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Acronym

BN	BasicNeeds
BNL	BasicNeeds Lao PDR
CMH	Community Mental Health
CMHD	Community Mental Health and Development
CMHOC	Community Mental Health Outreach Clinic
DFID	Department for International Development of United Kingdom
DH	District Hospital
FGD	Focus Group Discussion
GP	General Practitioner
HW	Health Worker
Lao PDR	Lao People's Democratic Republic
LDPA	Lao Disabled People's Association
MH	Mental Health
MHU	Mental Health Unit
MoH	Ministry of Health
MOU	Memorandum of Understanding
NGOs	Non-Government Organisations
OC	Outreach Clinic
PM	Programme Manager
VCDH	Vientiane Capital Department of Health
VHC	Village Health Centre
VTE	Vientiane Capital
VV	Village Volunteer

I. Introduction

BasicNeeds Lao PDR is the first NGO running the Mental Health and Development Programme in the country. Within the organisation at this time, it has one and a very first project titled, “Community Mental Health and Development in Vientiane Capital of Lao PDR Project (CMHD)”. Its target beneficiary communities are set to be in 9 districts of Vientiane Capital. However currently, it is only operating in two pilot districts namely – Xaythani and Sikhottabong districts.

The work of BasicNeeds Lao PDR’s CMHD in Vientiane Capital Project, funded by Department for International Development UK (DFID), is to deliver help to improve the quality of life of those suffering from mental disorders through implementing 5 BasicNeeds’ modules of Mental Health and Development, namely - Capacity Building; Community Mental Health; Promoting Sustainable Livelihoods; Research Policy and Advocacy and; Program Management and Administration.

Community Mental Health Care Service is defined as a decentralised model, for example, the mental health care is provided at the grass-root, i.e. at district and village levels, for those with mental illnesses, this service is called ‘Outreach Clinic’. Community-based mental health care is designed to reach and decrease the mental health care need for more costly inpatient delivered in central hospitals. This thematic study will analyse the relative advantages and challenges. Especially, it will look into the assurance and quality of CMH model being implemented in Lao PDR by BNL.

II. Methodology

The study applied Case Study method used. It was taken place at two outreach clinic of BasicNeeds Lao PDR, that is, NongNiew and Chansavang village health centres. This study was carried out from May – June 2008,

• Data Collection

Data used in this report was gathered using four methods:

- Reading numbers of relevant reports on CMH service;
- Observation of mental health outreach clinics in NongNiew and Chansavang village health centres which are part of target locations of the CMHD project;
- Two focus group were conducted – one in Thangone and other in Nalao village involved 11 mentally ill people and 12 carers; and

