health care. However, Chile is unique among these examples in its inclusion of a strong psychosocial intervention component in its primary mental health care services. The availability of psychologists to work at this level may, however, not be matched in other contexts. Use of students in training as a resource may also only be possible in an urban setting.

The stepped care approach does appear to encourage a more rational use of limited resources, primarily through its use of a highly structured approach, with specific guidelines on conduct of the psycho-educational groups and monitoring, and its reliance on staff categories that are more readily available at this level. These staff not only monitor treatment progress, but act as case managers and intermediaries between patients and doctors. The focus on high risk, poor women patients as a specific target facilitate interventions tailored to their needs. However, wider application would require adaptation to the needs of other groups.

#### ***Example 4: India***

##### ***Integrated primary mental health care and specialist outreach, Kerala, India: Mental health in and at primary care with limited community outreach***

Source: WHO/Wonca, 2008.

This example is located in Thiruvananthapuram, a district of Kerala state, which has an extensive network of decentralised primary health care centres, ranging from village level centres, through to subcentres serving a small number of villages and primary care centres serving about 20 villages. First-level referral services are offered at community health centres and Taluk hospitals. District hospitals (11), medical college hospitals (5) and general hospitals (3) offer higher levels of care. In addition to psychiatric beds in general, district and medical college hospitals, Kerala has three community mental health centres and three (private) psychiatric hospitals (one located in Thiruvananthapuram District).

Through a process of development over time, primary mental health care is now firmly established and integrated with general health care in primary care centres, community health centres and Taluk hospital outpatient services. People with mental disorders are identified and directed to the services from lower levels of health care, community organisations and community workers, as well as by more specialised mental health services.

About 10% of primary care patients have identified mental disorder. The disorders seen are a mix of CMD and more severe disorders. Those most commonly presenting are depression, bipolar disorder, schizophrenia and epilepsy, but significant numbers of cases of anxiety (primarily generalised anxiety disorder) and somatoform disorder are also seen.

First-line care includes, as part of general health care consultation, identification of possible mental health disorder, diagnosis, prescription of psychotropic medication, follow up and, where necessary, referral. Whereas previously special arrangements had to be made for supply of psychotropic medication, it is now available directly through the health centre. First-line care is supplemented by specialist outreach services provided on a monthly basis by mental health teams, who, in addition to diagnosis and treatment planning for newly identified patients, review and follow up established patients and undertake individual/family counselling, group therapy, psycho-education and, where appropriate, home visits and referrals within the health care system or to other resources.

The primary staffing resource is general medical officers working in primary care or community health centres. A distinction is made between medical officers who have been trained and who undertake the full package of first-line care as outlined above, and untrained medical officers who, by contrast, tend to provide only follow-up repeat medication. There are three district mental health teams, each consisting of a psychiatrist, clinical psychologist, social worker and staff nurse, and supported by a clerk, clinic attendants and driver. In addition to the direct patient care described above, the mental health teams are involved in consultation-liaison and to some extent training of first-line staff, as well as staff in related sectors and community-based organisations.

#### ***Comment***

Primary mental health care in Thiruvananthapuram District combines the use of general medical officers to provide mental health care in the course of their ordinary consultations with direct patient care by visiting specialist mental health teams. This contrasts with the example of Belize (to follow), which provides a more restricted specialist expertise (psychiatric nurse practitioners only).

The service has been effective in reaching an underserved population. Newly registered cases have been well over 1 000 a year (over 11 000 in 8 years). Access to free psychotropic medication has been a major benefit. The service has achieved high levels of acceptance within the health services and in the community.

The process of establishing the Thiruvananthapuram District primary mental health care services is described in detail in the WHO/Wonca report. This highlights the care taken to start small, initially establishing the service in a few centres where health workers showed a willingness to treat people with

mental disorders and then gradually expanding to other centres as staff became more confident and independent in the provision of mental health care. The success of the programme is partly attributed to its organisational placement under the health services department, rather than linked to college hospital services. Having a senior level coordinator at district level was also valuable, particularly in dealing with problems.

Three problems which are highlighted relate to the supply and prescription of psychotropic medications at this level, a system of regular staff transfers which necessitated continual training of staff, and restrictions on the use of funding for training. Such problems may well occur in other settings as well.

### ***Example 5: Belize***

#### ***Decentralised mental health care in Belize:***

##### ***Mental health at primary care with limited community outreach***

Source: WHO/Wonca, 2008.

The Belize national government is the main provider of health services and medication. Mental health services are based at seven of the country's eight hospitals. In addition, decentralised primary mental health care is offered in the community, mainly through mobile clinics at health centres, home visits and other community activities. Patients are referred to the services by general health workers, including general medical practitioners, public health nurses and community nurse aides. Links with the police services are becoming increasingly important.

The main reasons for mental health consultations are clinical depression, psychotic disorders, anxiety disorders, stress-related disorders and substance abuse. Harmful alcohol use is regarded as problematic, particularly among men. Family violence is increasing at an alarming rate, with most victims being female and most cases occurring in urban areas.

Mental health care is provided primarily through outpatient services, crisis management and outreach services. These services include counselling for people with mental disorders, victims of domestic violence and rape, and people undergoing testing for HIV. Psychotropic medications recommended by the WHO are available in all district hospitals and in polyclinics in the capital city, although there are sometimes supply problems. Apart from the counselling mentioned above, psychological therapies do not appear to be offered in the public health sector.

The services are provided by specially trained psychiatric nurse practitioners (at least two per hospital), who form part of the district health team. One of the nurses attends to patients at the hospital outpatient clinic, while the other provides services through mobile clinics. Psychiatric nurse practitioners have special prescription rights for a limited range of psychotropic medication. Increasingly, general practitioners are themselves taking on management of some cases, thus alleviating pressure on the psychiatric nurse practitioners.

Supervision is provided by a psychiatrist who visits the district hospitals in rotation (frequency not stated). On these visits, the psychiatrist also assesses difficult cases and provides mental health training for general health workers at the district hospitals. The psychiatrist also plays a backup role in psychiatric emergencies. Prescriptions for psychotropic medication written by psychiatric nurse practitioners are reviewed by a psychiatrist or general practitioner.

Evaluation of the service has indicated a consistent and significant increase over time in the number of cases seen. There has also been a marked reduction in admissions to the psychiatric hospital.

#### ***Comment***

Belize is of interest primarily because of its effective use of psychiatric nurse practitioners to provide decentralised mental health care through district and local health facilities and in the community. Seen as the initial stage of a two-stage approach to the development of primary mental health care, the intention is that general practitioners will increasingly take on the management of less complicated cases, leaving the

nurse practitioners to deal with more difficult cases and to act as consultants and trainers. Whether this will in fact happen remains to be seen, but it is encouraging that general practitioners are beginning to take on the clinical management of some cases.

The decision to adopt a two-stage approach was based on the view that it would be unrealistic to expect the limited numbers of mental health practitioners in the country to train all primary care practitioners in mental health. In addition, to add mental health to the responsibilities of overloaded primary health care staff could lead to neglect of patients. Moreover, without adequate resources to supervise and support general health practitioners, it was considered unlikely that primary mental health care would be sustained.

Even at the current stage there have been challenges to sustainability: about half of the psychiatric nurses trained since the programme started in 1992 until the present are no longer working in primary mental health care, emphasising that training of additional psychiatric nurses on an ongoing basis is necessary to take account of inevitable attrition over time. Earlier, three years after the start of the new service, psychiatric nurse practitioners reported a number of familiar implementation barriers, including lack of transportation to make regular home visits; inadequate funding for services; inadequate office space and long working hours. There was also reference to too few mechanisms for conflict resolution with colleagues; suggesting that interaction with and support from general health workers has not always been plain sailing. Whether these issues have been resolved with time is not reported, but this highlights the importance of considering these apparently micro-issues in planning implementation.

### ***Example 6: Pakistan***

#### ***Thinking Healthy mental health programme, Pakistan:***

##### ***Mental health community outreach through auxiliary workers***

Sources: Mirza & Jenkins, 2004; Pakistani Ministry of Health, 2009 Patel & Kirkwood, 2008; Rahman, 2007; Rahman, Malik, Sikander, Roberts & Creed, 2008.

Pakistan's public sector primary care is provided through Basic Health Units (BHUs), each serving about 20 000 people. Staffing consists of a doctor, midwife, vaccinator and 15–20 female PHC workers, called Lady Health Workers (LHWs). LHWs, who have completed secondary school, are recruited from the local community and trained to provide mainly preventive mother and child health care to approximately 150 households each. The LHW programme has had a major impact in reducing maternal and infant mortality rates.

As regards mental health services, Pakistan's 350 psychiatrists and 3 000 psychiatric beds are concentrated in the major cities. There are no specialist mental health services in rural areas. In addition, owing to low levels of awareness and high levels of stigma in the population, the majority of CMDs are not diagnosed or treated, despite evidence of rates of depression in excess of 30%, with women particularly at risk.

Some pilot programmes to extend mental health care have been reported for Pakistan. The example reported here is a pilot programme conducted in two rural subdistricts close to Rawalpindi, focusing on women with mild-moderate depression diagnosed in the last trimester of pregnancy. The intervention was delivered as part of routine mother and child outreach care in the women's homes. Visits took place every week for four weeks in the last month of pregnancy, three times in the first postnatal month, with nine monthly visits thereafter. The main component of the intervention was a manual-based counselling intervention, the Thinking Healthy Programme (THP). The programme is based on CBT principles, but adapted to local cultural concepts and practices. Essentially, it encourages the identification of unhelpful or unhealthy patterns of thinking, learning to replace these patterns with more adaptive thinking and practising these new patterns in daily life. In practice, the formal CBT approach of the THP was enhanced by the use of other counselling skills such as empathic listening, other psychosocial interventions such as engaging with families and partners and accessing social support, and health interventions that are part of the more routine work of LHWs, such as advice on infant care and attention to the mother's physical health and nutrition.

The programme was delivered by LHWs, who were trained to deliver the THP as part of their regular work with women during the perinatal period and thereafter. The LHWs received monthly group supervision and support, which assisted in maintaining their interest and motivation and in helping them negotiate difficult situations and accept the limitations to what they can achieve. Supervision was provided by the psychiatrist responsible for the development of the programme and an MCH expert (i.e. personnel external to the health services).

The intervention has been tested in a cluster randomised controlled trial. The rate of depression amongst women in the intervention groups was halved as compared with control groups, while the former also showed significantly less disability and improved social functioning overall. These differences were sustained after one year.

### *Comment*

This programme, which has been shown to be effective in reducing depression and disability, is unusual in its defined target group, the nature of the intervention, its delivery through home visits and by non-professional auxiliary workers. The ability of the latter to implement CBT may have been enhanced by the use of a simplified, pared down three-step CBT intervention developed for the THP. The fact that the intervention was detailed in a manual, backed up by supporting materials, may have added to its suitability for use with this category of staff. High levels of support and supervision were also provided, both direct and through advocacy to overcome systemic problems, an aspect possibly not easily replicated in other settings where specialist resources are likely to be more limited.

In this pilot, perinatal depression was identified through screening by professional mental health staff using standard instruments. Introducing routine screening by LHWs to identify depression in women who have not been identified by other health care routines would strengthen the intervention. A stepped care approach to provide for cases of persistent depression not responding to the THP approach would also be valuable.

An important feature of the development of the programme was its careful attention to a range of cultural, systemic and other factors. Many of these are common to other settings and those that are not seem amenable to adaptation. The fact that the programme focused on a defined target group (women with perinatal depression) and made use of materials developed for this specific group limits its wider application, but at the same time suggests an approach that could be used to develop interventions suitable for other groups. With regard to staffing, the approach could probably be adapted for use by other categories of lay worker, such as community health workers or peers. The unique access of the LHWs to this target group through their MCH role and the motivation it provided for the mothers to engage with the programme may, however, not be easily replicated in other settings.

## 4.7 Conclusions

In this section, we reviewed the good practice examples against the background of the literature on good practice in primary mental health care for CMD. With regard to the package of care, none of the good practice examples reported above used routine, formal screening as a means to aid identification of CMD. This may reflect the demands on the time of general health workers that formal screening would entail and/or reluctance on their part to change habitual consultation patterns. Although there was reference to informal screening as part of routine consultations, it is not clear how effective this screening is.

All the good practice examples described (bar the Pakistani Thinking Healthy Programme, which does not provide relevant information) provided access to at least a basic range of psychotropic medication. In some cases, however, some psychotropic medications (particularly "newer" antipsychotics) were only available on prescription by specialist mental health professionals. In the Chilean example, prescribing guidelines, in combination with other factors, appeared to contribute to effective use of psychotropic medication. This is in line with the findings and recommendations reported in the overview.

All of the good practice examples included specific non-medical counselling or psychotherapeutic interventions. These include:

- counselling (form not specified) by psychiatric nurses (Belize) and lay health workers in the course of interaction with clients (Pakistan);

- individual/family counselling, group therapy and psycho-education provided by members of the specialist mental health team (Kerala, India);
- therapeutic groups (form not specified) facilitated by mental health and primary care professionals and support groups run by community workers and lay participants (Brazil);
- individual, family and group psychosocial interventions provided by psychologists (form not specified, but presumably some variant of brief psychotherapeutic intervention) or, in the stepped care approach, a group psycho-educational intervention run by social workers or nurses (Chile);
- a manual-based group IPT intervention (Uganda); and
- a manual-based individual CBT counselling intervention (Thinking Healthy Programme, Pakistan).

These interventions are reflective of a growing recognition that non-medical interventions offer significant benefits for people with mental disorder, in particular, those with depression.

The psycho-educational intervention used in Chile was similar in some respects to that reported by Conradi et al (2007) (see section 4.1.4.2), in the areas covered, the duration of sessions and the level of training and supervision of facilitators; yet the Chilean intervention was found to improve outcomes without the negative outcomes found by Conradi et al. Possible reasons are that, in Chile, the intervention was group-based (adding an element of peer identification and support), involved a larger number of face-to-face sessions over a shorter period (possibly laying a sounder foundation for self-management thereafter) and appeared to put less emphasis on self-monitoring for relapse and more on positive problem-solving strategies (thereby possibly reducing patients' sense of vulnerability). Perhaps more importantly, the intervention was part of a package of stepped care, which included regular monitoring by health workers. The contribution of the psycho-educational intervention to the success of the total package was not separately evaluated in the Chilean example. However, where it is replicated, on its own or as part of a package (as reported for a stepped care trial in India [Patel et al, 2008]), the cautions derived from the study of Conradi et al would need to be kept in mind.

Questions of cultural applicability or adaptation need to be considered in using interventions developed in Western countries in other settings. The CBT approach used as part of the Thinking Healthy programme was adapted to local circumstances. In Uganda and India, the basic principles of IPT were considered compatible with local cultures, but adaptation was nevertheless required in some respects, including to local concepts and ways of talking about depression. However, this did not entail major departures from the basic approach. The Ugandan trial was able to demonstrate the efficacy of IPT in group format, but in an ongoing trial in India, group IPT was found culturally inappropriate and has been substituted with individual IPT (the efficacy of which has yet to be demonstrated).

With regard to the organisation of care, in most of the good practice examples formal case management was not an explicit part of the service offered, although it is possible that it was provided informally. The stepped care approach used in Chile did, however, include case management as a key part of the intervention. In the pilot, there was close specialist supervision of the staff undertaking case management. This may be more difficult to achieve with scaling up and in settings where mental health specialists are in short supply.

The Brazilian example makes use of a collaborative, shared care approach in which joint consultation between specialist and generalist staff is a central feature. It is not clear whether other aspects of effective collaborative care, such as the use of supervised case managers, are also included, or the particular case mix seen at primary care level. These components need to be borne in mind in assessing the relevance of collaborative care in a particular setting.

Of the special categories of need identified, women have been the target of the good practice examples described in Chile and Pakistan, in both cases with positive outcomes. In both instances, manual-based approaches were used with good effect by health workers who were not mental health professionals. However, these were both pilot programmes and effectiveness must still be tested in more routine implementation.

None of the good practice examples has focused on suicide specifically. With regard to situations of disaster and conflict, the good practice examples have not been designed to address such situations.

With regard to staffing, most examples make use of general health workers, although usually with substantial support from mental health specialists in support roles. However, general health care managers and workers have tended to resist inclusion of mental health care as part of general health care. Use of new categories of mental health worker offers a promising, but as yet not widely tested, alternative. Limited training and supervision resources do, however, constitute a barrier to extending the use of such workers, assuming that their capacity to undertake mental health care can be shown outside of demonstration projects.

Specifically with regard to the use of psychotherapeutic interventions in resource-poor settings there is a question whether staff who are neither mental health professionals nor psychotherapists can effectively deliver such interventions. The good practice examples provide some pointers in this regard: one (Pakistan) demonstrating the effective use of auxiliary workers to deliver a CBT-based programme; the other (Chile) using more readily available nurses and social workers rather than psychologists to deliver the psycho-educational intervention. In both cases, the fact that the intervention was manual-driven and high levels of supervision were provided probably contributed to the ability of these categories of staff to deliver the intervention effectively.

Some of the good practice examples reported here have employed staff additional to that routinely available in the general health care system. The question of sustaining these resources beyond the demonstration phases must arise in these instances.

Few of the practice examples provide much detail regarding the nature or extent of training for general health workers in mental health care. In the case of demonstration projects, such as the Chilean stepped care, Ugandan IPT and Pakistani auxiliary worker examples, trainer expertise and, in some cases, time available for training, as well the quality and extent of supervision, were probably more than would generally be offered, or would be available to sustain the projects (a concern noted in the case of the Pakistani example).

With regard to systemic and organisational issues, the good practice examples included both pilot projects and others that were integrated into larger district, regional, state or national health systems. In the case of the latter group, it is not always clear how representative of the larger system the specific instance described is, or what obstacles there may have been in the way of extending such practices more widely. With regard to costs and funding, detailed information on the costs of the various good practice examples was not available. Where specialist mental health staff are used (as, for example, in Belize), costing of staffing may be more straightforward, but the costs related to infrastructure will be shared with the general health care services where they provide mental health care. The reliability and continuity of funding may in any case be problematic (as, for example, reported for Kerala). In this regard, cost-effectiveness studies are important to support advocacy for the extension of the programmes; yet even in good practice examples where effectiveness has been studied cost-effectiveness studies have generally not been undertaken.

In only three of the good practice examples has there been rigorous evaluation of outcomes related to some aspects of the programmes. Randomised controlled trials of the Ugandan group IPT programme, the Chilean stepped care approach and the Pakistani Thinking Healthy Programme found significantly better outcomes for the intervention as compared with usual or enhanced care. Whether these impressive results can be carried forward in the event of scaling up remains to be seen. For the remaining practice examples, most have reported utilisation and output data only, generally showing increased utilisation and decreased hospitalisation. In some cases, user satisfaction has been tested, generally with positive results.

