

## Barriers to mental health services at public health centers: Providers' perspectives

Putu Aryani,<sup>1\*</sup> Pande Putu Januraga,<sup>1</sup> Komang Ayu Kartika Sari,<sup>1</sup> Lisanne Gerstel,<sup>2</sup> Willem F Scholte<sup>3,4</sup>

### ABSTRACT

**Background and purpose:** The disparity between the increasing prevalence of mental health (MH) illness and the availability of treatment in Indonesia remains high, despite the campaign to provide MH services at public health centers (PHCs) initiated by the government in 2014. This study explored barriers to MH service provision at PHCs in Denpasar, Bali, Indonesia in order to identify priorities for service improvement.

**Methods:** This explorative qualitative study was conducted from March to December 2015 and employed in-depth interviews and focus group discussions (FGDs). In-depth interviews were conducted with the Head of Denpasar City Health Office and with general practitioners (GPs) from four PHCs in Denpasar, to explore the perspective of policy and service management and experiences in PHC clinics, respectively. To further explore MH service implementation in the community, two

FGDs were conducted with MH program managers and community health workers (CHWs). The interviews and FGDs were recorded, and verbatim transcripts were analyzed using thematic framework analysis.

**Results:** Barriers to MH service provision identified in our study are poor dissemination of the national policy to the local government and PHCs; low prioritization of MH issues; organization workforce issues; funding concerns; poor coordination and supervision; poor management and recording system; scarcity of ancillary facilities and other resources such as psychotropic medicines.

**Conclusion:** The findings of this study highlight the importance of national policy dissemination and collaboration between local government, health providers and CHWs to overcome the barriers in providing MH services at PHC level.

**Keywords:** mental health services, primary care, public health center, barriers, Bali

<sup>1</sup>Department of Public Health and Preventive Medicine, Faculty of Medicine, Udayana University, Bali, Indonesia

<sup>2</sup>Royal Tropical Institute, Amsterdam, Netherlands

<sup>3</sup>Department of Psychiatry, Amsterdam UMC, University of Amsterdam, Amsterdam, Netherlands

<sup>4</sup>Equator Foundation, Diemen, Netherlands

### INTRODUCTION

Mental health (MH) and substance use disorders accounted for 183.9 million disability adjusted life years (DALYs) worldwide, or about 7.4% of all DALYs in 2010.<sup>1</sup> Based on a systematic review by Steel et al., the pooled lifetime prevalence of MH illness across 59 countries in the world was estimated to be 29.2%. Across 54 surveys conducted in high income countries, the prevalence rate was greater at 32.2% (95% CI: 29.9-36.8) compared with 22.7% (95% CI: 17.4-29.0) across 31 surveys conducted in lower middle income countries.<sup>2</sup> There has been a rapid expansion in the number of large-scale mental health surveys providing population estimates of the combined prevalence of common mental disorders (most commonly involving mood, anxiety and substance use disorders) in Bali, according to the Indonesia Basic Health Research or *Riset Kesehatan Dasar (Riskesdas)* in 2013, the prevalence estimate of severe MH disorders was much lower with only 2.3%; this was 4.4% for mild mental illness.<sup>3</sup> While this figure is comparatively very low, restraining practices for people with severe mental illness is still common in almost all provinces across Indonesia including in Bali.<sup>4</sup>

There are various factors behind the lack of adequate treatment for MH illness. Amongst patients and families there is reluctance to seek professional medical help. A study in Bali in 2015 found the main reason was the community belief that mental illness is caused by "black magic" or other spiritual issues. This study reported that 78% of 54 families in Bali believe in traditional healers as the first choice of mental illness treatment. Only 7% visited a general practitioner, 6% visited a public health center (PHC) and 4% directly went to a hospital. Another reason for treatment delay is the scarcity of MH specialists and hospitals, and most of the psychiatrists are available in the City of Denpasar, the capital of Bali Province.<sup>5</sup>

In 2014, the MH Act was established by the Indonesian Government to improve MH service provision at the primary, secondary and tertiary level. Since, the Indonesia Ministry of Health has actively brought the need forward to provide MH services at PHCs as a primary health care in Indonesia.<sup>6</sup> Most PHCs in Bali, however, have been unable to implement the MH program optimally, which may be due to the fact that there are certain barriers faced by the PHCs in providing optimal

\*Correspondence to:  
Putu Aryani, Department of Public Health and Preventive Medicine, Faculty of Medicine, Udayana University, Bali, Indonesia  
aryanicomprev@gmail.com

MH services for the community. Studies showed that barriers to MH service provision were constituted by a lack of priority in the local policy, which affects financial funding; challenges in decentralization of MH services; the low number of trained MH care providers; and insufficient public health skills among the MH leaders.<sup>7,8</sup>

This study was conducted to explore these barriers at PHCs in Denpasar, Bali. It examines the issues in policy, collaboration, management and resources in implementing MH services at PHCs from the perspectives of policy makers and health care providers.