- Interview 3 key informants who are involved in the outreach clinic work

- **Data Analysis**

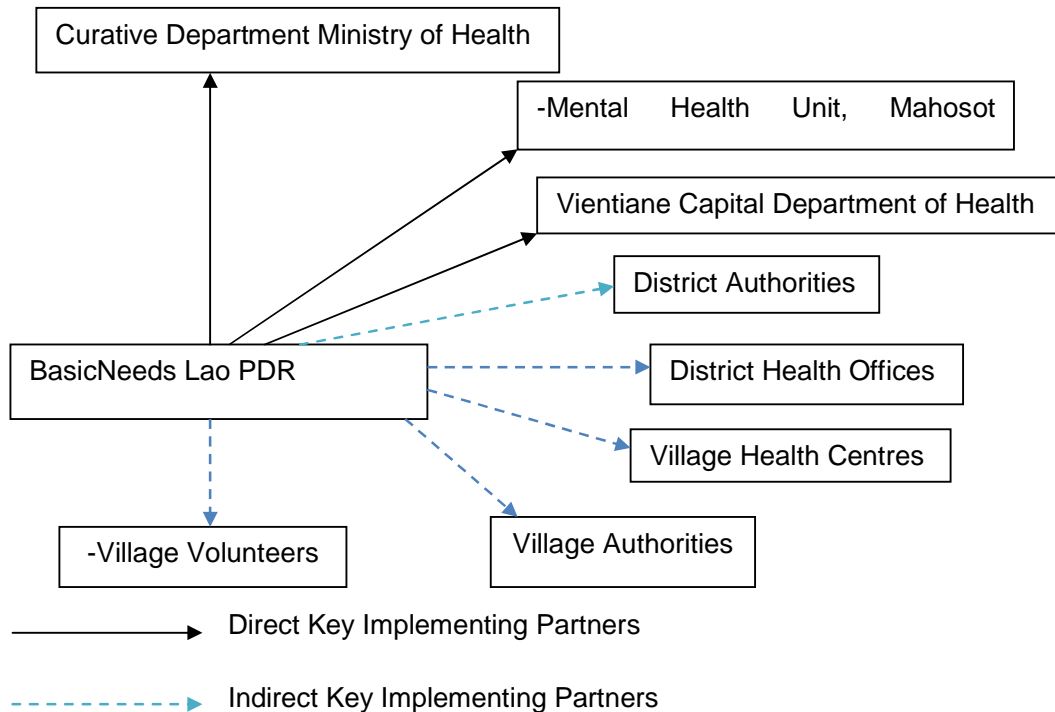
The analysis was done by reviewing BasicNeeds' CMHD project introduction, MOU, key informants interview notes, field notes of observation, outreach clinic's documentation structure, and reports of FGDs. The relevant information for the study were extracted from those document, two FGDs reports was synthesised and summarised into one report under each question theme.

III. BasicNeeds Lao PDR's Community Mental Health Implementation

1. Background of Community Mental Health in Lao PDR

Since May 2007, BNL office has been established to facilitating and supporting CMH model concept of BasicNeeds organisation as a whole, on the other hand, the project expiration will be on May 2010. CMH has been set up through collaboration between BasicNeeds and the Ministry of Health, particularly Curative Department where mental health operation falls under. And under this department, the project is also designed to work together with Mental Health Unit of Mahosot Hospital and Vientiane Capital Department of Health (VCDH). Following illustration shows the relationship between BNL and its key implementing partners:

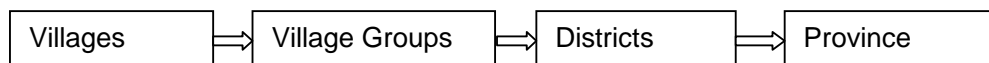
Figure 1: BasicNeeds Lao PDR Key implementing Partners Structure



Decentralised system is used within Lao government bodies. Therefore, all of project implementation is needed to get approved starting from municipal, district to village lines. Figure 1 illustrates key implementing partners range from top to grass-root levels, each of them however, are playing distinguished roles on the CMHD project implementation process, for example, MoH is a main authority who issues an approval/order to lower concerned party, this process afterwards was carried on until the approval and message about the activity reached the village level.

2. Location of Community Mental Health Outreach Clinic

In Lao PDR, it uses following characteristic geography terms:



At present, the coverage of BNL's CMH Outreach Clinic (CMHOC) is launched in two pilot districts in VTE that is, Xaythani and Sikhottabong districts. Yet, not all villages under these two districts are reached due to the lack of MH care provider resources. So, currently there are altogether three CMH outreach clinics settlements. It should be noted here that, the Village Health Centre (VHC) is a primarily target for BNL's OC operation, however, not all village group has VHC. If target community does not have a VHC, then the OC has to be operated at District Hospital (DH). Below explains the CMHOC location of pilot districts:

▪ In Xaythani

Thangone village group, about 30 KM from central of VTE, is the very first CMHOC settlement; eleven villages form Thangone village group. Xaythani DH is also located here. At the outset of project intervention, the CMHOC used to, at one point, operate a few times at the temple at one of these villages. Then the service was moved to Xaythani DH as it has more convenience given the fact that there are more rooms and basic resources for the OC operation. Recently, the CMHOC is expanding its service to a new village group calls 'Khoksivilay', the OC expects to provide MH care service to the new community on July 2008.