In summary, there are significant examples of good practice in primary mental health care, but few that have been widely implemented. The key challenges are to find ways to scale up and extend good practice more widely with careful monitoring and evaluation to assess whether the benefits of demonstration projects are maintained in more routine implementation.

## 5. MENTAL HEALTH CARE FOR PEOPLE LIVING WITH HIV/AIDS

### 5.1 Mental health and HIV/AIDS

There is an interdependence and “vicious circularity” between mental health and HIV/AIDS (Kelly, Freeman, Nkomo, & Ntlabati, 2008) that leaves little doubt about the critical need to increase and improve mental health interventions. Mental health programmes are needed because of the vulnerability of people with mental disorders and substance abuse to contracting HIV; because mental ill-health is an important health outcome of being infected with HIV; and because mental health status impacts on the course of the disease in various ways.

People with mental disorder are at higher risk for contracting HIV/AIDS than the general population. People with serious mental disorder have been shown to be less likely to wear condoms, to have multiple sexual partners, to trade sex for money or goods and to inject drugs (McKinnon, Cournois & Herman, 2002; Meade & Sikkema, 2005). They have also been shown to have less knowledge of HIV/AIDS, to lack the appreciation of risk, to have lower levels of assertiveness, to be more likely to be coerced into sex and to be homeless – all of which increase the risk of contracting HIV. People with CMD also appear to be at greater risk for infection. A study done with South African youth found no correlation between HIV knowledge and risk behaviour but did find that youth who were depressed engaged in more risky sexual behaviour than those that were not depressed. This suggests that depression was an even more important indicator of risky sexual behaviour than knowledge of HIV (Moghraby, Ferri & Prince, 2005). People who abuse alcohol have also been found to engage in risky sexual behaviour (Smit, Myer, Middelkoop, Seedat, Wood, Bekker & Stein, 2006).

Studies in both more and less developed countries show that just under half of all PLHA also have a diagnosable mental disorder (Bing, Burnam, Longshore, Fleishman, Sherbourne, London, et al, 2001; Ciesla & Roberts, 2001; Olley, Seedat, Nei & Stein, 2004). This means that around 10 million people in sub-Saharan Africa alone have both HIV and mental disorder. In a review of 39 studies that examined neuropsychiatric disorders and HIV in low and middle-income countries, Collins et al (2006) found that although many of these studies had methodological problems such as small sample sizes and no control groups, almost all studies found a high prevalence of mental disorder. In those studies that had control groups, PLHA had consistently higher levels of mental disorder than sero-negative people. More recently in Nigeria, Adewuya, Afolabi, Ola, Ogundele, Ajibare and Oladipo (2007) found a threefold higher rate of mental disorder among a clinic-based sample of PLHA compared to community controls. In a study in five provinces in South Africa, Freeman and colleagues (2008) found that around 44% of PLHA had a diagnosable mental disorder. Thirty percent suffered from depressive disorder (11.1% major depressive disorder), 12.4% had an alcohol use disorder and 2.9% alcohol dependence. Participants in stages 3 and 4 of HIV disease had higher rates of mental disorder. This prevalence of mental disorder amongst PLHA can be contrasted with the 16.5% prevalence of mental disorder found in a South African community sample using the same diagnostic instrument (Williams et al, 2008). A number of factors were associated with mental disorder in the HIV-positive group, including being unemployed, having children, experiencing discrimination and isolation, and having lost a close person as a result of AIDS. Participants in a support group were significantly less likely to have a diagnosis of a mental disorder (Freeman, Nkomo, Kafaar & Kelly, 2007). Suicidal ideation, even where people are on antiretroviral treatment, has been found to be high (Carrico, Johnson, Morin, Remien, Charlebois, Steward, et al, 2007; Sherr, Lampe, Fisher, Gilly, et al, 2008).

Simbayi and colleagues (2007) studied the relationship between internalised stigma and depression in PLHA receiving social and health services. Forty percent of the participants had experienced discrimination since learning their status. Men reported more internalised stigma than women, and women reported more depression. More than 30% of the sample met criteria for a depressive syndrome, and internalised stigma was an important predictor of cognitive-affective depression. Internalised stigma was associated with greater substance use, while social support protected against depression and internalised stigma.

The high prevalence of mental disorder amongst people living with HIV/AIDS can to some extent be accounted for by the increased risk of contracting HIV in people who already have a mental disorder; however, there are other biological as well as psychological reasons (Freeman 2005). For example the virus can penetrate the brain resulting in dementia for some people. It is possible that the weakening immune system may similarly result in depressive symptoms through the infection impacting the brain – though more research is needed on this. Notwithstanding, for most people an HIV diagnosis comes as a major shock and together with ongoing stresses of living with HIV can have serious psychological consequences – resulting in mental disorder for some. The stigma associated with being HIV positive can also greatly exacerbate this situation. Even with the greater availability of antiretroviral therapy PLHA still often experience high levels of psychological distress and mental disorder. Difficulties often include problems and decisions around relationships, having children, side-effects of medication and dealing with stigma.

Mental disorder affects the course of HIV/AIDS in two fundamental ways. Firstly, there is increasing evidence to show that where mental illness and HIV co-occur, the progression of the virus is greater. Secondly, mental disorder affects adherence to medication. Access to mental health services has been shown to decrease AIDS progression and mortality. A range of studies show that where HIV infection and mental illness co-occur, physical health suffers (Cook, Grey, Burke, Cohen, Gurtman, Richardson, et al, 2004; Antelman, Kaaya, Wei, Mbwambo, Msamanga, Fawzi & Fawzi, 2007; Greeson, Hurwitz, Llabre, Schneiderman, Penedo & Klimas, 2008; Hartzell, Janke & Weintrob, 2008). Moreover, one North American study (Cook et al, 2004) showed that AIDS-related deaths occurred more often in women with chronic depressive symptoms than in those who were not depressed; amongst the former those who used mental health services were less likely to die than those who did not. A Tanzanian study showed that 57% of HIV-positive women experienced depression at least once during the study period and that depression was associated with disease progression and mortality (Antelman et al, 2007).

Another very important means through which mental disorder impacts on physical health is through non-adherence to antiretroviral treatment. Depression, traumatic life events and psychosis have been linked to poor adherence to medication in adults and adolescents (Mugavero, Ostermann, Whetten, Leserman, Swartz, Stangl & Thielman, 2006; Williams, Storm, Montepiedra, Nichols, Kammerer, Sirois, et al, 2006). A review of HIV medication adherence studies found that “feeling depressed” was the second most cited barrier to adherence (Mills, Nachega, Bangsberg, Singh, Rachlis, Wu, et al, 2006). Moreover people with depression and/or anxiety have been found to be less likely to initiate antiretroviral therapy compared with those without mental illness (Tegger, Crane, Tapia, Uldall, Holte & Kitahata, 2008). Poor adherence has also been attributed to alcohol use (Dahab, Charalambous, Hamilton, Fielding, Kielmann, Churchyard & Grant, 2008) and to a reduced network of potential adherence support due to alcohol use among family members (Nachega, Knowlton, Deluca, Schoeman, Watkinson, Efron, et al, 2006).

## 5.2 Interventions supporting the mental health of PLHA

The World Federation for Mental Health Africa Initiative (2008) notes that “mental health has yet to be highlighted as a major issue in the context of the HIV/AIDS epidemic ... [and that] there is a significant gap between what is known about mental health and HIV/AIDS and what is done in practice” (p. 3). This is evident in the literature regarding primary mental health care for people living with HIV/AIDS (PLHA).

As indicated earlier (5.1), mental disorder is common amongst PLHA and has major implications for the treatment of HIV/AIDS. In developed countries, mental disorder and mental distress are increasingly being addressed in a range of ways, both at the individual and systems levels. In developing countries, there has been some attention to interventions to address severe mental disorder associated with HIV/AIDS, usually in specialised mental health settings (e.g. Jonsson, 2008). However, an extensive search failed to retrieve

more than a few reports from developing countries that specifically address CMD or distress in PLHA as part of primary or secondary-level interventions either within the formal health or social services or provided by organisations outside of the government sector.

In contrast, there is fairly extensive literature on what might broadly be called mental health interventions (including counselling and psychosocial support) in support of other priorities in combating HIV/AIDS but which have not been developed as mental health interventions as such. These priority areas include prevention and risk reduction, including prevention of mother-to-child transmission (PMTCT); voluntary counselling and testing (VCT) for detection of HIV and for its potential role in prevention; and promoting adherence to antiretroviral therapy (ART\*). In addition, reflecting the risk profile of a country, specific subpopulations have received attention, for example people with tuberculosis (TB) and injecting drug-users (IDUs).

To the extent that the above interventions may be intended to address mental health alongside the primary focus, the nature of mental health problems (whether sub-threshold or diagnosable mental disorder) is seldom specified and the mental health interventions are generally mentioned only in passing – usually as counselling or psychosocial support – without much detail about what exactly is involved. In the case of counselling, as many programmes make use of volunteer or community counsellors with limited training, it seems likely that in most instances interventions are limited to supportive counselling and perhaps problem-solving. Psychosocial support, on the other hand, appears to include a broad range of practices intended to address emotional, social and sometimes economic issues affecting PLHA. These may include individual, couple and family counselling, peer support or therapeutic groups, income generation activities and involvement in advocacy activities.

Few of the interventions have been subject to evaluation. Generally there are only descriptive statistics of utilisation (and then not always restricted to the mental health intervention itself) and, sometimes, qualitative accounts by users or providers of the interventions, which, although valuable as a tool for further development, do not answer questions of efficacy or effectiveness.

The above may reflect an early stage in a path that appears to have been followed in developed countries where the dominant focus was initially on the biomedical aspects of HIV/AIDS, but where the importance of attention to psychological and mental health issues for effective medical treatment and, especially, prevention has been recognised. More recently, there has been growing awareness of the need to develop interventions specifically aimed at CMD and distress, as a part of routine health care for PLHA, although still predominantly in the interests of engaging and retaining PLHA in medical care and treatment. Even so, it is not clear how far this awareness extends beyond pilot and model projects, given findings of low rates of referral for mental health care in some studies (Basta, Shacham & Reece, 2008).

In many developing countries, the scale of the epidemic, the lack of resources for effective treatment of HIV/AIDS, human resource limitations (especially of mental health professionals) – and, it has been argued (Kelly et al, 2008), the dominance of a biomedical approach to HIV/AIDS – has meant slow progress in developing mental health interventions. Hence, despite growing awareness of mental health issues (Remien & Mullins, 2007), steps to address mental health issues are usually not yet seen as an essential component of HIV/AIDS intervention programmes. Where mental health or psychosocial issues do receive attention, the target is often children and youth rather than adults (who are the focus of the present report), or adults primarily in their role as parents or caregivers (see, for example, World Federation for Mental Health Africa Initiative, 2008).

Because of the difficulties in identifying good practice examples of primary mental health care for PLHA in developing countries, we have taken the approach of initially listing potential targets for mental health interventions with PLHA, especially in developing countries. These include illness-related or psychosocial stressors; specific mental health symptoms or disorders (e.g. depressive symptoms, posttraumatic disorder (PTSD)); specific groups (e.g. women, or PLHA abusing substances) and social and structural cultural factors that may constitute barriers to maintaining or improving mental health.

\* We have used the abbreviation ART rather than HAART (highly active antiretroviral therapy) to include any use of antiretroviral drugs, including HAART and situations where more limited regimens may be used.

Within this context, we describe components of what appears to be emerging good practice in mental health care for PLHA – the package of care, provision for special categories of need, organisation of care, staffing issues and systemic and organisational issues – as previously discussed in relation to CMD in general health care settings. In some instances, practices piloted or implemented in developed countries are included, with the proviso, of course, that these practices will inevitably need adaptation for resource-poor settings. Guidelines and recommendations developed specifically for resource-poor settings that include mental health interventions are referred to where relevant, even when these were not specifically formulated for CMD as previously defined. This is on the basis that interventions addressing sub-threshold mental distress may, in fact, be particularly relevant to support PLHA in dealing with the stresses of learning their status and living with a chronic disease. (A selection of such guidelines is provided in Appendix A.)

We then describe a few specific examples of what we view as promising practices – selected primarily because there is sufficient information to illustrate the nature and target of the intervention and in some cases because at least some form of evaluation has been attempted. Those described have much in common with the more limited descriptions of a range of other projects across many countries and therefore provide a sense of the kinds of practices currently available. Finally, we draw some conclusions on mental health care and HIV/AIDS.

### 5.3 Specific targets for mental health interventions for PLHA

Taking a broad view, the literature has identified a range of potential targets for mental health or psychosocial interventions at individual, family and societal levels. They include the following:

- Illness-related stressors such as the experience of learning one's HIV-positive status, the challenges of lifestyle changes, living with a chronic illness, fluctuations in the course of the disease and long-term treatment with ART (Fernandes, Sanches, Mill, Lucy, Palha & Dalri, 2007; Thom, 2007; Arakelyan & Cholakhyan, 2008; Freeman et al, 2008; Kelly et al, 2008).
- Psychosocial stressors, in particular, dealing with disclosure and anticipating or experiencing HIV-related stigma and discrimination (Leonard, 1994; Rachier, Gikundi, Balmer, Robson, Hunt, Cohen, 2004; SIAAP India, 2004; Mahendra, Gilborn, Bharat, Mudoji, Gupta, George, Samson, Daly & Pulerwitz, 2007; Steward, Herek, Chandy, Singh, Panicker, Osmand & Ekstrand, 2008; Logie & Gadalla, 2008; Visser & Mundell, 2008).
- Quality of life and coping styles (Tostes et al, 2001; Jelsma, Maclean, Hughes, Tinise & Darder, 2005; Gopukumar & Rukmini, 2008).
- Specific mental health symptoms or disorders, in particular, depressive symptoms, anxiety, posttraumatic stress disorder (PTSD) (Tostes et al, 2001; Jelsma et al, 2005; Olley et al, 2005; Kelly et al, 2008).
- Groups with greater vulnerability to both HIV infection and mental health problems, in particular women (Lindsey, 2003; Olley et al, 2005; Tarakeshwar, Fox, Ferro, Khawaja, Kochman & Sikkema, 2005; Gwandure, 2007; Puig, Jimenez, Ramos Ayes, Sala, Castro Figueroa, Morales, Deliz, Santiago & Zorrilla, 2008) and PLHA abusing substances (Khalsa, Francis & Mazin, 2003; Malta, Carneiro-da-Cunha, Kerrigan, Strathdee, Monteiro & Bastos, 2003; Klinkenberg & Sacks, 2004; Stoff, Chief Mitnick & Kalichman, 2004; Malta, Petersen, Clair, Freitas & Bastos, 2005; Golichenko, Purick, Nerubaeva & Popandopylo, 2008).
- Potential sources of support (or additional pressure), such as sexual partners, family, peers (Seeley, Wagner, Mulemwa, Kengeya-Kayondo & Mulder, 1991; Leonard, 1994; Rotheram-Borus, Flannery, Rice & Lester, 2005; Orner, 2006; Priya & Sathyamala, 2007).
- Social and structural factors, such as stigma and discrimination, poverty (SIAAP, 2004; Chingore, 2007; Priya & Sathyamala, 2007; Stangl, Wamai, Mermin, Awor & Bunnell, 2007; D'Souza Yephthomi, Lakshmi, Ganesh, Gonzalez-Figueroa, Thompson, Deepak, Freiberg & Solomon, 2008; Freeman et al, 2008; Kelly et al, 2008; Sethulakshmi, Srikrishnan, Gonzalez-Figueroa, Thompson, Freiberg, D'souza Yephthomi, Vasudevan & Solomon, 2008; Visser & Mundell, 2008).

- Cultural factors, such as cultural communication patterns, or reliance on traditional healing practices, which may necessitate the adaptation of practices developed in other cultural settings (Seeley et al, 1991; Leonard, 1994; Leonard & Muai, 1998; Priya & Sathyamala, 2007; Lo, 2008; Luseno, Wechsberg, Kline, Middlesteadt-Ellerson & Browne, 2008; Mapara, 2008).

#### 5.4 Emerging good practice

As indicated above, emerging good practice is described in terms of the components previously described for CMD in general health care settings.

##### 5.4.1 Package of care

###### 5.4.1.1 *Screening for CMD*

Tostes et al (2001) in a study of HIV-infected women attending referral centres in Brazil, most of whom were on ART, found that a considerable number showed significant levels of psychiatric morbidity, but had not been receiving mental health care despite in some cases having previously received psychiatric treatment. Based on this finding, it was suggested that systematic screening, using a few questions or a short screening instrument, is necessary to improve detection of mental health problems amongst PLHA at primary care level. Chibanda and colleagues (2008) found similar rates of CMD amongst women and men attending an HIV clinic attached to a hospital in Zimbabwe and reached the same conclusion regarding the need for screening. This recommendation is similar to that reported above in relation to CMD in general. In Guyana, mental health screening is being integrated into the community-based home and palliative care programme (Gordon-Boyle, Steilen, Osborne, Singh & Williams, 2008). The WHO IMAI programme (IMAI, 2004a) also advocates routine screening for mental health problems.

###### 5.4.1.2 *Assessment*

As previously indicated, screening would be expected to identify a certain number of false positives for CMD and assessment is therefore necessary to confirm diagnosis and decide on treatment, even for conditions deemed to be sub-threshold. The IMAI Guidelines referred to above (IMAI, 2004a) outline steps for an initial assessment. A more comprehensive, but still quite concise guide for assessment and treatment of both common and more severe mental disorder in PLHA forms part of the WHO Mental Health & HIV/AIDS series (Cournos, Wainberg & Horwath, 2005). Although intended primarily for second-level care, the guide may be useful in distinguishing those cases that should be referred, or could be treated at primary care level. The latter would include depression and anxiety of mild-moderate severity.

###### 5.4.1.3 *Pharmacotherapy*

A range of studies has shown that access to ART significantly improves well-being and mental health, specifically depression and anxiety, implying that access to ART is itself a key mental health intervention. However, a diagnosis of HIV remains "profoundly distressing" for most people (Green & Smith, 2004) and suicidal ideation, even where people are on ART, has been found to be high (Carrico et al, 2007; Sherr et al, 2008). In addition, PLHA tend to have "new" problems around forming relationships, disclosure and demoralisation around side-effects of medication that also cause them to be depressed or suffer from anxiety. Findings in developing countries have been inconsistent and have tended to focus on measures such as quality of life (QOL) rather than mental disorder. For example, improvements in QOL have been reported from Kenya and South Africa (Jelsma et al, 2005; Fox, McCoy, Larson, Rosen, Bii, Sigei, Shaffer, Sawe, Wasunna & Simon, 2008). A Zimbabwean study of CMD among PLHA found that those on ART were significantly less likely to be diagnosed with CMD (Chibanda, 2008). A study in India (Gopukumar & Rukmini, 2008) did not, however, find any significant effects on QOL and coping styles, although it was noted that longer-term findings might differ. Jelsma and colleagues (2005) suggested that, to maintain adherence and hence improved QOL related to ART, additional support measures such as counselling and support groups may be necessary.

PLHA with CMD can benefit from the use of psychotropic medication. The WHO basic guide to assessment and treatment referred to earlier (Cournos et al, 2005) provides guidance in this regard. The key messages are that most psychotropic medications are well tolerated by PLHA on ART, but that dosages need to be adjusted to the individual depending on response and tolerability. Drug interactions and resultant reduced effectiveness or toxicity may occur when using some psychotropic medications and specific antiretroviral drugs (ARVs). Hence it is advisable to “start low, go slow” and to avoid as far as possible using multiple psychotropic medications, as this may increase the risk of drug interactions and toxicity. Developing countries differ, however, as to the availability of psychotropic medications (in particular, at primary care level) and the extent to which primary care staff (e.g. doctors, psychiatric nurses) are permitted to prescribe these medications. Issues of supply similar to those previously discussed also apply.

#### 5.4.1.4 *Counselling and psychosocial support*

The literature on HIV/AIDS abounds with references to “counselling” or “psychosocial support”, sometimes used interchangeably. However, as indicated before (5.2), in many instances the terms are used without any indication of what is involved. An exception is a thoughtful review of counselling for HIV-infected women and their families (Lindsey, 2003). Written primarily from the perspective of prevention-of-mother-to-child transmission (PMTCT) services, it nevertheless outlines key issues relevant across the board in HIV-related counselling and psychosocial support. In particular, the review highlights the need for counselling services of various kinds alongside lack of awareness or prioritisation of that need.

##### **HIV/AIDS-related forms of counselling**

*Voluntary counselling and testing (VCT):* Counselling provided to individuals requesting an HIV test; prior to testing, intended to assure informed consent, based on an understanding of HIV transmission, assessment of personal risk, consideration of the implications of testing positive or negative and information about the test itself; with post-test counselling in the case of those testing positive intended to help the person understand the result and cope with feelings and implications related to the result.

*Couple counselling and testing (CVCT):* As for VCT, but provided to a couple, with the intention of maximising support between the partners to cope with a positive result.

*Adherence counselling:* Counselling provided in preparation for starting antiretroviral therapy and regularly thereafter to maintain adherence, which includes provision of information on ART and dealing with interpersonal and emotional barriers to the high levels of adherence required.

Among the forms of counselling which are intended either directly or indirectly to provide psychosocial support specifically for PLHA are voluntary counselling and testing (VCT), couple counselling (CVCT), adherence counselling, and support groups for PLHA. Seldom mentioned is informal counselling in the course of health care consultations or other activities (e.g. home-based care, income generation) in which PLHA may be engaged. Although the primary focus of all these interventions is generally to support the well-being and treatment of PLHA, rather than mental health as such, they are currently the most widely available psychosocial interventions of any kind for PLHA.

In addition to the foregoing, there is reference, primarily in developed countries, to the use of more traditional mental health interventions, namely psycho-education and various psychotherapeutic interventions (e.g. cognitive behavioural therapy, short-term psychodynamic therapy) with PLHA. A module of the WHO Mental Health & HIV/AIDS series (Catalan, 2005) provides a brief account of five psychotherapeutic interventions that referral-level health workers may find useful in working with PLHA. The extent to which these are available or feasible in developing countries is unanswered in the literature.

Each of the various counselling interventions is now discussed in more detail.

##### **a) Voluntary testing and counselling (VCT)**

Counselling and testing has been essential to HIV diagnosis and entry of PLHA to treatment and care. Because of the levels of stigma, limited access to treatment in developing countries and human rights concerns, the emphasis has been on voluntary counselling and testing, involving pre-test counselling,

informed consent for testing and post-test counselling in relation to the test result. In recent years, because of relatively low rates of uptake of VCT and with increasing access to treatment, arguments have been made for a shift to routine, provider-initiated, opt-out testing (as opposed to the opt-in basis for VCT) to increase the numbers in treatment and decrease infection risk for others. This approach would generally truncate the extent of any counselling. In some cases the provider need merely indicate that testing will be performed unless the client declines and there is no requirement for written consent apart from the general consent for health care (CDC, 2006). The standard of care remains that, regardless of opt-in or opt-out, clients must be given the option and have the right to refuse testing; consent to accept testing must be informed, based on certain minimum information provided to the client (which may be primarily through groups), and obtained in private, though not necessarily in writing (UNAIDS/WHO, 2004).

There are concerns that routine, provider-initiated, opt-out models ignore the continuing reality of stigma and discrimination and the lack of access to treatment for many and also fail to recognise the importance of properly informed consent as a first step towards treatment readiness and positive prevention (Chingore, 2007). However, even with VCT, the power imbalance between health care workers, especially doctors, and patients (WHO, 2006), organisational factors such as time and human resources and low levels of counsellor skill have often combined to limit pre-test counselling to the provision of standard information only and to render consent neither informed with regard to the health, emotional and social implications of a positive test, nor voluntary (SIAAP, 2004; Rohleder & Swartz, 2005). Post-test counselling, even in the case of people testing positive, is likewise often brief and limited to a once-off session, with priority given to medical investigation and care rather than helping the person deal with the implications of the test result.

Nevertheless, VCT (and any follow-up counselling where it occurs) is currently often the primary and usually the only intervention that may be said to address mental health issues related to HIV-positive status to any extent. Pre-test counselling is usually intended to cover provision of information regarding HIV/AIDS, risk assessment and risk reduction counselling and consideration of the implications of testing HIV-negative or positive (e.g. options for disclosure and support). Post-test counselling is intended to deal with emotional reactions to the test result (including assessment of mental state and suicide risk) and to refine plans for responding to the outcome (see, for example, SEARO, 2004). The extent to which and how appropriately these issues are covered varies depending on the competence of the counsellor and limiting or enabling organisational factors.

The intervention is by definition limited to the very early stages of learning one's status, when most individuals are likely to be asymptomatic. A number of studies have found this stage to be associated with lower rates of mental disorder (Freeman et al, 2008). It has been suggested, however, that counselling at this stage may reduce the chances of mental disorder at later stages of the disease.

In a study of 900 PLHA recruited at primary care and NGO sites in South Africa, Freeman et al (2007), however, found no association between the presence of diagnosable mental disorder and having had pre- and post-test counselling, the number of sessions, the professional status of the counsellor (generally a lay counsellor or nurse), or perceived helpfulness of counselling. The authors noted that pre- and post-test counselling in South Africa is limited by its usually relatively short duration and by the fact that post-test counselling for individuals testing positive occurs when the individual is having to absorb confirmation of the diagnosis and associated feelings and concerns. There is seldom more than limited, if any, follow-up or referral to work through feelings and concerns or consolidate gains. Nevertheless, the authors noted that it is possible that, though not protective for mental disorder, counselling may assist PLHA to cope with their HIV-positive status and that this in itself would have value.

Finding out one's HIV-positive status evokes a range of emotional reactions (commonly including shock and disbelief), as well as concerns related to relationships (including sexual and parenting relationships), disclosure, stigma and discrimination and one's future. It is these, as well as informational needs related to management of an HIV infection as a chronic disease and engagement in positive prevention, that counselling linked to VCT might usefully address (Kelly et al, 2008). Provision of information should thus extend beyond what is required to obtain (informed) consent – it should also counter misconceptions about HIV/AIDS as synonymous with death and help the person understand that it is possible to live with the disease. In this regard, it is worth noting that it is this aspect of counselling that many clients want and most value (Rachier et al, 2004; Sibeko, MacPhail, Pettifor, Mwale, Moyes, von Molendorf & Rees, 2008).

To provide the necessary information and to help the person understand it and process the implications, as well as deal with the feelings and concerns mentioned above, however, requires an intervention extending beyond the immediate post-test period. This is because the individual's mental state at that point is generally "fractured, chaotic and often lacking in resolve to raise and discuss the consequences" of having tested HIV-positive (Kelly et al, 2008). In other words, follow up counselling is essential for effective intervention. It should be noted, however, that individuals do not always wish to have further counselling at this stage. Sibeko et al (2008) reported from a small qualitative study that some of their subjects preferred not to discuss their status further after first learning the diagnosis. This preference may reflect an avoidant coping response, which, alongside more practical issues of costs related to attendance, may account for anecdotal reports of a significant drop-out rate where follow up counselling is in fact offered. There is also the question whether the quality of VCT as presently provided – in terms of counsellor skill and duration of sessions, to mention just two factors – impacts negatively on the perceived usefulness of counselling and hence motivation to return for follow up.

If VCT is to have value, therefore, it is essential that measures are put in place to assure its quality. Measures related to staffing, training and supervision are discussed further below. Here we note only that other members of the health care team and management frequently have a rather limited understanding of both the potential and the requirements of effective counselling (Rohleder & Swartz, 2005). Unless there are changes in this regard, counselling will continue to fall short of what it might achieve by way of contributing to the mental health of PLHA.

#### **b) Couple counselling**

Couple HIV counselling and testing (CDC/Global AIDS Programme, 2007) is a variant of VCT as discussed earlier. It has been promoted as a means to address high levels of sero-discordance in stable couples as well as a number of other problems commonly arising in individual counselling of sexual partners (Desgrées-du-Loû & Orne-Glieman, 2008). These include, in particular, reluctance to disclose the PLHA's positive status to sexual partners – in the case of women, often linked to fear of rejection, abuse and/or withdrawal of financial and material support for her and, often, also children of the partnership; with the consequence of failure to adopt safer sex practices, specifically, condom use.

The rationale for couple VCT counselling is that partners are prepared for and learn their status, whether concordant positive or negative or discordant, together, in an environment that supports their managing and dealing with the outcome jointly, as a couple. In this model, disclosure and negotiating safer sex practices is not a separate process, reliant on one partner facing the other partner alone, but is integral to the process of the couple learning their status. The model also promotes support between partners to deal with other implications of the outcome, particularly in the case of one or both testing positive. However, it has been noted that thorough risk assessments or dealing with discordance are challenges that many counsellors find difficult to manage in couple counselling (Lindsey, 2003).

It is not clear whether couple counselling in fact reduces the likelihood of negative or violent outcomes (Desgrées-du-Loû & Orne-Glieman, 2008). In cases of sero-discordance, more frequent break-up of partnerships has been reported, particularly where the woman is the sero-discordant partner. However, this appears to occur regardless of the form of counselling (individual or couple). With regard to violent reactions to disclosure of positive status by a woman to her partner, although rates may be lower than many women assume, there are conflicting findings. In particular, there is no definitive indication of the extent of violence or its reduction as a result of couple counselling.

Promotion of couple counselling apart from its application in VCT has been described by Voramongkol and colleagues (2007). Health workers working in prevention of mother-to-child-transmission (PMTCT) were trained in communication and counselling skills and introduced to concepts of couple counselling and family relations. Assessment by questionnaire indicated improvement in knowledge and participants rated the training positively. Follow up assessment is planned.

Despite its apparent promise and generally positive responses from those who participate, couple counselling programmes have faced challenges in recruiting couples (Rao Gupta, Whelan & Allendorf, 2003; Desgrées-du-Loû & Orne-Glieman, 2008;). When such services are based in health care settings, this may reflect the common underrepresentation of adult men in these settings and their predominantly

female character, both in terms of services and staffing. Cultural beliefs and practices regarding the respective roles of men and women, especially in engaging with health services, also appear to contribute to low uptake (Mlay, Lugina & Becker, 2008).

### c) Adherence counselling

Anti-retroviral treatment (ART) demands very high levels of adherence – in excess of 95% – both to promote viral suppression and to prevent the development of drug resistance. Adherence has been shown to be associated to a large extent with psychosocial factors, including depression, self-efficacy, behavioural skills, social support and the patient's relationship with health care providers (Remien & Mullins, 2007; Kelly et al, 2008). Hence, adherence counselling is commonly included in ART protocols and includes both preparatory counselling (commonly at least three sessions), as well as regular sessions once the patient has started ART (see, for example, Saloner, 2005). While medical, nursing and pharmaceutical professionals may be involved to some extent in adherence counselling, especially prior to ART initiation or in cases of poor adherence, their focus is often largely on the medical aspects, including dealing with side-effects. Other categories of staff, including lay counsellors, are often responsible for the more routine aspects of information provision and monitoring and for providing general psychosocial support and assistance in dealing with emotional and interpersonal issues.

Despite the important role of psychosocial factors, attention to them appears to take second place to biomedical factors in adherence counselling. In time-limited encounters with staff with limited training in counselling, there appears to be little room for the more in-depth exploration of personal issues that effective counselling demands (Lindsey, 2003).

### d) Psycho-educational counselling

What has been referred to as psycho-education (used here as in 4.1.4.2) may assist in overcoming the difficulty that many clients have in absorbing relevant information in the immediate post-test situation, with the lack of or distorted understanding potentially feeding anxiety and depression. Olley (2006) has reported the development and evaluation in Nigeria of a manual-driven, individualised, four-session psycho-education programme for HIV-positive individuals in the weeks following testing and diagnosis. On short-term (4-week) follow-up, compared with wait-listed individuals, those exposed to the psycho-education programme reported higher rates of self-disclosure of their HIV status and improvement in safe sexual practices and showed reduced rates of depression. Although longer-term evaluation is necessary to assess whether these gains are sustained, this approach does offer a means of supplementing VCT. Although its individualised nature may limit its wider application, the fact that it is manual driven may increase the range of personnel who could be trained to use the approach.

### e) Follow up/ongoing counselling

As indicated above, the mental health and psychosocial issues confronting PLHA can seldom be dealt with adequately within the confines of once-off VCT and follow up is essential to provide effective support. Issues facing PLHA change over time and counselling can assist them to deal with these issues, which may otherwise constitute a stressor, possibly contributing to the development of more severe mental disorder and deterioration in the person's physical health. Some of the issues commonly confronting PLHA include dealing with the feelings associated with living with a potentially fatal but chronic illness, questions of disclosure, relationship problems, periodic crises, (often related to changes in health status, suicidal thoughts), and grief and bereavement. One of the modules in the WHO Mental Health & HIV/AIDS series (Lazarus & Saloner, 2005), drawing on guidelines developed by the Southern African AIDS Trust (2000a; 2000b; 2001b), provides basic guidelines to assist lay counsellors and generalist health workers to deal more effectively with issues of this kind.

### f) Informal counselling

Communication about health and related matters, as discussed in relation to CMD (see 4.1.4.1), undoubtedly happens in the course of health care consultations with PLHA. This would include, for example, discussion about options for termination of pregnancy or infant feeding with an HIV-positive pregnant woman in a PMTCT service, providing information about an HIV-positive patient's health status (in particular, CD4 and viral load levels), discussing adherence levels and providing adherence support for those on ART and

dealing with changes in health status and treatment regimes. Guidelines on health care of HIV-positive patients generally refer to the need to address mental health and psychosocial issues in the interests of assuring effective health care (see, for example, WHO IMAI guidelines on acute, chronic and palliative care, 2004a, b, c). A programme in Tamil Nadu, India, includes psychosocial counselling alongside nutritional and adherence counselling as part of case management by outreach workers (Srinivas, Lokabiraman, Viswanathan, Kanagasabapathy, Vallinayaki, Saravanan, et al, 2007). However, the manner in which psychosocial issues are dealt with in general health consultations is likely to range from simply giving information and advice, to more genuine engagement with patients around lifestyle and emotional and social issues and mental health problems.

#### 5.4.1.5 Psychosocial support groups

Psychosocial support groups are widely seen as a cost-effective means of providing emotional and social support for PLHA. One of the modules in the WHO Mental Health & HIV/AIDS series provides detailed guidelines on running support groups (Sweetland, Lazarus, Freeman & Saloner, 2005). A number of other initiatives to develop and evaluate support group programmes addressing the needs of PLHA have been reported. Sikkema and colleagues (1995) reported on the development of an eight-session series of support groups addressing AIDS-related bereavement. Based on theories of cognitive behavioural coping, a pilot study demonstrated significantly reduced depression, intrusive experiences, grief reactions, demoralisation, and overall psychological distress immediately following the intervention and at a three-month follow-up assessment. Munoz and colleagues (2008) have initiated a structured ten-session series of psychosocial support groups in Lima, Peru. Initial participant evaluation of the groups was positive in respect of helping them to cope with their illness and reduce risky behaviour. Irregular attendance amongst a minority of participants was related to demands of work, childcare and medical appointment.

Some initiatives have focused on developing support group curricula for HIV-positive women (WLHA) specifically. It has been suggested that support groups may be particularly valuable for WLHA, who often have more limited opportunities for support (Sethulakshmi et al, 2008). A number of these initiatives will be described (5.4.3.1 *Special categories of need – women*).

A number of studies have indicated that it is the factor of peer support that is crucial. Arakelyan and Cholakhyan (2008) have noted that peer support is most valued because of its insider knowledge and support both in relation to the condition and its psychosocial consequences. Sethulakshmi and colleagues (2008) also noted that the involvement of PLHA themselves in developing support groups is critical to their success.

A study in South Africa (Freeman et al, 2007; Kelly et al, 2008) found that participation in support groups was significantly associated with reduced rates of mental disorder. Reported rates of attendance and assessments of the value of the groups were high. Although there may have been a selection bias in that those attending are already at less risk of mental disorder, the findings suggested that being a part of a support group may be protective in respect of mental disorder. If so, this may be the result of participants' perceptions of the availability of a supportive context, rather than the specifics of the experience. Similar findings with regard to the importance of perceived as opposed to actual support have been reported elsewhere (McDowell & Serovich, 2007). This suggests that extending the availability of support groups is more important than being too concerned about factors such as the number of sessions or content of those sessions.

Despite the generally positive views on the value of support groups, establishing support groups is not necessarily a straightforward exercise. Visser and Mundell (2008) have reported on attempts to set up support groups in clinic settings in Tshwane, South Africa and highlighted that establishing sustainable support groups requires attention to systemic factors, establishing relationships of trust (including with potential participants) and careful negotiation with relevant stakeholders.

Support groups often founder because PLHA cannot afford the costs of regular attendance. A more profound reason is that support groups do not address more basic needs for food and shelter. In an attempt to provide an integrated response, some psychosocial support initiatives include or are primarily focused on income generation (Southern African AIDS Trust, n.d.). This is seen as simultaneously a way to help

PLHA to deal with emotional and social challenges, to meet basic needs and, in some cases, to provide PLHA with skills and thereby promote empowerment and enhanced self-esteem (D'Souza Yephthomi et al, 2008; Sethulakshmi et al, 2008; Visser & Mundell, 2008).