▪ In Sikhottabong

There are two CMHOCs in this district; the selected village group is 'Nongniew', located about 16 KM from the VTE central. This group altogether comprises of about 8 villages. However unlike Xaythani, which only has one OC. Sikhottabong has two OCs within Nongniew village group itself. Since villages under this group are quite spread out. As this reason, the group has two VHCs that is, 'Nongniew and Chansavang VHCs' and this is

where the CMHOC operating. Moreover, 'Nongbeuk' village group was recently just included as one of the target community; this community will use the MH service at NongNiew VHC as it is quite close to their village group.

3. How Does BNL Find Mentally Ill People?

Before organising the entry field consultation meeting¹ at the target community, BNL would be in contact with DH for deciding together the location and a mental illness surveillance community. Not only DH that BNL is in contact with but also VHC (if any) and village mass organisation these include – village chief, Lao front, women and youth unions, village volunteers, and so on.

People with mental illness and their family usually are recognised by their village fellows. Hence, the meeting message would be distributed by the partners whose name mentioned as above. After the field consultation, mentally ill people and their family would be informed about the OC date and time and are encouraged to attend the OC.

4. Process at the BNL Community Mental Health Outreach Clinic

Since November 2007 up to present, the CMHOC has been operating in the target communities. The main providers involve in the process of OC are – one psychiatrist², one general practitioner³(GP), one doctor and one nurse from DH, Health Workers at the VHC and Village Volunteers. Sometimes, GP and nurses from MHU Mahosot also join the OC team. Moreover this June 2008 for the first time, GP from MHU Military and Friendship Hospitals, who were trained in MH care service by BNL, also agreed to assist the OC operation as the number of mentally ill people arisen and there are a lot of works at the OC.

¹ **Field Consultation Meeting** - Community meetings usually held before the start of activeprogramme implementation. These consultations are generally coordinated by a local community based organisation, potential partner or ally, and initially animated by BasicNeeds' staff. At the consultations people with mental illness, their carers/other family members, CBO field staff discuss mentally ill people's needs, suggest solutions and the way forward.

² Dr. Chantharavady Choulamany is not only a psychiatrist but also a BNL Programme Manager (PM). She is also a Vice Head of MHU Mahosot. But designated by MoH to work for BNL temporary

³ Mrs. Buoavanh Somsanith is also working as a Community Mental Health Assistant for BNL; she is a skilled GP in MH. Before BNL, she used to work at MHU Mahosot in 1999 – 2006.

The OC team provides treatment once a month for each OC settlement. Mentally ill people and their carers would be informed / reminded about the OC appointment date and time by Village Volunteers. At the OC day, mentally ill people will be handed out their queue number, as 'first-come first-served' concept, then they are registered and filled out their clinical file by Village Volunteers. Nurses are responsible for basic entry physical health check i.e. weight measurement and blood pressure⁴ and dispense psychotropic drug.

The OC usually has two rooms for consultation; one is stationed by a psychiatrist and other by GP. But now as more trained GP involved, the numbers of consultation rooms are also increasing. Consultation technique used at the OC is, mentally ill person and carer are entered the room at separate times, for example, mentally ill person talks to psychiatrist or GP first then carer can enter the room later. The purpose of this technique used is to have a comprehensive understanding about individual and family problem as to link them together and decide proper diagnosis and appropriate treatment for mentally ill person.

After being consulted and given prescription by psychiatrist or GP, mentally ill person and carers then obtain their medication with nurses who are sitting at the main entrance area of the OC.

5. Follow Up Visit Work

Follow-up visits happen at the OC, mentally ill person and carer meet psychiatrist or GP once a month. Other follow up work is done for a critical case, for instance, the OC team would conduct a home-visit accompanied by DH or VHC health workers to the house of acute case. Following weeks, DH and VHC continue a home follow-up visit on their own. The focus of this activity would pay attention to the taking of medication regularly, side effect and relevant obstacles patient is facing. Often this happens when family of patient are not be able to deal with the case, they then could ring DH health workers and can request for in-house MH care service.