#### 5.4.1.6 Formal psychotherapeutic interventions

##### a) CBT and related therapies

As outlined in 4.1.5.1, cognitive-behavioural therapies (CBT) are based on psychological models such as learning theory and information processing models and employ a range of therapeutic techniques to attempt to change thoughts, beliefs and/or behaviour that are understood to underlie distressing emotions such as depression and anxiety (National Institute for Clinical Health & Excellence, 2007).

As for CMD more generally, CBT has been widely advocated for use with PLHA. The Tool Box segment of the Summer 2008 issue of *Mental Health AIDS* provided an overview of recent reviews and meta-analyses of CBT, stress management (regardless of type) and cognitive-behavioural stress management used with PLHA (Feingold, 2008a). With regard to CBT, the findings have generally been positive, as they have also been for both generic and behavioural stress management. However, it was noted that in one study, negative mental health outcomes were reported for PLHA receiving CBT. More importantly, the overview pointed to a number of methodological shortcomings in the studies reviewed. As a way forward, it was suggested that it could be worthwhile to develop cognitive behavioural and stress reduction interventions that are tailored more directly to the kinds of stressors experienced by PLHA. Finally, the need to find acceptable means of disseminating interventions more widely was highlighted – because of concerns about confidentiality, not all PLHA are comfortable when such interventions are delivered on a group basis, but intervention at the individual level may not be cost-effective.

##### b) Short-term psychodynamic psychotherapy (STPP)

Short-term psychodynamic psychotherapy (STPP) involves a time-limited and focused application of key psychoanalytic concepts and techniques. It aims to “elucidate a patient’s unconscious conflicts, encourage the expression and resolution of disturbing emotional states, create conditions in which the patient gains insight, and explore predisposing factors arising from the patient’s developmental history. These aims are achieved by focusing on current and past interpersonal relationships and via the therapeutic effects of the patient-therapist relationship” (Lewis, Dennerstein & Gibbs (2008), quoted in Feingold, 2008b).

In an overview of recent reviews of the status of STPP, Feingold (2008b) indicates that there is increasing evidence that STPP can be an effective treatment for mental health problems, specifically depression and anxiety disorders. However, only one study of the use of STPP with PLHA was identified. Significant reductions in distress were reported after 20 sessions with graduate student therapists in training, but it is questionable how far these results can be generalised, since the sample was of American, predominantly white MSM (men who have sex with men), who had voluntarily sought therapy. In addition, although 20 sessions may be considered short term in comparison with traditional psychodynamic therapy, in the context of the lack of resources in developing countries, models requiring this number of sessions would not be feasible.

##### c) Cognitive processing and post-traumatic growth

Before leaving the subject of counselling and therapy, it is worth referring to two further reviews in *Mental Health AIDS*. The first reported on efforts to understand the role of expression of emotion in psychosocial support for PLHA (Feingold, 2003). Contrary to popular perceptions in some social contexts, there is evidence that both high levels and strong inhibition of expressed emotion may have adverse effects on health and mental health. On the other hand, moderate expression of emotion has been shown to be helpful, specifically when it is processed and given meaning in a counselling or therapeutic encounter. Rather than encouraging emotional expression as a release for its own sake, it is the working through and making meaning of experience that is of value. These conclusions have implications for counselling of all kinds.

In a second review, aptly entitled "From surviving to thriving", Feingold reported on findings indicating the occurrence of post-traumatic growth (PTG) in the course of HIV/AIDS, that is, some individuals experience positive changes following diagnosis and thereafter, including increased appreciation for life, more meaningful interpersonal relationships, increased sense of personal strength, changed priorities and a richer spiritual life (Feingold, 2007). There is some evidence that PTG is associated with lower levels of depressive symptoms/distress over time. However, the findings suggest that while developing and maintaining PTG may have a protective effect on the development of depressive symptoms, the presence of depressive symptoms is an obstacle to achieving PTG.

PTG does, of course, most often happen in the course of interaction with significant others and through involvement in support groups and other peer support initiatives. However, it may also be facilitated in the course of counselling or psychotherapy and the review has summarised guidelines on how this may be done. A caution particularly relevant for lay counsellors addressing "positive living" with their clients is that promoting post-traumatic growth does not amount to simplistic encouragement of "positive" thinking and avoidance of negative thoughts and feelings. Rather, clients need to be supported and encouraged when, through their own process of meaning-making, they recognise and celebrate growth.

#### *5.4.1.7 HIV/AIDS-specific psychosocial techniques*

Despite or perhaps because of the limited provision of formal mental health interventions, a number of novel techniques have been introduced to address psychosocial issues affecting PLHA. These have often been developed by practitioners outside the formal mental health field and many are specifically designed for use by non-professionals, often working with groups of PLHA. Many share common features, such as using drawing, painting, collage and writing, together with discussion (usually in groups), to explore and work through experiences of PLHA and to develop alternative understandings and plans to deal with problems. Three such techniques are the health journey, body mapping and memory work.

##### **a) Health journey**

The health journey (Green, 2007) is a simple tool that can be used with groups or individuals to support the treatment and care of PLHA. It was developed during the early days of the public health scale-up of ART and has been used in a wide variety of settings in the Caribbean, Zambia, Uganda, Nigeria, Myanmar and China. The tool makes use of the concept of a journey to explore experiences of PLHA, including both positive and negative aspects of physical health and treatment, emotional reactions, relationships, service delivery and coordination, and community attitudes. The key activity involves drawing a map of a person's health journey, based on interactive discussion about the person and the people and institutions that affect that person's journey. The discussion that generates the map encourages sharing of perspectives on issues relevant to treatment, care and support and generally leads to discussion of ways to overcome obstacles captured in the map. Most often, the discussion is based on a fictional person, who typifies a problem or problem for the group or community. However, the tool has been used with individuals, or in a support or therapeutic group setting, as a starting point for developing positive living plans or providing adherence or other support, or problem-solving in relation to emotional and interpersonal issues.

Because of its simplicity and flexibility, the health journey offers a tool that could be used to address a range of psychosocial issues on an individual or group basis. However, to realise the tool's full benefits, facilitators working with groups need to be skilled in the use of a participatory approach. If used with individuals, partners or families (e.g as an adjunct to adherence counselling), the facilitator would need to be aware of the need to contain emotions that the discussion and mapping exercise might evoke.

##### **b) Memory work**

For PLHA who are parents, their children's future is one of their greatest concerns, particularly where there is limited access to ART (TASO, 2003; 2005; Tarakeshwar, Krishnan, Johnson, Solomon, Sikkema & Merson, 2006). Memory work provides an opportunity for addressing this concern. It was first used by Barnado's in the United Kingdom in the 1990s in work with African families affected by HIV/AIDS and then introduced in Uganda in 1997 in collaboration with the National Community of Women living with AIDS (NACWOLA). Working with the International Memory Project (IMP), the approach has been extended to Ethiopia, Kenya, Tanzania and Zimbabwe and recently to three states in India. In each case, the approach (documented in a manual) has been adapted to the local context, but the objectives and principles remain

common. These are to support parents and other caregivers of children facing potential loss of their parents through AIDS-related death by encouraging open communication about HIV within the household, providing children with a sense of identity and belonging and helping parents and children prepare for the possible loss and separation together. Memory work is usually introduced in a group setting, where PLHA who are parents or caregivers come together in the interests of their children, thus also providing a context of peer support. While the objective of memory work is primarily to support children, the impact is wider – providing emotional release and increasing support for parents and caregivers and combating stigma in the family and community. The work has been evaluated using a qualitative approach (Most Significant Change) technique, which tends to confirm its utility in a range of settings.

An important tool in memory work is a memory book or (box) developed by PLHA (sometimes in collaboration with children and other family members) as repositories of memories and histories of the parent and family and which provide for the sharing of information and feelings in a supportive, structured and safe way. A development from the original memory work that takes into account the wider availability of ART (Morgan, 2004) uses a similar approach, but focuses on empowering PLHA to live positively, hold on to and even celebrate life. Memory here includes knowledge, thought, feeling and action and encompasses past, present and future as a continuous process. The work also more directly acknowledges the great diversity of experiences of PLHA.

### c) Body mapping

The body mapping approach was developed as part of a Memory Box Project then being run in Khayelitsha, South Africa. It became a tool for helping people to tell their life stories and share their feelings by drawing and painting, or putting things into words. Whereas the original memory box approach helps PLHA to prepare for their own deaths by putting together a story of their life for their children, body mapping, like the more recent memory work described above, helps PLHA in the age of ART to find ways to live as people with a future. A recent variation of the approach encourages PLHA to question the centrality of HIV/AIDS to their identity and to rediscover and celebrate other parts of themselves. The approach has been field-tested in Tanzania, Zambia and Canada and is described in a detailed facilitator's guide (Solomon, 2007).

As in the case of the health journey, facilitators of memory work or body mapping need to be skilled in group work and able to contain emotions that may be evoked by participation in the activity.

## 5.4.2 Organisation of care

### 5.4.2.1 Case management

With reference to approaches previously discussed in relation to CMD, Handford and colleagues (2006) reported that, in respect of HIV/AIDS, case management appeared to hold promise as regards improving mortality, uptake of ART and other health-related outcomes. No specific mention was made of improved mental health. Malta and colleagues (2003) have reported on the use of a specialised outreach case management team in Brazil to address the clinical and psychosocial needs of PLHA who are also IDUs through group discussions and individual counselling of PLHA at drug centres. Whether the highly specialised outreach team, supported by its multi-disciplinary home base, could be replicated more generally in Brazil or in other developing countries is open to question.

### 5.4.2.2 Collaborative care

Drawing on models of treatment for dual diagnoses (mental health and substance abuse), a central theme in the literature is the need to address multiple co-occurring diagnoses (CODs) simultaneously. These include not just HIV infection and mental disorder, but also, frequently, substance abuse – hence reference to a "triple diagnosis" (Klinkenberg & Sacks, 2004). HIV infection, post-traumatic stress disorder (PTSD), and substance abuse are a set of common CODs that would benefit from an integrated approach to treatment (Bookhardt-Murray, n.d.). In many developing countries, it is recognised that the common dual diagnoses of HIV infection and TB share similar treatment challenges and cannot be treated in isolation from each other (Kemenang & Ndikum, 2007). The existence and growing problem of CODs in developing countries makes the development of appropriate models particularly urgent.

Traditional approaches have required people with CODs to access different facets or systems of care in sequence or in parallel, according to differing criteria and on an uncoordinated basis, posing barriers to effective care (HIV/AIDS Treatment Adherence, Health Outcomes and Cost Study Group, 2004). In contrast, successful treatment of COD is seen as requiring an end to the fragmentation of services in order to provide for the multiple needs of PLHA – to “treat one person – not three [or more] diagnoses” (Stoff et al, 2004, p. 2). To meet these needs, care must be integrated, comprehensive and continuous (Klinkenberg & Sacks, 2004). Care is seen as integrated when active steps are taken to combine interventions for HIV, substance abuse and mental health. This may be facilitated through a range of measures, from improved communication between different service providers, through to consultation, coordinated treatment planning, delivery through a single primary treatment provider or within the same service site and, finally, integrated service teams. Care is comprehensive if it addresses a range of issues (including specifically adherence because of its importance for all the co-morbid conditions), as well as issues in related sectors, for example housing and transport allowance. Continuity of care refers to factors such as consistency and coordination across time and across levels of care and different sectors. These proposals are reminiscent of primary mental health care models discussed earlier that involve expanded linkages or more integrated collaboration between generalist primary health care and specialist mental health care and with other sectors, although perhaps with a stronger emphasis on continuity of care.

A 2004 review of care for PLHA supported the use of a range of primary and ancillary and supportive services provided by a multidisciplinary team, but noted that the evaluation of existing integrated care models had been limited to utilisation and operational issues such as sustainability, rather than outcomes (Soto, Bell & Pillen, 2004). A Cochrane review (Handford et al, 2006) found that multidisciplinary and multi-intervention programmes may improve outcomes, but concluded that variation between programmes made it difficult to determine which components were critical. The review noted the need for more detailed description of models, clearer definition of terms and the development of innovative models for developing countries. It appears that, beyond a certain minimum of services, it may be the principle of service integration, rather than the presence of a variety of services (specifically multidisciplinary or specialist services), that is important.

Projects supporting collaborative care in developed world settings have been described in the literature. In what appears to be an example of a relatively early stage of integration as described above, Halloran and colleagues (2008) have described a combined educational and liaison initiative developed to combat fragmentation and stigma, which were found to be major barriers to patients with COD accessing relevant services, especially in relation to trauma. Two programmes were designed to enhance, on the one hand, the medical knowledge of mental health workers (social workers, counsellors and peer advocates) and, on the other, the mental health knowledge and skills of HIV primary care providers, while also building stronger relationships between the two sets of providers and countering stigma. It was noted that this initiative did not need major additional resources.

A similar primarily educational intervention has been described in Canada (Mahan, de Prinse & Halman, 2008). The programme drew on existing expertise in mental health and aimed to enhance knowledge on mental health issues amongst practitioners dealing with PLHA, good practice, resources and treatment options. The programme created a forum for inter-professional education, inter-agency communication and review of current practices.

A project located at an inner-city clinic in Providence, Rhode Island, USA, that extends beyond educational interventions has been described by Zaller, Gillani and Rich (2008). The project is staffed by a multidisciplinary team that works closely with primary care staff to ensure that PLHA with CODs receive comprehensive and continuous services. This is done through case management and advocacy and by building linkages with referral services within and outside the health sector.

The above projects are located in developed world settings, where access to resources is substantially greater than in the developing world. However, the need for comprehensive care for CODs that is as far as possible continuous and integrated across care providers has also been recognised in a number of developing countries, particularly where there are high rates of injection drug use (Khalsa et al, 2003; Malta et al, 2005; Golichenko et al, 2008). A similar initiative with strong linkages to TB care has been reported for Mocambique (Raposo, Mabaia, Benevides de Barros, Muiambo, Sebastian, Nelson, et al, 2008). However, apart from counselling linked to HIV testing, these examples do not all explicitly include mental health. In

the project described by Malta and colleagues (2003) in Brazil, the outreach team that provided clinical and psychosocial services for PLHA with co-morbid injecting drug use also offered consultation to and engaged in collaborative care with health care professionals from diverse backgrounds at the drug centres.

Whether such shared or collaborative care invariably requires multidisciplinary or specialist involvement is, as indicated above, not clear. It is possible that alternative resources, in particular, nongovernmental, community-based and faith-based organisations may be able to supplement health care to provide, if not fully comprehensive care, then at least more comprehensive, integrated and continuous care than the health sector alone.

#### *5.4.2.3 Collaboration with nongovernmental, community-based and faith-based organisations (NGOs, CBOs, FBOs)*

In many developing countries NGOs are playing a leading role in providing care, including psychosocial support, for PLHA. Indeed, it has been argued (Leonard, 1994) that CBOs are, in the African context and in the face of the immense demands on health and other infrastructure and resources, the first line of defence against HIV/AIDS. Whether one accepts the argument or not, it is clear that in many instances, organisations outside of government are the only source of psychosocial care for PLHA. Some organisations focus on particular groups, for example, children and youth, or women or pregnant women, or injecting drug users (IDUs). Women have often been at the forefront in starting and expanding the work of NGOs dealing with HIV-related issues.

A variation on the theme of integrated, "wrap-around" care, especially in the case of CODs, which may be particularly relevant to poorly resourced countries, is therefore that between health services and care in the community by NGOs, CBOs and FBOs. The development of linkages and closer collaboration between the various role-players can be challenging and requires recognition, negotiation and adaptation of the different cultures characteristic of health care and these organisations (Jackson & Ilaria, 2008). For this to happen, it is necessary that there be a structured and developmental process to create agreed mechanisms and procedures that will facilitate the entry and maintenance of PLHA in care. Although the specific dynamics may be different in different countries (e.g. differences in power based on expertise or access to funding), the need for negotiation is likely to be similar if positive outcomes are to follow.

An integrated care approach has been used to significantly expand prevention, VCT, treatment, psychological and nutritional services and uptake thereof in a number of countries. In Mali, the approach involved building a tightly-knit network of partners amongst CBOs, PLHA and public and private health providers, and training community leaders and peer educators to engage in community mobilisation and support (Dembélé, Koné, Traoré & Traoré, 2007). Similarly, in Brazil, a close connection between health services and NGOs that provided support for PLHA was considered instrumental in maintaining their well-being and ART adherence levels (Remien & Mullins, 2007). In the Ukraine, close collaboration between government health services and NGOs, including groups and organisations of PLHA, was considered key to providing a comprehensive treatment package of ART, peer counselling, psychosocial support and adherence support (Perepelytsia, Filippovych, Scherbynska, Burgay, Antonyak & Kurpita, 2007). In India, NGOs have worked with public sector health services and engaged in community mobilisation to extend care for PLHAs (Punitha, Baskeran & Edward, 2004). In Armenia, closer collaboration with organisations of PLHA in particular has been seen as important to create a more comprehensive psychosocial support network for PLHA (Arakelyan & Cholakhyan, 2008).

### **5.4.3 Special categories of need**

#### *5.4.3.1 Women*

For a complex variety of reasons, women are more vulnerable than men to HIV infection (WHO, 2000). In South Africa, for example, rates of infection of women are almost double those of men (Shisana, Rehle, Simbayi, Parker, Zuma, Bhana, et al, 2005). There have been inconsistent findings regarding any added risk of mental distress and disorder for women living with HIV/AIDS (WLHA) (Freeman et al, 2008); however, they certainly share with men increased risk as compared with the general population. Women who are pregnant or have recently given birth are at high risk for CMD and suicide; HIV-positive status is likely to elevate these risks (WHO/UNFPA, 2008). Although WLHA generally report higher levels of post-traumatic

growth (see above, 5.4.1.6) than men, HIV-positive women with children generally report lower levels than those without (Feingold, 2007). Freeman et al (2008) found that individuals (both men and women) with children were more likely to suffer from mental disorder than those without, possibly reflecting stress related to child-rearing and concerns for their future. These findings suggest the need for special attention to WLHA who have children.

Programmes aimed at preventing transmission of HIV from mother to child during pregnancy and after birth (PMTCT programmes) would appear to have great potential for addressing mental health concerns of WLHA, especially in the early stages of parenting. As previously mentioned (4.3.1), an expert meeting convened by WHO/UNFPA (2008) recommended screening for mental health problems for all women who are pregnant or have recently given birth, together with a range of simple and affordable interventions at a primary care level to assist women, including those who are HIV-positive, with mental health problems. However, despite these recommendations, PMTCT protocols may do no more than mention the possibility of emotional problems being observed and the need for support and, possibly, referral – despite the general lack of referral resources (see, for example, National AIDS Control Organisation, 2006b; National Department of Health, 2008). Salter and colleagues (2008), drawing on experience in Kenya and Canada, have reported on the initial stages of developing evidence-based psychosocial assessment guidelines for use in PMTCT settings to address more systematically the needs of pregnant women. Key areas for assessment include maternal depression, coping with stigma and disclosure decisions, concerns about infant HIV status and infant feeding. The variety, complexity and intensity of issues (e.g. relationships, poverty, migration and resettlement) affecting women and their families also need recognition and assessment.

Couple counselling also potentially contributes to providing psychosocial support for WLHA and reducing stress by providing a setting for assisted disclosure of HIV status of the partners and facilitation of supportive responses between partners. However, as indicated before (5.4.1.4), there are questions regarding the extent to which negative outcomes are reduced by couple counselling. In addition, barriers to the uptake of this form of counselling currently restrict its utility.

The link between HIV infection and gender violence has received increasing attention in recent years (Rao Gupta et al, 2003; Dunkle, Jewkes, Brown, Gray, McIntyre & Sioban Harlow, 2004; UNAIDS Inter-Agency Task Team on Gender and HIV/AIDS, 2005; WHO, 2006). This link should also be noted for its potential to predispose to mental distress and disorder. WLHA often fear that disclosure to their partners will result in rejection, abuse and violence. Although there is evidence that these fears are less often proven in reality (Lindsey, 2003), the fear itself is likely to constitute a stressor, as well as being a powerful disincentive to seeking the emotional and material support that a partner may be able to provide. Experience of sexual violence (Olley et al, 2005; Puig et al, 2008) or a history of child sexual abuse (Tarakeshwar et al, 2005; Gwandure, 2007) may be further predisposed to later difficulty in coping with an HIV-positive diagnosis. Strelbel and colleagues (2006) have noted that links between gender roles, gender-based violence and HIV/AIDS risk (and, one may add, mental distress and disorder) are complex and culturally specific. Clearly, however, there is a need for special, but culturally informed, attention to these diverse but overlapping needs, preferably through programmes that provide coordinated prevention, care and treatment of both HIV infection and gender-based violence (Jansen van Rensburg, 2007).

An example of potential coordination would be routine screening for intimate partner violence that has been proposed in relation to VCT for HIV, where fear of violence as a consequence of disclosure of positive status is a frequently stated concern, both for client and counsellors. It has been recommended (WHO, 2006) that, as part of the counselling process, counsellors should engage women clients in discussion of the role of violence in their decisions on testing and disclosure\* and, in the event violence is a concern, should assist women to explore possible solutions (including mediated disclosure).

The comprehensive literature review previously mentioned (Lindsey, 2003) provides a detailed overview on areas and approaches to psychosocial support for HIV-infected women and their families. As indicated before (5.4.1.5 Psychosocial support groups), a number of psychosocial support projects have specifically

\* One protocol described in the 2006 WHO report includes the following questions asked routinely: 1) Is your partner aware that you will be tested for HIV? 2) If you told your partner you tested positive for HIV, do you think he would react supportively? 3) Are you afraid of how your partner will react if you share your HIV test results with him? 4) Has your partner ever physically hurt you? 5) Do you think that your partner may physically hurt you if you tell him that you have tested for HIV and your HIV test results are positive?

focused on women. Visser and Mundell (2005) reported on an initiative in Tshwane, South Africa, to develop a structured support group programme addressing the needs of HIV-positive women. Formative evaluation indicated that participants perceived the programme to be beneficial. Sethulakshmi and colleagues (2008) reported on a large-scale support group initiative in South India. The programme involved a structured six-session series of support groups to address the psychosocial and mental health issues of women including stigma. Participants evaluated the groups positively. Initiatives addressing the needs of women as mothers are also fairly common. Jirapaet (2000) reported on a six-week programme to address the psychological well-being and maternal role adaptation of HIV-positive mothers of infants in Thailand. Findings were that the women in the programme group as compared with those in a control group showed significantly increased levels of coping ability, quality of life and adaptation to their role as mothers. Five components of the programme identified by mothers as essential were peer group meetings, professional support on infant rearing and maternal self-care, stress management, access to available social support and alternative medicine. One of the examples of promising practice described below also targets WLHA specifically.

As mentioned earlier, the efficacy of programmes to address the needs of women may, however, be limited if they are not mainstreamed into organisational structure and culture. A clear example of failure to recognise the role of gender is PMTCT programmes that implicitly represent the issue as a woman's issue, without reflecting men's role in procreation and parenting (UNAIDS Inter-Agency Task Team on Gender and HIV/AIDS, 2005). The Indian PPTCT programme appears to have tried to address this bias by referring to "parent" (rather than "mother") to child transmission (National AIDS Control Organisation, 2006a; b). The fact that most of the material in the training guides still refers to women and mothers would suggest, however, that the approach has not substantially addressed gender mainstreaming, for example, by addressing barriers to male engagement in health care already mentioned in relation to couple counselling and probably greater in antenatal care settings. Other gender-related issues not substantively addressed by PMTCT programmes are the cultural norms for and pressures on women, for example, in relation to child-bearing and breastfeeding. To properly address these issues, gender mainstreaming is necessary, involving in-depth analysis of the cultural and organisational context of such programmes and involvement of women in the development of programmes that will meet their needs.

Guidelines on mainstreaming gender issues in care and services for WLHA are provided in a number of the publications mentioned previously (Rao Gupta et al, 2003; UNAIDS Inter-Agency Task Team on Gender and HIV/AIDS, 2005; WHO, 2006). A practical guide to mainstreaming gender in organisations is provided by the Southern African AIDS Trust (2003).

#### 5.4.3.2 *People abusing substances*

As previously indicated (5.4.2.2), there are some significant programmes targeting particularly injecting drug users. We did not locate programmes that target users of other categories of substance, amongst which alcohol, marijuana, khat and a range of other drugs would be obvious targets, because of their potential to increase risk for HIV infection, reduce adherence to ART and pose additional threats to both physical and mental health (Alem et al, 2008). Training materials developed for the WHO's Integrated Management of Adolescent and Adult Illness (IMAI) programme make some reference to possible interventions for people abusing alcohol (Lazarus & Freeman, 2005a).

#### 5.4.3.3 *Suicide*

Kelly and colleagues (2008) reported that a number of respondents in their study stated that they had contemplated suicide or engaged in self-destructive behaviours and, as indicated above, some studies have shown suicidal ideation to be high, even where people are on anti-retroviral treatment (Carrico et al, 2007; Sherr et al, 2008).

The WHO Mental Health & HIV/AIDS guide for assessment of common and more serious disorders (Cournos et al, 2005) includes a question to assist detection of suicidal ideation and, as indicated above, screening for suicidal ideation and assessment of risk is generally part of VCT protocols (see, for example, SEARO, 2004). However, the extent to which this aspect is effectively utilised, especially when VCT is conducted by lay counsellors, is open to question. Where suicide risk is identified, resources for management in developing countries are often limited to the family. More effective training and supervision of VCT counsellors (as discussed further below) and other health professionals could result in improved detection and assessment and, perhaps, management of less severe cases.

#### 5.4.4 Staffing, training and supervision

##### 5.4.4.1 Staffing

In developed countries, it is usually taken as a given that multidisciplinary teams of professional staff are necessary for effective mental health care of people with HIV. However, with some exceptions such as the outreach project in Brazil already described (Malta et al, 2003) and the formal state and NGO psychosocial support system in Armenia (Arakelyan & Cholakhyan, 2008), staffing of this kind is generally a scarce commodity in developing countries, even in urban areas, let alone remote rural areas. Task shifting, with more administrative tasks shifted to specially trained aides, may free up professional staff and allow more effective use of their time and skills (Eustache et al, 2008). More generally, however, there has been recourse to generalist health care workers or new categories of mental health care workers (peer or lay counsellors) with limited training taking on mental health care functions (Remien & Mullins, 2007). Both these options are not without problems.

Some of the difficulties of effective counselling as an add-on function to general health care have been described in a WHO literature review on psychosocial support and counselling of HIV-infected women and their families (Lindsey, 2003). They include both systemic factors and issues related to the personal qualities and attitudes of health workers. With regard to the latter, not all health workers are suited to counselling and many see it as no different from the advice-giving that forms part of their usual IEC (information, education and communication) function. Because of its demanding and stressful nature, health workers may also be reluctant to undertake counselling on top of what are usually already heavy workloads. Stigma and discrimination by health care workers towards PLHA, particularly those with co-occurring disorders, has been reported in a number of settings (see, for example, Malta et al, 2003; Mahendra et al, 2007; SIAAP, 2008). These, together with the systemic issues discussed further below, must be considered and addressed if generalist health workers are to be effectively involved in counselling and other mental health interventions.

With regard to lay or community counsellors, there are many examples of the use of lay counsellors to undertake relatively circumscribed forms of counselling and psychosocial support, including facilitating support groups. Their involvement is usually restricted to particular phases in the course of HIV/AIDS (e.g. VCT, PMTCT or adherence counselling), following a more or less formal protocol or manual. Usually, there is some provision for limited counselling in relation to certain related issues that commonly arise, for example disclosure, safer sex negotiation and bereavement. In theory, issues falling outside this restricted scope should be referred for further assessment or counselling by appropriately trained health care workers, preferably mental health professionals. In the absence of such resources, lay counsellors may take on (or be expected by other health workers to take on) issues beyond their competence or the issues may simply not be addressed.

In some countries, efforts have been or are being made to establish standards and a regulatory framework for lay counselling. A conference of Southern African counsellors in 2002 made a number of recommendations in this regard (Rachier et al, 2004). However, from that conference and other reports (D Mutwale, Zambia and S Meyersfeld, South Africa, personal communication), it appears that, in some cases at least, adherence to standards is less than optimal.

##### 5.4.4.2 Training and supervision

The WHO IMAI project offers learning support for HIV care in general, including mental health care (McHarry, Asfour & Gove, 2008); it is not clear, however, to what extent this training has been extended beyond pilot sites. Materials designed to address the mental health care training needs of primary and secondary level health workers specifically have also been developed through the IMAI project (Lazarus & Freeman, 2005a; b) and have reportedly been used in a number of developing countries. Practical training programmes involving interaction with PLHA and case studies appear to be effective in engaging health workers (Kumar, Solomon, Ganesh & Mani, 2002). A structured education programme for social workers and other allied professionals has recently been described (Tomaszewski, Lopez & Moncada, 2008). The programme makes use of skill-building workshops and internet-based courses on HIV and mental health

and substance use to enhance practice with individuals, families and communities from diverse cultural backgrounds who are affected by HIV/AIDS. Although developed in the USA, given its professional target audience, the programme could possibly be useful in other countries.

Training in counselling is often assumed to have been part of the basic training of nurses and doctors. However, such training is usually very limited (often no more than a few lectures on communication skills and a few weeks' exposure to psychiatry) and does not equip these workers to deal with counselling or other interventions to address psychosocial and mental health needs. In some settings, brief training updates to assist generalist health workers to meet such needs in line with practice guidelines are offered, but the extent to which the training is effective or implemented is seldom evaluated. It is likely that implementation is to a large extent dependent on individual interest and personal qualities.

Training for lay counsellors is addressed in a plethora of national and international protocols and guidelines (see Appendix A for a selection). Most are based on a person-centred approach to counselling, adapted to a greater or lesser extent to local circumstances. The length of training varies, but in many cases is very brief – sometimes less than five days, despite recommendations for longer training (Rachier et al, 2004, for example, refer to recommendations for training equivalent to 15-20 days). Frequently this training is focused on just one aspect of counselling, such as VCT, or adherence counselling. Add-on modules, usually of short duration, may be offered at a later stage, usually in response to an extension of the responsibilities of counsellors to a new area, for example, adherence counselling in addition to VCT, or in an attempt to introduce a new focus, for example risk reduction, PMTCT, couples counselling.

Apart from specific counselling skills, it is important that potentially stigmatising attitudes of counsellors be addressed in training, or in other ways. Greef and colleagues (2008) have reported on a promising pilot project across five Southern African countries that involved PLHA and nurses in joint training on stigma and discrimination, leading to the establishment of a variety of projects to combat stigma and discrimination in health care settings.

To ensure implementation of skills learned in often brief training, mentoring and supervision are essential. The emotional issues of working with PLHA, including having to cope with multiple losses (Perrault, Scott, Lopez & Fitton, 2003) and the stress of counselling should also be addressed (Lindsey, 2003; Mayer, 2005). Issues similar to those that arise in working with victims of trauma have been noted and may benefit from the same kinds of interventions (Feingold, 2008c; d). However, despite indications that it is highly valued (Kumar et al, 2002) mentoring and supervision of generalist health workers seem to be the exception rather than a rule. Despite strong support for mentoring and supervision of lay counsellors in many guidelines (see, for example, Saloner, 2005), low prioritisation by management and lack of suitable mentors seem to mean that in practice, lay counsellors do not receive the supervision and mentoring they need to maintain effective practice.

Evaluation tools for use in supervision and mentoring are commonly included in counselling programme protocols. However, it is not clear whether they are used routinely as intended and there are few reports of more formal assessment of the quality of counselling. An exception was a study conducted in four Indian states (Ramarmurthy, Meitram, Chan & Mahanty, 2008), which made use of a criterion-referenced grading tool to assess counsellor performance. Weaknesses identified included how to communicate about behaviour change and PMTCT, manage mental health concerns, deal with sexual assault and manage difficult clients. Follow-up training was planned to address these areas. It was also hoped to extend the use of the tool nationally.

#### 5.4.5 Systemic and organisational issues

Despite frequent reference to the need to attend to mental health and psychosocial needs of PLHA, the systemic and organisational issues outlined in relation to integration of mental health into primary care unfortunately apply equally with regard to the provision of mental health for PLHA. These include low prioritisation of mental health care by generalist health workers and management, lack of mental health professionals to provide either direct mental health care or to train and supervise generalist health workers and lay counsellors and the organisational challenges posed by the introduction of mental health care into

general health care settings. Amongst the latter are the need for privacy and confidentiality and the extended consultation time needed for effective counselling (Lindsey, 2003). Differences between biomedical and psychosocial models increase the difficulties (Rachier et al, 2004; Rohleder & Swartz, 2005). The low status of lay counsellors within the health care system in many countries and lack of clear job description or career structure adds to the difficulty of their asserting their right to working conditions that would allow them to perform effectively (Lindsey, 2003; Rachier et al, 2004; Rohleder & Swartz, 2005) and contributes to low morale and commitment (Leonard, 1994). These issues all need attention to assure good quality mental health care for PLHA. One of the modules in the WHO Mental Health & HIV/AIDS Series (Kelly & Freeman, 2005) offers some guidelines in this regard.

## 5.5 Promising practice examples

In earlier reviews of promising practice in developing countries, (Leonard, 1994; Leonard & Muia, 1998; Lindsey, 2003), descriptions of the projects were brief and little detail was provided with respect to any interventions supporting mental health and psychosocial care. The World Federation for Mental Health Africa Initiative (2008) has also identified a number of "best practices". Most, however, provide for children or are guidelines or manuals, rather than practice examples.

The examples of promising practice included here have been selected primarily because, if not the main focus, they clearly incorporate attention to mental health and psychosocial issues, that this aspect of the project is described in some detail and that there has been some evaluation of the project to date that suggest it holds promise as an approach to mental health care.

### *Example 1: Uganda*

#### *The AIDS Support Organisation (TASO)*

Sources: Kalibala & Kaleeba, 1989; Kaleeba, Kalibala, Kaseje, Ssebhanja, Anderson, Van Praag, et al, 1997; Coutinho, 2003; Lindsey, 2003; TASO, 2003; Petrushkin, Boardman & Obuga, 2005; TASO, 2006; Khanakwa & Kusemererwa, 2007; TASO website: [www.tasouganda.org](http://www.tasouganda.org); UNAIDS/WHO, 2008.

Uganda is known for its early and effective response to HIV, particularly for the prominent and sustained support of then President Museveni from as early as the mid-1980s. Critical to its success were a coordinated, multisectoral response and broad partnership of a range of governmental and non-governmental role-players with international support. Nevertheless, in 1991, HIV prevalence had reached a peak of 13.8% of the adult population. The rate of HIV infection has subsequently dropped substantially – in 2007 prevalence was estimated at 5.5%. ART was introduced in Uganda in 1996. Currently 940 000 individuals are living with HIV/AIDS and about 115 500 are on ART (approximately 33% of estimated need).

Uganda has a vibrant NGO sector working in the field of HIV/AIDS. TASO, established in 1987, is a leading and probably the first of these NGOs. TASO was established by a group of volunteers – people infected or affected by HIV/AIDS – to provide psychosocial support for and improve the quality of life of PLHA. In 2005, TASO had 11 centres distributed throughout Uganda, as well as monthly outreach clinics in most districts. It has strong links with other NGOs and with governmental services and coordinating bodies and is engaged in collaborative projects with other NGOs and district health units to provide quality comprehensive HIV/AIDS prevention, care and support services. TASO is a strong proponent of the GIPA principle (Greater Involvement of People with AIDS), both in its own operation and in other organisations and arenas.

TASO's mission, many years before ART was introduced in Uganda, was to bridge the gap between African approaches to disease and western, hospital-centred approaches, using a community-based approach. Through its centres, clinics and national office, TASO offers a holistic approach to the needs of PLHA, offering counselling, medical care, home-based care (including home-based VCT for family members of PLHA), material and social support, income generation and projects to promote self-sufficiency with regard to food and energy requirements, and advocacy, as well as supporting community efforts to respond to the AIDS epidemic.

TASO provides training in counselling both to its own staff and to the staff of other organisations and has been centrally involved in initiatives to strengthen and standardise HIV counsellor training in Uganda. It has formal quality assurance programmes for all its own services, including counselling services. It routinely monitors performance and has been formally evaluated on a number of occasions. In response to recommendations emanating from reviews, it has engaged in organisational development initiatives that have contributed to the sustainability of the organisation.

Key lessons identified by TASO include the value and importance of involving communities in the design and implementation of programmes of care and support for PLHA; the importance of collaboration between organisations to share and build capacity; the importance of long-term, sustained approaches to behaviour change; and the need for integrated strategies to address the interlinked issues of HIV/AIDS and poverty. Major challenges include funding (including maintaining cash flow from donors), heavy workloads because of high levels of demand for its services, attracting and retaining staff (especially in rural areas), providing and maintaining the full range of services at all its centres, and maintaining the quality of its services.

As regards counselling, TASO defines counselling as a dialogue in which counsellors identify clients' concerns and help them make decisions and plans appropriate to their circumstances. Counselling is usually done on a one-on-one basis; however, with the consent of the PLHA, counselling involving the extended family is also undertaken. The relationship between a client (and family) and a counsellor is long term, with clients able to return for follow-up sessions. Counselling has been particularly effective in encouraging disclosure to at least some significant others (usually family members, less often sexual partners), thereby increasing care and support for PLHA. Memory work and will-making as ways to cope with concerns about the future care of children have been usefully incorporated into counselling, although there has been a decline in the latter since the advent of ART.