6. Alternative Treatment

Apart from general mental health care service, counselling is also provided at the OC by psychiatrist or GP. And not only does counselling is provided to patient but also to their carer and family. Besides counselling, patient and their family rely on temple as a place for putting their mind at ease and pray for their hope in getting better.

⁴ Except young children patient

7. Records and Documentation

At the outreach clinic, four main records are used:

- 1) New patient code book – this book is used to record only new patients as to identify easier at the end of the day how many new patients arrive at the clinic. Content inside this book are: list number, new patient code number, name, age, sex career, house unit, village name, date of visit, diagnosis and name of mental health care provider. This book is recorded by either village volunteer or nurses.
- 2) Summary of patient record book – this book includes both old and new patients as to see how many patients in total at the day. Information required in this book is: list number starting from 1, 2, 3 etc, patient code number, name, age, sex, career, village, house unit, tick box if new or old patient, diagnosis, date of visit and name of MH care provider. This book is recorded by either nurse or medical student - who is on field practice at the VHC or DH.
- 3) Medication record book – this book is used to summarise various medicine types which are available and this is to see how many are provided to patient at the end of the day at the OC. Usually this is recorded as milligram along side with patient name in which the medicine was subsidised to.
- 4) Clinical file – is typically an integral part document of the OC, this document is not only used to analyse each case individually but also to document relevant background history information of patient as to enhance a better diagnosis and treatment process. A basic background information section in this file is recorded by either volunteer or HW at the VHC then the rest parts is recorded by psychiatrist or GP.

Main information needed in this document are – general background of patient and main carer, illness symptoms, illness history, patient's family tree, mental health status checklist, physical examination, diagnosis, referral, treatment follow-up and agreement paper for carer to acknowledge that the he/she agrees on mentally ill people involved in the programme.

Furthermore after the diagnosis, clinical file is kept inside different plastic colour folders, each colour stands for different diagnosis, for instance, light pink folder represents epilepsy patient while yellow folder represent schizophrenia patient. This method used is however

only understood by the MH care providers at the OC as to avoid any discrimination/confusion that might be a case if any.

At the moment, all of records above are kept at BNL's office since main MH care providers are also BNL staff. Nevertheless, BNL is planning to handover this record to be kept and maintained by DH and VHC in coming future.

8. Resources at the Mental Health Outreach Clinic

In order to allow the OC runs smoothly, there are number of resources needed to be available at the OC. Following is a list of resource requirement at the OC:

- Psychiatrist and GP for providing treatment and counselling to patients and family
- Consultation rooms preferably quiet space
- Nurses and village volunteer for assisting psychiatrist and GP
- Medication is currently provided to patient with no cost bourn by BNL's budget; however, at present all psychotropic drugs are stored at BNL office. At district hospital level, only Xaythani DH is provided a few psychotropic drugs by BNL.

List of psychotropic drug which BNL has in stock:

List	Name of Psychotropic Drug	Type	Milligram
1	Largactil	Antipsychotic	100
2	Haldol	It is used in the treatment of schizophrenia and, more acutely, in the treatment of acute psychotic states and delirium	5
3	Phenobarbital	Anti-Epileptic drug	100
4	Hydantoine	Anti-Epileptic drug	100
5	Tryptanol	Anti-depression drug	25
6	Olanzapine	Anti-psychotic drug	10
7	Propranolol (Trade name: Avlocardyl)	it is a non-selective beta blocker mainly used in the treatment of hypertension	40
8	Cinnarizine	Cinnarizine is an anti-histaminic drug which is mainly used for the control of vomiting due to motion sickness	20
9	Valium	to relieve anxiety and relax muscles	5
10	trihexyphenidyl (trade name: Artane)	Artane, a brand-name for the drug trihexyphenidyl used to treat Parkinson's disease	2
11	Mg B6	Vitamin	
12	B1	Vitamin	100