The number of clients seen and the number of counselling sessions per client has shown consistent increases over the years. In 2005, close to 50 000 clients were counselled; each seen on average for four to five sessions. The strong demand for services, together with additional requirements for counselling linked to the introduction of ART, increased the workload and posed challenges to the quality of counselling services. In an attempt to meet these challenges, group counselling has been introduced, in which five to ten clients are seen in a group to discuss issues of common concern, following group counselling guidelines. Emerging personal issues are reserved for one-to-one counselling.

As indicated above, counselling, like other services, is subject to a formal quality assurance programme to ensure that service delivery by the counsellors meets minimum standards and to promote quality improvement. This includes:

- availability of guidelines for individual and group counselling;
- induction and support of new counsellors;
- supervision of counsellors;
- periodic observation of counselling sessions by counselling coordinators;
- regular in-service training (continuous counselling education) aimed at updating training and skills and improving relationships between counsellors, medical staff and other front-line staff;
- dissemination by counselling coordinators of information updates from stakeholder or education workshops; and
- regular meetings between medical and counselling departments to address challenges such as increased workload of counsellors or deal with issues such as disclosure and will-making.

Because of the stressful nature of work with PLHA, care-for-carers is recognised as essential to avoid burnout and maintain staff morale.

With regard to mental disorder, confirming earlier findings in Uganda, a study (Petrushkin et al, 2005) of psychiatric disorder identified high rates of mental disorder in a sample of HIV-infected clients attending a TASO clinic based at a hospital. Depressive and anxiety disorders were common. Severe mental disorders were seen in half the clients. It is not clear whether these high rates reflect the hospital setting and to

what extent they would be reflective of community-based services. None of the clients with psychiatric disorders were, however, receiving mental health treatment other than the usual counselling. Counsellors significantly under-estimated the rate of disorder amongst their clients, and most counsellors had not received any formal training regarding mental disorders and lacked confidence in their capacity to deal with such disorders in their clients. Attitudes towards people with mental disorder were mixed, with some counsellors fearing that they might display violent behaviour. Some counsellors felt it most appropriate to refer clients with mental disorder to psychiatric services, but most counsellors stated that, if given the necessary training, they would be able to provide care for such clients. The findings indicated a clear need to provide additional mental health services in the TASO clinic through appropriate training of TASO counsellors to improve their awareness of psychiatric disorders, delivery of some psychological therapies and liaison with the psychiatric services at the hospital. It is not clear whether this recommendation has been implemented.

A participatory evaluation of TASO (Kaleeba et al, 1997), involving staff and clients, concluded that it demonstrated a strong capacity to address four key problems for AIDS care: disclosure of HIV status by PLHA, acceptance of PLHA in the family and community - seeking early treatment - and combining prevention with care. Apart from a strategic review referred to in the 2005 annual report (TASO, 2006), we were not able to locate more recent, or external, evaluations. The 2005 annual report does, however, provide ample quantitative evidence of growth in services over time and of a self-reflective approach to the internal evaluation of successes and weaknesses.

#### *Comment*

TASO has been in operation for more than 20 years and appears to have developed and maintained a successful model of care and support for PLHA. This has included a strong emphasis on counselling in order to address not just HIV testing and adherence to ART, but a broader range of psychosocial needs. TASO may thus be described as an example of mental health care provided through other sectors (see 3.3.4), in this instance a non-statutory organisation allied to but extending beyond the health sector. Although not a full package, TASO does provide some – and perhaps the only - aspects of primary mental health care to PLHAs and their families.

The importance of the counsellor-client relationship has been recognised, as has the need for more than once-off counselling. To address growing demand, counselling has been adapted to allow for group counselling without abandoning individual counselling. Counselling has also been embedded in a broader range of psychosocial support initiatives, including attention to partners and families, as well as children of PLHA and poverty, all identified as key areas relevant to mental health and psychosocial well-being of PLHA. Training, quality assurance and support for counsellors appear to be well integrated into the structure and operation of the organisation. Despite its apparent success in meeting psychosocial needs, not enough attention appears to have been given to mental disorder amongst PLHA.

#### *Example 2: South Africa*

##### *Mothers2mothers (m2m)*

Sources: Baek, Mathambo, Mkhize, Friedman, Apicella & Rutenberg, 2007a; b; Horizons, 2007a, b; *m2m* website: [www.m2m.org](http://www.m2m.org); Smith, Teasdale, Besser & Schmitz, 2008; Teasdale & Besser, 2008; UNAIDS/WHO, 2008.

South Africa has one of the highest prevalence and number of HIV infections in the world. The adult rate of infection reported for 2007 was 18.1%, with about 5 to 6 million people living with AIDS. Initial government reluctance to confront the pandemic resulted in lengthy delays in introducing antiretroviral therapy, which was only rolled out after substantial pressure from civil society. South Africa now has the largest ART programme in the world, with approximately 500 000 people on treatment (approximately 28% of estimated need). NGOs, supported by international agencies and funding, but now often working in partnership with government services, continue to play a significant role in providing access to and exploring innovative approaches to treatment.

mothers2mothers (*m2m*) was established in September 2001 in Cape Town as a means of supplementing the limited numbers of professional medical and nursing staff in relation to the high volume of patients needing care, specifically in relation to HIV infection. The programme works in partnership with provincial, district and municipal services to support the effective delivery of antenatal care and postpartum child and maternal care (including HIV testing, and ARV prophylaxis and treatment). It is located in community health facilities and involves the use of trained mothers living with HIV ("mentor mothers") as peer educators and psychosocial care supporters for women through pregnancy and during the first year of their baby's life. It currently operates at 308 sites in South Africa. Other sites have been established elsewhere in Southern Africa: 34 sites in Lesotho, 25 in Zambia, 28 in Kenya, 35 in Malawi, 14 in Rwanda and 14 in Swaziland, with the programme reaching more than 150 000 women each month across all sites.

The programme uses education and empowerment as tools to prevent mother-to child transmission of HIV/AIDS during pregnancy, combat stigma within families and communities, support a mother's adherence to medical treatment, and reduce the likelihood of children being orphaned. The programme is seen as contributing to continua of medical care (antenatal care, delivery, postnatal care and access to HIV-related medical services) and psychosocial care (assisting WLHA themselves through these processes and extending to their partners, families and communities). Although key objectives are to improve medical care and outcomes, the programme has a strong focus on psychosocial issues and emotional support, recognising the critical importance of providing a safe, caring environment that encourages WLHA to share their feelings and fears regarding their pregnancy, health status, treatment and future, the health of their children and possible consequences of disclosure.

The mentor mothers are recruited locally from amongst women who have gone through PMTCT services themselves and are paid a stipend for the work they do as members of the health care team. Training extends over two weeks and covers basic medical knowledge about HIV infection and ART, behaviours that help prevent mother-to-child transmission, safer feeding options for infants, strategies for helping women disclose their status and negotiate safer sexual practices, and nutritional guidelines for women living with HIV. Programme activities include health talks conducted in waiting rooms to introduce new mothers to *m2m*, individual and group education, and regular support group meetings. Mentor mothers also support women in their choice of infant feeding method promote safer sex and family planning, encourage mothers to return for wellness HIV care or treatment and to bring their baby back to the clinic for HIV testing and care and, where necessary, conduct community outreach to assist women at home with disclosure.

Mentor mothers are supervised by site coordinators, also HIV-positive mothers who have themselves been mentor mothers. In recognition of the stresses associated with their work, monthly group debriefing sessions run by registered mental health practitioners were introduced in one region to address the stress levels of site coordinators (Smith et al, 2008). The intention was to encourage a sense of community amongst the coordinators, to facilitate sharing of knowledge and skills and of emotional responses to their work. Individual crisis debriefing was also made available in case of need, for example, in case of death of a relative, or rape. Site coordinators reported increased feelings of well-being and self-confidence and improved interaction with clients, family and colleagues, resulting in improved job performance. Mentor mothers supervised by the site coordinators have also benefited from the project through counselling and support from site coordinators.

A formal cross-sectional pre-post quasi-experimental evaluation of the programme (Baek et al, 2007) prior to and one year after its introduction in Kwazulu-Natal, South Africa has been reported. Findings were positive, both with respect to both medical outcomes and psychosocial variables. With regard to the latter, WLHA who had had at least two contacts with the programme were more likely to report disclosure (usually to their partners) and reported improved psychosocial well-being. Pregnant participants were significantly more likely than non-participants to report feeling they could do things to help themselves, cope with taking care of the baby and live positively. Compared to postpartum non-participants, postpartum participants reported feeling less alone in the world, less overwhelmed by problems and less hopeless about the future. The potentially positive effect of the programme may perhaps best be captured by a client quoted on the *m2m* website as saying: *"Only after I had conquered all my fears, doubts, uncertainties and ignorance towards my condition ... only then I was able to dream again."*

### *Comment*

Although an NGO, in terms of the generic models previously outlined, m2m may be described as a combination of mental health at primary care (see 3.3.2) and community outreach (see 3.3.3), since it relies primarily on counsellors (i.e. specialist mental health auxiliary workers) to provide the psychosocial aspects of care as an add-on to medical care on site, as well as through outreach into the community.

m2m shows clearly the synergy that can be created when psychosocial interventions are introduced into medical care settings: there are improved medical outcomes and, simultaneously, the mental health and psychosocial needs of clients are addressed. According to the available information, formal mental disorder is not directly addressed, but, as in the case of TASO, it is possible that limited training could lead at least to improved rates of detection.

It is clear that participation of mentor mothers in the programme also has important additional psychosocial benefits for them. The introduction of a specific programme to address the emotional needs of staff through debriefing by professional mental health practitioners is an important development and one that highlights appropriate use of scarce resources to support front-line staff.

### *Example 3: India*

#### *YR Gaitonde Centre for AIDS research & Education (YRG CARE)*

Sources: Brown, Varma, Daly, Duraisamy, Kumarasamy, Mahendra, et al, 2002; Solomon & Ganesh, 2002; Horizons, YRG CARE, & the International HIV/AIDS Alliance, 2004; Tarakeshwar et al, 2006; 2007; D'Souza Yephthomi et al, 2008; NACO, 2008; Sethulakshmi et al, 2008; UNAIDS/WHO, 2008; YRG CARE website: [www.yrgcare.org](http://www.yrgcare.org).

Despite a low prevalence rate (0.34%), with a population of more than 1 billion India has 2.31 million people living with HIV/AIDS,\* of whom about 158 020 are on ART. Poverty and rapid urbanisation, resulting in the creation of large urban slums, have contributed to the spread of HIV/AIDS. The serious implications of HIV/AIDS for the country were recognised in the government's establishment in 1992 of the National AIDS Control Organisation (NACO), which is responsible for planning and implementing HIV surveillance, prevention, control and management.

The pattern of infection and HIV prevalence differs across the country. States with higher numbers of PLHA are predominantly located in the southern half of the country, which includes the state of Tamil Nadu where this project is located. YRG CARE, situated in Chennai, was established in 1993 when it began to offer voluntary counselling and testing for HIV. It has since grown to include education, prevention, care and research activities and has been recognised by NACO and other organisations for its innovative and client-centred care. Its objectives with regard to HIV/AIDS care and support are to provide comprehensive and integrated care along the continuum of care at low cost and in a non-stigmatising, caring and confidential environment. Positive, client-centred attitudes are expected of its multidisciplinary staff and the needs of clients and their families are at the forefront of service planning and delivery.

YRG CARE offers training across the spectrum of medical, pharmaceutical and psychosocial care, including training in counselling for nursing and paraprofessional staff. The organisation has been involved in developing guidelines on and acting as a training site for counselling for the South East Asia region.

The organisation has maintained a consistent emphasis on psychosocial aspects of care, in particular, counselling extending beyond the index client to partners and families in the belief that this can contribute to maintaining health and quality of life. It offers counselling linked not only to medical care, such as pre- and post-test counselling, PMTCT counselling and adherence counselling, but also follow-up counselling (as an integral rather than occasional part of the service), couple and family counselling, and grief and end-of-life counselling. In this regard, it differs from many settings, where testing is often provided without any counselling and, when provider-initiated, often without consent, and where attention to emotional and social

\* Estimates of prevalence in India vary widely. The official figures, based on WHO/UNAIDS methodology adapted to the form taken by the epidemic in India, are used here.

issues related to testing is completely lacking. Psychosocial support groups, often including an income generation component, are also run. A very practical response to social isolation amongst unmarried PLHA is a matchmaking service.

YRG CARE recognises that material factors affect access to care and hence physical and emotional well-being. As the cost of antiretroviral treatment is out of reach for most Indians, it has developed an innovative approach to funding treatment. In addition to seeking funding from local, national and international sources, a Graduated Cost Recovery (GCR) tool is used to ensure that PLHA with the ability to pay subsidise and sponsor those PLHA who are partially or totally unable to do so.

In 2000, YRG CARE initiated a scaling-up process in southern India by entering into partnerships with other NGOs and private sector partners in HIV care in Tamil Nadu and neighbouring states. The scaling-up process was documented and monitored by an external agency, with valuable lessons being learned from the process applicable not only to the specific setting but also more widely.

An early evaluation of the work of YRG CARE (Brown et al, 2002) found that, despite a positive impact on general health, physical and medical/financial QOL dimensions, YRG's services did not seem to be affecting the psychological and social dimensions. However, a recent qualitative evaluation of YRG's centre-based programmes (D'Souza Yephthomi et al, 2008) suggested that sustained access to an integrated care programme of psychological treatment and economic opportunities had improved the health status and mental health and psychological well-being of clients, in particular women. A separate study (Sethulakshmi et al, 2008) was undertaken of a six-session psychosocial support group programme initiated by the organisation. The groups reached 1 000 WLHA and their caregivers (families/friends) in 27 districts of Tamil Nadu in South India. Findings were that the groups provided a rare opportunity for women to express feelings in a safe environment and address issues of stigma and discrimination. Studies (Tarakeshwar et al, 2006; Tarakeshwar et al, 2007) exploring cognitive, emotional and social factors amongst a group of the organisation's clients yielded additional insights regarding the psychosocial impact of living with HIV/AIDS on these clients, many of them particular to the local context and with implications for psychosocial and mental health care. One recommendation, for example, was that care for PLHA should take account of their emotional needs and should include a routine mental health assessment (e.g. for depression).

### *Comment*

Similar to m2m, YRG CARE may be described as a combination of mental health at primary care (see 3.3.2) and community outreach (see 3.3.3), since it relies primarily on counsellors (i.e. specialist mental health auxiliary workers) to provide the psychosocial aspects of care on-site, as well as through outreach to other sites in the community.

Even though none of YRG CARE's own documents specifically refers to mental health, the organisation has been included as a promising example of mental health care for a number of reasons. Firstly, there were indications that its client-centred model has gone beyond rhetoric into the structure and practice. User-friendly attitudes expected of all staff contribute to making the use of its services a positive and supportive experience for PLHA. Secondly, it has a solid track record of attention to counselling, not just in relation to medical care, but also taking into account broader psychosocial issues affecting PLHA. Its status as a highly regarded provider of training in counselling suggests that the quality of counselling offered by the organisation is good. Thirdly, it has initiated a number of collaborative psychosocial support programmes, which are reaching large numbers of people, particularly women, who would otherwise not receive any such service. Fourthly, as previously indicated, poverty affects mental health. YRG CARE appears to be keenly aware that poverty is a major determinant of its clients' health status (including mental health status) and has made efforts to address this in quite tangible ways (such as the GCR approach to payment for services). Finally, the model of scaling up, though not specific to mental health, did include attention to the key concepts and attitudes underpinning the model and to counselling as a key service. It may thus serve as a model for other scaling-up efforts.

A more specific focus on mental health care would in fact fit well with YRG CARE's focus on the continuum of care. Given also its track-record of investment in research and development, it is likely that recommendations such as those mentioned above regarding routine mental health assessment will be (or have been) incorporated into its model of care.

## 5.6 Conclusions

Looking both at what we have referred to as emerging good practice (5.4) and the promising practice examples (5.5), it is clear that there has been little direct attention to CMD or mental distress affecting PLHA in developing countries. Referring to potential targets for intervention (5.3), illness-related and psychosocial stressors are the most common targets and are generally addressed in the course of interventions primarily directed at supporting health care interventions such as VCT and adherence to medication. Quality of life and coping styles may be addressed incidentally in the course of these interventions. Specific mental health symptoms or mental disorders are seldom directly addressed, although it is likely that some of the foregoing interventions may provide some relief for PLHA experiencing mental distress short of mental disorder. These interventions have, in many instances, been targeted at specific groups, most often women and in some instances PLHA who are abusing substances (in particular injecting drug users – although this is not a particular focus in most high AIDS prevalence countries). Potential sources of support (or, alternatively, additional stress), such as sexual partners, family members and peers have all been targets of interventions, either together with the PLHA or in groups to encourage their support and address their own needs. Programmes to address social and structural factors at a macrolevel have not been explored here, but are obviously relevant insofar as they reduce stress for PLHA. Alongside mental health interventions, all the examples of promising practice described above address poverty and unemployment amongst clients in one way or another, either by promoting the subsistence growing of vegetables, skills training, or income generation projects. A feature of these programmes is that they all see PLHA in holistic terms; not just their medical condition, but also their social and psychological needs.

Gender issues and specifically the disempowerment of women is also addressed as part of psychosocial interventions in the more comprehensive programmes and through advocacy by the organisations. Although there is sometimes reference to differences in cultures, the extent of the cultural adaptation of interventions used in developed countries is not always made clear. However, both TASO and YRG CARE make clear reference to the importance of families and of local customs as influencing their approach.

With regard to emerging good practice relating to the package of care (5.4.1), it is clear that most practices are still in a pilot stage and not widely available. Rather than there being specific attention to mental distress and disorder, the primary focus for psychosocial interventions is in support of physical health care. It is clear, however, that with relatively small adaptations, the various counselling interventions could more adequately provide for mental health needs. However this will require additional skills and resources as practitioners are often stretched for time and are not comfortable or competent to provide more in-depth counselling.

With regard to psychotherapeutic interventions, there are a number of promising practices, but here, too, the issue of resources (staff, time and supervision) must be addressed to realise this promise. Innovative practices such as memory work and body mapping, which have been developed or adapted for work with PLHA and which can often be used with some (if not maximum) effect with relatively limited training, deserve more careful evaluation.

With regard to special categories of need (5.4.2), it is clear that the needs of women are receiving increasing recognition, albeit as pregnant women or mothers. However, since these are often critical aspects of women's identity in developing country contexts, this is an important advance. Recognition of symptoms of mental disorder, in particular, depression, would be an important addition. Already receiving some attention in some countries, the mental health needs of PLHA with substance abuse (not just injection drug use, but also abuse of other substances, in particular alcohol) needs to be more widely recognised.

With regard to organisation of care (5.4.3), case management and collaborative care offer considerable promise in being able to provide more effective mental health care. Such practices do, however, require greater flexibility in roles, shifts in power between different role-players, and, often larger organisational and systemic changes that are not always easy to achieve. No reports on stepped care – delivery of low intensity, low cost interventions as a first option before referral for higher intensity, high cost care (see 4.2.2.2) – were found in the context of mental health care for PLHA. However, given its focus on the cost-effective use of scarce mental health resources, this approach deserves attention.

With regard to staffing, training and supervision (5.4.4), it would be difficult to achieve significant advances in mental health interventions without attention to staffing. Adding mental health to the already long list of issues that professional health care workers must "treat" may not yield results. However, at the very least training to increase sensitivity to mental health issues should be undertaken. Screening (however performed) must form part of routine care, while, in the absence of referral resources, assessment may not easily be delegated to less trained staff. Paraprofessional counsellors seem destined to remain a mainstay of services. However, the available information suggests that supervision and mentoring, which could contribute to a greatly improved standard of mental health care, is generally inadequate.

Thought could also be given to the possibility of training the large numbers of unemployed graduates found in many developing countries as a more advanced cadre of counsellors. The experience of developed countries such as Britain, where the introduction of graduate mental health workers to work in general practice settings has not been without its problems, should, however, be taken into account (NIMHE, 2003). These graduate workers were expected to undertake a range of tasks to improve the capacity of primary care to meet the mental health needs of clients, including direct intervention with individual clients. Significant early attrition of graduate workers has, however, been reported, reflecting variation in management buy-in, the level and quality of supervision and in payment and terms of service of workers (Fletcher, Gavin, Harkness & Gask, 2008).

Without attention to systemic and organisational issues (5.4.5), however, none of the above can easily be achieved on a scale sufficient to address mental health needs of PLHA. Sustained advocacy is needed to effect change. In this regard, some of the above NGOs have been able, through their example, to effect change in other organisations, both at a nongovernmental and, to some extent, government level. This reflects the fact that many interventions described have been initiated by NGOs, rather than the public sector health or social services. This may be due to greater flexibility of NGOs to attempt innovative practices, as well as, in some instances, access to donor funding to support these practices. In contrast, public sector services appear to be constrained by the sheer enormity of caring for the physical needs of PLHA in the face of limited financial and human resources. Advocacy reflecting the interconnectedness of HIV/AIDS and mental health has perhaps also been inadequate and governments are not sufficiently aware of the need for mental health within HIV/AIDS care. Many psychosocial intervention projects have been initiated by women, reflecting the fact that women are most directly affected by the burden of HIV/AIDS, whether as infected or affected people. Harnessing the power of ordinary people – PLHA and their families – may therefore be a key way to influence public policy in favour of more effective mental health care.

## 6. CONCLUSION AND RECOMMENDATIONS

In this review, the focus has been on good practice in mental health care for common mental disorder (CMD) (rather than severe mental disorder) at the primary care level in resource poor settings. As a context for examining good practice, we have summarised key information regarding the prevalence and burden of mental disorders (in particular, CMDs) and the resources available for mental health care, various conceptions of primary health care and primary mental health care, concluding with an overview of generic models of primary mental health care. Against this background, we have described good practice by reviewing both general guidelines and specific examples of primary mental health care, firstly, in the health sector, and then for people living with HIV/AIDS. In this concluding section, we draw some conclusions and make recommendations, including scaling up good practice and research priorities based on gaps identified in the review.

It is clear that, despite strong support from leading international bodies such as the WHO, World Organisation of Family Doctors (Wonca) and the World Federation for Mental Health, and through influential publications such as the *Lancet and World Psychiatry*, primary mental health care in many developing countries remains largely restricted to innovative demonstration projects, which have not always been sustained or scaled up on a wider basis. With respect to HIV/AIDS specifically, where attention to CMD and mental distress could make a major contribution to supporting PLHA and their treatment, the situation is particularly disappointing. There are many reasons for the limited development of primary mental health care. Amongst these, the low priority accorded mental health care in health care services is a key factor. This reflects the dominance of biomedical paradigms in the health sector (and, even, extending beyond the health sector), failure to appreciate or acknowledge the burden of disease resulting from mental disorder and stigma attaching to mental disorder. Overcoming these barriers is no easy task. However, principles to guide the process have been identified and bear repeating.

### 6.1 Principles for successful integration

The WHO/Wonca report (2008) referred to above identified ten general principles for successful integration of mental health into primary care. These were based on lessons drawn from existing literature and from examination of good practice examples. Because the principles are essential building blocks for mental health in primary care, chiefly within the health sector, they are summarised in some detail here. We then outline key considerations drawn from the literature that relate to their implementation.

#### **1. Policy and plans need to incorporate primary care for mental health.**

Government commitment to integrated primary mental health care, shown in formal policy on both general and mental health, and legislation, is essential for success. Government directives that mandate primary mental health care can provide the impetus for integration by, for example, requiring reporting on certain outputs (e.g. number of mental health cases seen). However, a bottom-up approach based on local initiatives – for example, pressure from users and families, the efforts of individual health workers – can also kick-start a larger process of change extending to the level of policy and legislation.

#### **2. Advocacy is required to shift attitudes and behaviour.**

Advocacy involves the deliberate and strategic use of information and influence to shift perceptions of national and local leadership – political, health (management and worker) and community – regarding the benefits of integration in order to bring about changes in policy and planning. Using media, public events and lobbying to draw attention to the prevalence of mental disorders, their burden, human rights implications and the availability of effective treatments is critical.

**3. Adequate training of primary care workers is required.**

Training needs to cover both pre-service training for new entrant health workers and in-service training for existing health workers. Training should extend to ensuring that new skills are put into practice, with specialist support for effective implementation and continued learning. Collaborative or shared care, with joint consultations and interventions by primary care workers and mental health specialists, appears to be a particularly effective approach to providing ongoing training and support.

**4. Primary care tasks must be limited and doable.**

The mental health tasks to be taken on by primary health care workers should be kept to a limited number. The priorities in any setting should be identified through consultation with health workers and community stakeholders, assessment of the human and financial resources available and the capacity of the current health primary care system to provide mental health care. If integration of these functions proves successful, an expanded set of functions could be considered at a later stage.

**5. Specialist mental health professionals and facilities must be available to support primary care.**

Specialist support, at secondary level in particular, is essential for referrals, mentoring and supervision. Possibilities include community mental health centres, secondary-level hospitals or skilled practitioners working within the primary care system. Depending on local circumstances, specialist personnel may include nurses with advanced psychiatric training, psychologists or psychiatrists.

**6. Patients must have access to essential psychotropic medication in primary care.**

Access to essential psychotropic medication in primary care facilities is essential. This requires review of distribution chains, as well as legislation and regulations that prevent primary care workers from prescribing and dispensing psychotropic medication in settings where there are few doctors or mental health specialists.

**7. Integration is a process, not an event.**

Integration generally involves a series of developments, usually extending over a considerable period of time and often involving setbacks. Changes in personnel can add to the difficulties. Even when accepted in principle, essential tasks such as ensuring adequate budget, logistics and training remain.

**8. A mental health service coordinator is crucial.**

Because of the varied interests involved and the complexity of change processes, it is essential to have a coordinator to drive the process. This should be someone with sufficient seniority and commitment to take on the many challenges that face integration.

**9. Collaboration with other sectors and stakeholders is required.**

Other government non-health sectors, nongovernmental organisations, village and community health workers, and volunteers play a critical role in primary mental health care by facilitating access to educational, social, employment and rehabilitation opportunities for people suffering or recovering from a mental disorder, as well as providing support and care. Organisations and individuals at the community level may also play a role in identifying and referring people with mental disorders to primary care facilities. A collaborative approach is essential to ensure the effective use of resources and continuity of care.

**10. Financial and human resources are needed.**

The costs of introducing and maintaining primary mental health care include training and supervision of staff and, in many cases, the provision of psychotropic medication at primary care level where it may not previously have been available. It may be necessary to employ specialist mental health staff for supervision and referral and, in some cases, additional primary care and community health workers.

In applying the principles, some key considerations are the following:

- The diversity of practices on which the principles are based indicates that there is no single "best practice" applicable to all settings. It is essential to adapt the principles for local implementation.

- Effective primary mental health care is dependent on a well-functioning general health system. It may be necessary to strengthen that system and provide additional resources at the primary care level so that it can effectively perform the additional tasks of mental health care. Areas that frequently need specific attention are upgrading infrastructure, updating lists and ensuring supply of approved psychotropic medication (Nishtar, 2007), and ensuring adequate staffing.
- Specific skills and competencies are needed to effectively assess, diagnose, treat, support and refer people with mental disorders. It is therefore essential that a process is put in place to adequately prepare, train and support primary care workers in their mental health work. An incremental approach to skills training and areas of mental health responsibility is often helpful. Risk management systems, specifically for suicide, should be built into the development of services so as to provide the necessary support for health workers who have to deal with patients at risk. Outreach by specialist mental health staff or community mental health teams can provide an effective form of ongoing training and support.
- Primary mental health care should be seen as an essential part of both general primary care and comprehensive mental health care, and cannot function effectively in isolation. It must be coordinated with a network of complementary services, both formal and informal, at different levels of care and in different settings, including community-based and hospital services. This requires the clear definition of responsibilities in each setting, treatment and referral pathways and lines of accountability.
- Integration is a process that takes time and must overcome obstacles, even given substantial backing for the initiative. At the local level, an organisational change process should be adopted. This should include clearly defining roles and responsibilities in order to avoid role confusion and conflict and encourage positive relationships between staff operating at the primary care level and with mental health specialists (Nolan, Orford & White, 2003; Nolan & Hewison, 2008). For successful integration beyond the local level, mental health and specifically primary mental health care must be written into health policy and legislation and supported by leadership at a senior level.
- Sustained advocacy is necessary in alliance with people with mental disorders and their family members (Saraceno et al, 2007). Special attention should be given to ensuring clear and consistent messages regarding primary mental health care. Where policy or legislation mandates certain rights or access to health care, legal challenges may be considered if there is resistance to making the changes and accessing the resources necessary to assure rights, such as to accessible mental health care (Singh, Govender & Mills, 2007).

## 6.2 Package and organisation of care

According to the principles, mental health care tasks at the primary care level should be "limited and doable". Tomson and Shiers (2003), writing in the context of British general practice, have argued that, in defining these tasks (the package of care), it is important to keep in mind the differences between specialist and generalist contexts, in particular, the volume of patients and their undifferentiated presentation at primary care level. Rather than imposing a specialist approach, efforts should be made to adapt to characteristic, less intensive ways of working in primary care, such as seeing patients for short encounters although over longer periods of time. Despite the differences in context, these observations remain relevant in resource-constrained settings.

What then can be said about the package and organisation of primary mental health care? We summarise key indications based on the literature review and good or promising practice examples. Reference to special categories of need is incorporated into the summary.

### 6.2.1 Screening and assessment

Since CMD is, for various reasons, frequently not the presenting complaint, some form of screening (appropriately adapted for the local cultural context) is necessary to identify cases. Two approaches to screening have been reviewed: routine and selective. Routine screening of all patients or clients presenting to a service appears to have merit in increasing the likelihood of CMD being detected.

The alternative of selective screening for specific at-risk groups is intended to target people particularly vulnerable to mental health problems and may be particularly applicable where resources are severely constrained. Specific targets include people experiencing severe or persistent psychosocial stress, particularly poverty; PLHA; and women, especially mothers of young children; all of whom have been shown to experience elevated rates of CMD and distress. In the case of PLHA, screening for specific indications of CMD during routine follow-up care (where this exists), or when presenting with opportunistic infections would complement and extend the fairly common practice of routinely screening for suicide during VCT and for psychosocial stressors that could threaten adherence to ART. Screening for substance abuse amongst PLHA (particularly men) could likewise increase the likelihood of detection leading to intervention that could improve not only mental health, but also response to other aspects of health care.

In either routine or selective screening, use of formal screening questionnaires may be reliant on the presence of additional (lay) personnel to administer them. Briefer approaches using just two or three questions (as in the IMAI guidelines for first-level care for PLHA, see 5.4.1.1) may be more easily incorporated into routine consultations.

Whatever the form of screening, positive screening needs to be followed up by more in-depth assessment to confirm or rule out false positives. Taking into account the likelihood of sub-threshold conditions being present, including in the case of PLHA, where resources permit, both sub-threshold and more severe disorder identified through screening should be followed up by further assessment, particularly when screening is undertaken by less skilled auxiliary workers. Reference has been made (5.4.1.2) to guidelines that could assist in assessment, not only in the case of PLHA, but more generally.

### 6.2.2 Pharmacotherapy

Although depression can be treated effectively with low cost antidepressants, this may apply particularly to more severe forms of depression. For milder depression, alternative, non-pharmacological interventions are more appropriate as the first line of management.

To be effective, psychotropic medication must be taken at adequate dose levels and for an adequate duration. Assertive case management and collaborative care are recommended to counter poor adherence and prescribing practices contrary to guidelines. In addition, the negative features of existing psychotropic medication need to be acknowledged and built into plans for adherence support, developed collaboratively with the patient.

Findings regarding the effect of ART on the mental status of PLHA are inconsistent. PLHA with CMD do benefit from the use of psychotropic medications, which are generally well tolerated, including by PLHA on ART. However, specific knowledge is necessary to ensure safe and effective use (see 5.4.1.3).

### 6.2.3 Counselling, psychosocial support and psychotherapeutic interventions

Although there is some reference in the literature on primary mental health care to counselling, the term is much more widely used in relation to HIV/AIDS, sometimes also referred to as psychosocial support. A number of different approaches are used, primarily in support of physical health care, for example voluntary counselling and testing and adherence counselling, often, however, without much specification of what exactly is involved. Ongoing counselling may be the exception rather than the rule, despite the fact that once-off encounters may be of limited value. Counselling is often undertaken by auxiliary workers with limited training and frequently without supervision. Hence quality issues arise. Little in the way of evaluation has been reported.

In all aspects of primary mental health care, more effective use could be made of informal counselling in the course of health care consultation, even within the constraints of time characteristic of primary care settings. However, this would require a shift from the didactic mode usually characteristic of such encounters towards a more empathic yet purposeful intervention. Attention to mental health and psychosocial issues is expected in VCT and adherence counselling, but generally secondary to the primary focus. Mental health should be included more directly, at the very least through screening for CMD and through providing the time for counsellors to provide supportive mental health care for clients with sub-threshold conditions. The ongoing nature of these kinds of contact lends itself to the development of relationships between patient/client and counsellor which may increase the value of the counselling.

Psycho-educational counselling is referred to fairly often, although often without clear specification of what is involved. In some instances, it appears to overlap with informal counselling; in others a fairly structured approach is described. However, there are possible risks to what may otherwise seem to be a relatively low intensity intervention. There are some indications that there is less risk and increased effectiveness in group-based rather than individual counselling, involving a number of sessions over a period of a few months rather than over a more extended period, and with an emphasis on problem-solving rather than the self-monitoring of symptoms. Manual-driven approaches, together with adequate training and supervision for counsellors, may increase the value of psycho-educational counselling. Regular monitoring of the mental health status of participants by health workers is also required.

Psychosocial support groups have been widely used for PLHA and there is some evidence that they may be protective for mental disorder. Peer support offered through groups appears to offer a relatively low-cost, but apparently effective, mental health intervention at primary care level. The recommendations regarding group-based psycho-educational counselling are also relevant here. Barriers to participation (such as transport costs, time of week/day) may, however, restrict their reach and effectiveness – subsidising attendance may be a cost-effective use of resources.

HIV/AIDS-specific psychosocial interventions (the health journey, memory work and body mapping) offer a form of “manual” for psychosocial support, usually provided in a group setting. These approaches appear to have value, but more research and evaluation is necessary to evaluate their impact and whether they might be applied with other groups, for example women suffering from depression. It is important not to underestimate the level of skill needed to facilitate these apparently straightforward interventions.

Brief psychotherapeutic interventions, such as cognitive behaviour therapy and interpersonal therapy, have been shown to be effective in the treatment of CMD in general and specifically for PLHA. Moreover, they appear amenable to adaptation for different cultural and ethnic groups. However, the lack of specialist mental health personnel capable of implementing such interventions and questions about whether they remain effective when provided by non-specialist workers in primary care may restrict their application in developing country contexts.

Manual-driven approaches, delivered in a group setting, by specifically trained personnel appear worth pursuing, but require close monitoring of the quality and efficacy of the intervention. Manual-driven approaches may also reduce the likelihood of facilitators encouraging emotional expression as a release for its own sake and encourage instead a more careful working through and making meaning of experience. Specifically in the case of PLHA, cognitive behavioural and stress reduction interventions need to be tailored to the unique stressors that confront them and to the possibility of promoting post-traumatic growth. Group approaches may, however, be resisted by some PLHA because of concerns about stigma and confidentiality.

#### **6.2.4 Organisation of care**

In developing countries, referral involving transfer of responsibility for all or part of care is generally limited by a lack of suitable or accessible referral resources. To ensure the best use of scarce resources, therefore, there need to be clear guidelines and procedures for referral.

As outlined in sections 4.2.2, 5.4.2 and 6.4, case management, stepped care and various forms of collaborative care may offer effective alternatives to referral. These approaches can be applied whether dealing with the general population of primary care users, or specific groups such as PLHAs. Used systematically, these approaches separately and even more so when used together encourage the use of scarce resources appropriately and effectively. In the case of stepped care, a proviso is that it must be based on solid evidence of the effectiveness of the step-wise interventions used and that there must be clear guidelines on when to refer.

Collaborative care appears to be a particularly effective approach in the case of co-occurring diagnoses – here represented by mental disorder and distress co-occurring with HIV/AIDS – by providing direct support for primary care personnel in managing mental disorder. It may add less value and be less cost-effective if applied to sub-threshold or milder forms of disorder, implying the need for a filter regarding cases assigned to collaborative care. Extending collaborative care to include collaboration with NGOs, CBOs and faith-based organisations may add to its value by drawing in a wider range of resources for mental health care.

The risk in each of the approaches is that, without close monitoring of clients, supervision of staff and the development of a team ethos, necessary consultation or referral is delayed. Hence, access to consultation, either direct or through telephone consultation when this is not possible, is essential. It is particularly necessary in the early stages of implementation of primary mental health care following training and during the development of stepped and/or collaborative care in order to consolidate skills and teamwork.