- Records/books
- Allowance and transport budget for GP, Nurses, and Village Volunteers
- Some basic physical health check e.g. weight measurement and blood pressure machines – these machines funded by BNL
- Other materials – table and chairs for patients and their family while waiting to meet the MH care providers, these materials are also supported by BNL

1. Mentally Ill People and Carers Perspectives on CMH Service

Following are mentally ill people and their caregivers' perspectives on the subject of CMH service at the FGDs:

▪ *What are your general feelings toward the mental health outreach service?*

Users expressed strongly their happiness and appreciation towards the benefit they got from CMH care service. The majority of participants at the FGDs, who have attended the OC regularly, reported that they feel better. Though, a few still complained little about they are not completely recovered. Also, a few patients stated that they are happy that now they have someone to discuss and listen to their problem as well as to give a good advice. One patient said he now can earn a living after getting treatment at the OC. Many are particularly happy about the fact that they do not have to spend money on treatment drug and transport cost.

"I am so glad that is now a project for the poor like us that we can rely on to and give us a new hope since we do not have to spend money on treatment" carer expressed her gratitude to the project.

▪ *What will you say about the location of the CMH care service?*

All users attended the FGDs, expressed firmly that they satisfy very much with the location of the OC. They are happy that it is so close to their home and no transport cost is needed⁵. All of them said they do not wish the MH care service locate far from where they live. Following sentences are some example of users' expression:

⁵ It should be noted here that, the minimum distance to the outreach clinic of the target community is 100 m to maximum 7 Km.

"I am so satisfied the location is so close to where we live I do not have to spend extra money on transport cost"

"I do not want the outreach clinic to locate far from my house"

"I like the idea that outreach clinic is based at my community, it is not far I can ride bicycle or simply walk to the clinic "

▪ ***How do you feel about the consultation and service at the OC?***

Most participants gave a positive feedback about the treatment given at the OC. Things they are satisfied are – MH providers talk nicely with them, good advice on treatment, no bias occurred (first-come first-served) and free medication.

Some expectation users said they wanted to get from the CMH include – expect the OC would be available in the long run so that patient can get treatment consistently until they are back on their feet; want to understand clearer on the course of referring system to what extent that the patient is referred to higher level; would be good if the OC could provide emergency hotline number for users as to be in contact if there is an emergency case; there is one carer said he likes to see the project having more modern equipment such as brain scanning machine so the doctor can check properly of what is wrong inside his epileptic daughter's nerving system. This request comment perhaps might be a bit too ambitious to be taken into account for the project at the moment.

▪ ***Home follow up work***

There are a few participants stated that they were visited by the OC team at their home. A male carer said the response to the critical case of the OC team was prompt and he is happy. On the other hand, other male carer said he wishes the OC would do more home follow-up visit. Volunteers was also mentioned by the participants, the participants like the way the volunteers do home visit for collecting individual file and carrying message about any OC appointment or group meetings to them. Some example on the volunteer's work expressed by mentally ill person:

"This morning one of village volunteer visited me to inform me about this FGD meeting, he is very concerned"

▪ ***Psychotropic Drug***

All mentally ill patients, participated at the FGDs, said they are prescribed adequate treatment drug for a month and return to the OC as their appointment each month to receive more drugs. Most of which said they take their medication regularly, only one mentally ill male patient skipped a month as he did not go to the OC as appointed by psychiatrist. His carer promised to take him for next appointment. In addition, all participants said the OC is only place they obtain treatment and medication.

▪ ***Psychotropic Drug Side Effect***

It is important to mention this issue here too, at the FGD, a few participants complained to have side effect from psychotropic drug, for example:

- most of which often feel sleepy
- one had a skin rash, vomiting and cramp neck
- Some has pain around fingers
- Many feel tired and dizzy

Strikingly, many reported that they are not informed well about types of drug and their side-effect. However, despite pitfalls caused by the drug, some mentally ill people said they sleep better, can eat well than before, not in bad mood, and not wandering around.