### 6.3 Staffing, training and supervision

Staffing is key to effective primary mental health care. Lack of sufficient numbers of mental health professionals to provide mental health care at a primary care level has led to a strong emphasis on expanding the role of existing generalist primary health care workers to include mental health care. The heavy workload of primary health care workers and attitudinal factors, as well as organisational and systemic factors has, however, posed challenges to this strategy. The fact that some of the good practice examples use traditional mental health personnel in non-traditional ways (e.g. to offer collaborative care, or in outreach), or new auxiliary workers to undertake some components of mental health care (e.g. counselling of depressed women and PLHA) suggests recognition of the barriers to provision of primary mental health care through generalist workers only. Collaborative or shared care may in fact encourage more effective use of specialist resources. Supplementary low-cost auxiliary workers to assist general health workers, for example, in screening, or to extend their work through special programmes, may make all the difference to whether primary mental health care becomes a reality. However, some of these alternative resource strategies do raise issues in relation to scaling up services.

Regardless of personnel category, training is essential to avoid the possibility of causing harm and to ensure acceptable standards of care. Effective training should be designed taking into account the principles previously outlined, namely, that it should be systematic, participatory, tailored to the needs of the learners, combine two or more strategies and involve trainees in activities directly related to their daily practice. Training should address not only knowledge and skills, but also attitudes, particularly stigmatising attitudes towards patients/clients.

Training does not ensure its implementation. In addition to its other merits, collaborative care appears to offer an effective means of supporting the implementation of new knowledge and skills. However, limited professional mental health resources may place constraints on the extent to which this model can be used to promote implementation.

For supervision in its more traditional form to be effective, it needs to occur regularly and preferably be conducted by a more experienced colleague, but, in the absence of such a resource, regular group supervision, with less frequent attendance of a more experienced supervisor, offers an alternative and may have advantages in allowing for learning from peers. A necessary condition for effective group supervision is that all members of the group feel comfortable sharing problems within the group. Taking into account the culture of particular settings, it is therefore important to assess whether to involve all members of a mental health team or to have different groups for members at different levels, for example community workers and doctors/nurses. Various tools have been developed to help supervisees to record and assess their own performance and for supervisors to use in direct observation of supervisees. Their use may assist in the supervision process.

### 6.4 Systemic and organisational factors

Unless systemic and organisational barriers are addressed, primary mental health care will not become a reality. Advocacy is essential for highlighting to planners and managers the importance of mental health care, not only because it deserves attention in its own right, but also because of its potential contribution

to improved health care for PLHA. Sound cost and cost-effectiveness information can assist in addressing long-held assumptions in this regard. At a local level, organisational development approaches are necessary to challenge the traditional structure and culture of general health care so as to accommodate new ways of working and, possibly, new categories of workers. Partnerships with NGOs can help to address gaps and assist in developing new ways of working.

One of the systemic barriers to implementation and scaling up of primary mental health care is the issue of costs and funding. If psychotropic drugs form part of the package of care, there will, as a minimum, be increased costs at that level related to the costs of psychotropic drugs. Arguments that this is in effect a transferred cost are unlikely to satisfy primary care managers who have to be able to fund this new line item. If additional staff are required (whether to allow for increased time pressures on generalist staff, or dedicated auxiliary or professional staff), this is a further cost.

Although sensitive to critiques of donor funding (including sustainability, accountability and donor influence on priorities and even the form of projects), Mcdaid and colleagues (2008) have suggested that international and local donor funding of primary mental health care pilot projects may offer opportunities to test and cost locally relevant primary mental health care projects. If found to be cost-effective, such projects may then be scaled up in partnership with local communities and governmental authorities: this implies that costing should be a central requirement of such projects.

## 6.5 Scaling up

With regard to scaling up examples of good practice, a report on getting research findings into policy and practice (Nath, 2007) contains important lessons. Factors that can facilitate scaling up include:

- ensuring the involvement of and maintaining good relationships with all relevant stakeholders in development and implementation of a project;
- sensitivity to local social, religious and cultural values and practices in development and scaling up;
- timing plans for scaling up appropriately relative to the country context (taking into account factors such as the economic, political or administrative situation or changes);
- communication about the project and scaling up that ensures the right messages to the right persons at the right time;
- continuing donor commitment and support for scaling up; and
- availability of sufficient resources and commitment from local role-players who have the authority to facilitate scaling up.

With regard to staffing, with appropriate adaptations the resource estimation model referred to above may be useful to assess the resource requirements and cost implications of using either more traditional primary health care workers or new categories on a larger scale. As indicated previously, a trade-off of effectiveness versus cost-effectiveness may be required.

Specifically in relation to counselling and psychotherapeutic interventions, there is the question of whether in a developing country context staff at the levels cited for pilot programmes will be available in sufficient numbers to provide these interventions on a large scale. However, given high unemployment rates in many developing countries, it may be less a question of whether suitable personnel are available to deliver the intervention, than whether there are sufficient personnel to offer good quality training and supervision. In deciding on whether to offer these kinds of intervention, both aspects need to be considered.

## 6.6 Some neglected issues

A number of important issues raised in the literature do not appear to have been addressed substantively in much of the good practice described in this report and need attention in future:

- Most developing countries are characterised by high levels of poverty, uneven levels of development, high income inequality and gender inequality. Some of the good practice examples explicitly took these factors into account – for example, those in Chile and Pakistan focused specifically on poor women. However, it remains important to avoid the individualisation and medicalisation of what are essentially social problems. This does not mean ignoring mental distress and disorder, but does require that advocacy addresses social and human rights issues in parallel with developing primary mental health care.
- Stigma has been identified not only as an obstacle to seeking care for mental health problems, but also to engaging primary care health workers in mental health care (Saraceno et al, 2007). Primary mental health care practice needs to address stigma in both these respects.
- Populations of many developing countries are made up of diverse ethnic, cultural and language groups, with different understandings of and attitudes towards mental disorder and mental health care. As increasingly recognised in developed countries (Dwight-Johnson & Lagomasino, 2007), primary mental health care projects, especially those intended for wide scaling up, need to be sensitive to and take account of these differences.
- In many developing countries, traditional healers and religious leaders are consulted instead of or in parallel with the use of modern health care. For many, these resources are in fact the only ones available. Projects that operate in countries or areas where these practices are prevalent need to find ways to engage and collaborate with these parallel resources to ensure that there is no conflict between the different forms of care provided, but rather that both address the best interests of the patient (Alem et al, 2008).

## 6.7 Factors to assist in deciding on a practice model

This review has attempted to outline general guidelines and examples of good or promising primary mental health care in resource-poor settings. The point has been made that there is no single practice model that is equally applicable in all settings and that adaptation to the local context is always necessary. In this section, we attempt to highlight some factors to consider in deciding between possible practice models for a particular setting.

The first set of factors to be considered are those raised by the principles referred to earlier. These provide a checklist of primarily systemic and organisational factors to consider when comparing different models that might be introduced in a particular setting. Phrased as questions, the factors may be summarised as follows:

- *To what extent do national, regional and local policy and plans facilitate the introduction of one rather than another model of primary mental health care?* Without these, only demonstration projects would be possible and there is no guarantee that successful projects would be scaled up. If policy and plans are available, they may mandate one rather than another model of practice.
- *What sort of collaboration is possible between government health and non-health sectors, NGOs, village and community health workers, and volunteers?* Making use of the widest possible array of resources can facilitate the introduction of primary mental health care and may influence the model used, for example collaborative care with NGOs or outreach community health workers.
- *Has there been sufficient advocacy to shift attitudes amongst all stakeholders (especially at management and staffing levels) concerning the provision of primary mental health care in general and in relation to a specific model?* If not, there may be resistance regardless of which model is introduced.
- *What mental health functions are envisaged for primary care workers? In the case of generalist workers, have they been identified in consultation with these workers? Are the functions limited and doable? What referral resources are available?* Stepped care may offer an efficient means of defining primary care functions and referral routes and procedures.

- *What are the training implications for generalist or other workers who would be involved in the direct provision of care? Are the necessary resources available for continued support and supervision?* Incremental approaches and involvement of specialist staff in collaborative care may be helpful in ensuring training is implemented.
- *How could essential psychotropic medication be provided?* This implies attention to supply chains, prescribing and dispensing regulations and referral routes where psychotropic medication is not available in particular settings (e.g. nonmedical settings).
- *What are the infrastructural, human resource and financial implications of one rather than another model?* This implies consideration of improvements to infrastructure and the availability of human resources (both generalist and specialist and existing and possible new categories), as well as costing and budgeting (including for psychotropic medication at primary care level).
- *What steps would be necessary in the process of introducing the model? What are the time-frames? What organisational change process would be required? Is there someone of sufficient seniority available to take on the task of coordination to drive and oversee the change process?*

A second set of factors is derived from the discussion of the generic models described in section 3 and expands on the question of functions and staffing. The questions to be considered might then be phrased as follows: which staff, providing which package of care?

In our review of staffing there has been mention of generalist staff (most often in health care settings), mental health specialists and auxiliary staff (either facility-based or outreach or community health workers). Although primary mental health care is promoted on the grounds that most CMD presents in the first instance in primary care settings, the limited numbers of professional mental health staff in most resource-constrained settings is often the key motivation prompting its development. On the other hand, resistance from general health workers and managers, often on the grounds that their existing workload does not permit them to take on additional functions, is often a barrier to introducing primary mental health care. Hence, the first factor to consider would be the numbers and distribution of professional mental health staff and the workloads of general health workers. This may dictate initially greater involvement of professional mental health staff through placements 'at' primary care settings, or through engaging in collaborative care with generalists, at least during an introductory phase. Such an approach would imply phased introduction of primary mental health care, starting with demonstration projects, then gradually withdrawing professional resources and making them available in other facilities. Use of stepped care approaches to offer continued support and referral resources for primary care staff could provide another option.

Where there are real constraints on primary care staff taking on additional functions, the option of using auxiliary workers to assist generalists by performing limited and defined functions such as screening, manual-driven counselling or psychotherapeutic interventions could be considered. Here it would be important to assess the kinds and level of human resources potentially available for such positions, since a minimum level of education (probably at least high school) is necessary to engage with training and conduct such interventions. In addition, resources for supervision need to be available – during the early stages of an intervention, ideally mental health professionals, although experienced auxiliary workers may later be able to take over some of this work.

The provision of psychotropic medication has generally not been devolved to auxiliary workers and generally also falls outside the functions of nonmedically trained professional staff within the health sector or in other sectors. The national context with regard to regulation of prescribing and dispensing would need to be considered first in assessing whether generalist health workers could take on this task. Barriers might need to be challenged in order to implement fully what we have referred to as mental health *in* primary care. Alternatively, a stepped care approach may be necessary to deal with this issue.

Finally, the possibilities for collaboration across sectors and in particular with NGOs should be considered. While it is not suggested that the latter should be the mainstay of primary mental health care, it is clear that, in many settings, innovations in primary mental health care are being driven by these organisations. Engaging with and building on such initiatives could offer a way to pilot and test models that could subsequently be extended more widely.

## 6.8 Research priorities

Research is important in informing the development of evidence-based interventions for mental health at the primary care level. This review has highlighted the limited availability of research from developing country settings on this topic. Research priorities to guide the implementation of primary mental health care in resource poor settings, include the following:

- The ten principles for successful integration summarised earlier provide a template for some of the issues needing research: in any particular project, to what extent have these been followed and with what results?
- A number of the good practice examples are represented as typical of services throughout the district, region, state or country as a whole. However, there is some doubt as to how comparable services are across the relevant geographical or political unit, a question that could be answered by comparative research.
- Given the increased emphasis on provider-initiated VCT and the huge reliance on counsellors with very limited training, research to assess both the models and quality of VCT, including the constraints on effective counselling, is urgently required. It is particularly important to explore women's experiences of being counselled and tested, especially when testing is provider-initiated.
- While randomised controlled trials have much to contribute in terms of assessment of the ability of particular good practice examples to deliver services that are efficacious and effective, they cannot usually provide answers regarding the mechanisms involved. Qualitative research, including comprehensive descriptions and observational studies of interventions, is needed to inform an understanding of which of the components in these extremely complex interventions are critical for success and how they may operate.
- The psychotherapeutic interventions referred to in the examples of good practice have generally been specifically developed or adapted for those settings. A more in-depth evaluation of these interventions may assist in highlighting features that contribute to good practice. The question of the relative effectiveness of group versus individual interventions would be of particular interest, given differing findings in this regard.
- As indicated by the failure of group IPT as used in Uganda to transplant to India, there are also questions about replicability across different cultural contexts. The careful evaluation during the development of the Thinking Healthy Project in Pakistan (Rahman et al, 2007) and the MANAS project in India (Chatterjee et al, 2008) addresses some of these questions in their context and also provides models of formative evaluation that could well be emulated elsewhere. Attention should also be given to investigating the efficacy of alternative cultural healing practices that may be perceived as more accessible and appropriate than psychotherapies imported from the developed world.
- There is a need for broader health systems research addressing a more complex range of questions with a wide range of appropriate methodologies and for research tracking the process and assessing the effectiveness of scaling up to assist in the further development of primary mental health care and to indicate possible barriers to wider application (Patel et al, 2007). This should include evaluations of primary mental health care beyond the introductory stage when it should be a routine part of primary care, particularly in rural areas (Alem et al, 2008).
- Cost and cost-effectiveness studies of interventions are urgently needed to assist in determining implementation priorities and to support advocacy efforts.
- Gaps in this review that appear to be priorities for further research are the question of good or promising practice in primary mental health care for adults abusing substances (touched on only briefly in this review) and for children (where, despite some guidelines, more in-depth evaluations of specific interventions, particularly those developed to provide psychosocial support for and promote psychological and emotional development in children infected or affected by HIV, would be useful).

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## APPENDIX A

### SELECTED GUIDELINES ON MENTAL HEALTH INTERVENTIONS FOR PLHAS IN RESOURCE-POOR SETTINGS

#### WHO documents

Integrated management of adolescent and adult illness (IMAI):

- Acute care - Interim guidelines for first-level facility health workers. (2004).
- Chronic HIV care with ARV therapy - Interim guidelines for first-level facility health workers.(2004).
- Palliative care: symptom management and end-of-life care - Interim guidelines for first-level facility health workers. (2004) .
- Acute Care Guidelines: Neurological and mental problems: Facilitator guide (draft). (2005).

Mental Health & HIV Series:

- Basic counseling guidelines for Anti-retroviral therapy programmes. No. 2 (2005) (adapted from SAT Basic Counselling Guidelines).
- Psychotherapeutic interventions in anti-retroviral therapy (for second level care). No. 5 (2005).
- Psychiatric care in anti-retroviral (ARV) therapy (for second level care). Mental Health & HIV/AIDS series: No. 3 (2005).
- Organization and systems support for mental health interventions in anti-retroviral therapy programmes. No. 1 (2005).
- Psychosocial support groups in anti-retroviral (ARV) therapy programmes. No. 4 (2005).
- Psychiatric care in anti-retroviral therapy (for second-level care): Facilitator Guide. (draft). (2005).

Miscellaneous WHO guidelines/reports:

- Guidance on provider-initiated HIV testing and counselling in health facilities. (2007).
- Maternal mental health and child health and development in low and middle income countries: Report of a WHO-UNFPA meeting, Geneva, Switzerland, 30 January-1 February, 2008.
- Preventing suicide: A resource for primary health care workers (2000) (who/mnh/mbd/00.4).

#### Counselling training guides

Centers for Disease Control and Prevention, National Center for STD HIV Viral Hepatitis and TB Prevention, Global AIDS Program [www.cdc.gov](http://www.cdc.gov):

- *Couples HIV counselling and testing Intervention and curriculum: Trainer's and participants' manuals.* (2007).

Department of Health, South Africa [www.doh.gov.za/docs/](http://www.doh.gov.za/docs/):

- *Operational plan for comprehensive HIV and AIDS care, management and treatment for SA. Annex V.4: HIV Counsellor training model.* (19 November 2003; last modified 25 April 2008).

National AIDS Control Organisation, India (NACO) [www.nacoonline.org](http://www.nacoonline.org):

- *Counselling training modules for VCT, PPCT and ART counsellors: Facilitators' guide.* (2006).
- *Counselling training modules for VCT, PPCT and ART counsellors: Handouts.* (2006).

WHO SE Asia Regional Organisation (SEARO) [www.searo.who.int](http://www.searo.who.int):

- *Voluntary HIV counselling and testing: Manual for training of trainers.* (2004).

Zambia Counselling Council:

- *HIV/AIDS counselling: A handbook.* (2003).

Centre for the Study of AIDS [www.csa.za.org](http://www.csa.za.org):

- *Trauma and HIV course – facilitator and participant manuals.* (2004).

## Counselling guidelines

Southern African AIDS Trust [www.satregional.org](http://www.satregional.org):

- Basic AIDS counselling guidelines. (2000).
- Counselling guidelines on disclosure of HIV status. (2000).
- Counselling guidelines on domestic violence. (2001).
- Counselling guidelines on palliative care and bereavement. (2001).
- Mainstreaming gender in HIV and AIDS work. (2004).

Centre for the Study of AIDS/Perinatal HIV Research Unit  
[www.csa.za.org](http://www.csa.za.org) / [www.hivsa.com](http://www.hivsa.com):

- *Adherence resource pack for antiretroviral adherence counseling and support.* (2005).

## HIV/AIDS-specific psychosocial techniques

REPSSI [www.repssi.org](http://www.repssi.org):

- *Memory/Life story work manual.* (2004).
- *"Living with X": A body mapping journey in the time of HIV and AIDS: Facilitator's Guide.* (2007).

International HIV/AIDS Alliance [www.aidsalliance.org/publications](http://www.aidsalliance.org/publications):

- *The health journey: Understanding the dimensions of care and treatment for people with HIV: A community-centred methodology.* (2007).

International Memory Project (Healthlink Worldwide) [www.healthlink.org.uk](http://www.healthlink.org.uk):

- *The memory work trainer's manual: Supporting families affected by HIV and AIDS.* (2005).

## Project Sustain/AIDS Bereavement Project of Ontario [www.abpo.org](http://www.abpo.org)

- *Basics of grief and multiple loss: A training manual for workers in AIDS service organisations.* (2003).

## World Federation for Mental Health Africa Initiative [www.wfmh.org](http://www.wfmh.org)

- *Online resource directory: Psychosocial support – Reports, resources & best practices.* (2008).





Sexual Violence Research Initiative  
Gender and Health Research Unit  
Medical Research Council  
Private Bag X385  
0001  
Pretoria  
South Africa

Telephone: + 27 12 339 8527  
Facsimile: + 27 12 339 8582

E-mail: [svri@mrc.ac.za](mailto:svri@mrc.ac.za)  
Website: [www.svri.org](http://www.svri.org)

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