“The first batch of treatment was good but later the drug is a bit too strong, my son’s neck is cramp, he vomited and not relaxed so I decided to reduce his dose” – This is one example that the side effect is not well understood that the carer reduced the dose without consulting a MH care provider.

▪ ***If you can change CMH approach, what will you change the way it is now? And what that should not be changed?***

When participants were asked to rank their satisfaction⁶ toward the CMH care service, almost all participants (22 out of 23 persons) gave ‘very good’ impression for the project, while only one participant gave ‘good’ score.

Additionally, they were asked if they wish to change anything on the course of project implementation. Most of them said they are already happy of what it is now and that nothing

⁶ 1) very good;2)good; 3) satisfy;4) it is ok;5) not good at all

necessary need to be changed. Nonetheless, three of mentally ill participants said they hope the project would provide a livelihood opportunity and one carer said she wishes to see a set-up of school for special children like her child. In the subject of livelihood opportunity, it should be noted here this mission is one of BNL's working modules. But at the time of this data collection, this mission has not been implemented yet.

IV. Discussion

Good quality of CMH service needed numerous key ingredients, these ingredients however, are not necessarily implied to all countries as such countries have their own challenges.

Key ingredients in having good quality of CMH services for Lao PDR, First ingredient should go to *the involvement of various partners* including central, district and grass-root levels, both government and private sectors, as well as religious bodies, the operation could not be done without these partners. However, since CMH is very new to the country, the model of CMH is therefore not understood by all. So, this might take a bit of time to let these partners embrace this model. Second ingredient is to have *sufficient MH care providers*; the lack of this resource is dominantly delayed the expansion of CMH service to reach those that do not reside in BNL's target community. Third ingredient is *a budget* for running the OC operation, budget is needed to cover the cost of medication management, allowance for health staff and volunteers working for the OC, and some for basic equipments for the OC.

Fourth ingredient is *the OC location*, the OC should be based primarily at VHC. In a case that such VHC is not available at the community then DH can be an alternative location. Fifth ingredient is *a thorough patient record and documentation*, this task is crucial, given the fact that an effective diagnosis and treatment need a well-recorded in terms of patients illness history, symptoms, family's background, and so on so as to ensure suitable treatment for each individual. Sixth ingredient is *a Home Follow-Up Visit* since there are certain number of patients who need special MH care more than the other. Lastly, the seventh ingredient should also have *a counselling work*, this is particularly true among users when they expressed clearly that they are very happy they have someone who they can share their problem with. This work would augment the recovery of patient without doubt.

Seventh ingredients as mentioned above, however, are very challenging when it comes to reality at the ground work; for example, the BNL's CMHD in VTE Project would be completed in the next few years while there are a lot of patients needing long term treatment. Though, the plan is to handover the work to government's shoulder but there are still many obstacles

to make this plan becomes realistic given that this work need budget⁷, people, skills and management, and so on.

Users have a hope that they would be provided MH care in a long run. Other issue, is awareness and be prepared for side-effect of treatment drug that are still facing by the users, this issue needs to be taken into account critically for all MH care providers when it comes to consultation about the side-effect and the use of drug. Other challenging of the CMH is a lack of skilled MH care providers, this is issue, however, is not new or a surprised topic since there is a call for more MH care providers for the country.

V. Recommendation

Community mental health care is more accessible and responsive to local needs because it is based in a variety of community settings rather than aggregating and isolating patients in central hospital. Following are some suggestion in ensuring quality and assurance of CMH service work:

- Increase number of MH care providers through MH training at village, district and central levels;
- National budget should be allocated for CMH service and psychotropic medicines, and include this work into health care primary settings since BNL is currently bearing all relevant costs;
- More education and campaign on the subject of CMH service model needs to be emphasised for all relevant partners as to ensure the sustainability;
- Strengthening collaboration among all key relevant partners in order to make CMH service becomes realistic for the country; and
- MH care providers need to emphasis users on the matter of treatment drug side-effect and its usage. Especially, newly trained MH care providers are needed to be informed about this issue

⁷ There is no national budget for mental health at present.