## METHODS

This explorative qualitative study was conducted from March to December 2015 in Denpasar, Bali. Data were obtained through in-depth interviews and focus group discussions with key informants recruited based on their roles in MH service provision in PHCs in Denpasar, Bali.

A total of eight key informants participated in this study. They were classified into three categories. The first group comprised of two policy makers at district level: the Head of Denpasar City Health Office and the MH program manager at district level. A second group comprised four general practitioners (GPs) in PHCs who were selected based on their involvement in MH services in each subdistrict. A third group comprised the two psychiatrists from the district and the provincial hospital, respectively, which are both situated in the city of Denpasar.

Two focus group discussions (FGDs) were conducted in different time settings. A first FGD involved the eleven MH program managers from all PHCs, and a second one involved eleven community health workers (CHWs) nominated by program managers based on their involvement in MH services at each PHC.

Verbal and written informed consent was obtained prior to the interviews and FGDs. Interviews and FGDs were conducted in a mixture of the Indonesian and Balinese languages, and recorded electronically. Verbatim transcripts were generated in the Indonesian language. For this article, respondents' quotes were translated into English by a native translator.

Data were analysed with a thematic analysis framework. The emerged themes were grouped based on a modified service framework of sustainability requirement for providing service in primary care. For this study, we applied the framework published by Humphreys et al. to discuss the emerging themes, as this was the most suitable given the context of primary care provision in limited resources setting. Based on this framework, provision to health care service at the primary care level are influenced by environmental enablers at macro-level and the meeting of essential service requirements at micro-level.

This study has been approved by the Ethics Committee of Faculty of Medicine, Udayana University/Sanglah Hospital, Denpasar, Bali, on 25<sup>th</sup> April 2015 and KIT Research Ethic Committee, Netherlands, on 13<sup>th</sup> August 2015.

## RESULTS

Based on the Humphreys' framework, the results of this study were grouped into six factors: 1) environmental influence (policy at national and local level); 2) workforce organization issues; 3) funding; 4) governance, management and leadership; 5) coordination and supervision; and 6) infrastructure.

### Demographic characteristics of the in depth interview informants

Demographic characteristics of the eight in-depth interview informants are presented in [Table 1](#).

**Table 1** Demographic characteristics of the in depth interview informants

Code of informants	Age (years)	Gender	Role	Educational level	Length of work in current position (years)
IDI_01	51	Female	Psychiatrist	Post graduated specialist (consultant)	2
IDI_02	33	Male	GP	Medical doctor (MD)	6
IDI_03	53	Female	Denpasar City Health Office	MD	9
IDI_04	40	Female	GP	MD	5
IDI_05	31	Female	GP	MD	5
IDI_06	40	Female	GP	MD	6
IDI_07	48	Female	Public health practitioner	Bachelor in Public Health	3
IDI_08	33	Male	Psychiatrist	Specialist	2

### Demographic characteristics of FGD participants

The first group of FGD participants were program managers from 11 PHCs in Denpasar. All program managers were female nurses and midwives who had worked for more than two years in PHCs. Their ages ranged from 25 to 55 years.

The second group FGD participants were CHWs officially appointed as mosquitos larva controllers or *juru pemantau jentik (jumantik)*. They had worked as CHWs for more than three years, but had additionally been involved in the MH program four to six months prior to the FGDs. Two were males, ages ranged from 30 to 55 years and education level varied from high school to university graduates.

### Environmental influence on MH service provision at PHCs

The psychiatrist indicated that while dissemination of the national policy to the local level is crucial to initiate MH service provision at PHCs, the dissemination of the MH act remained poor because the law had just been launched and it might take a long time for the policy to be well disseminated to all local stakeholders. The policy had just been disseminated to the mental and educational hospitals while other local stakeholders might remain unaware of the policy existence.

*“MH act is available since a year ago.... But it does not make sure that it is can be used... because there are no regional rules nor dissemination to all ministry... It may need 5 years to disseminate this law...at the moment, this law has just disseminated at mental and educational hospitals level” (IDI\_01)*

The psychiatrist also elaborated that MH services is not considered a priority by the government and health stakeholders, which is different from other programs such as HIV prevention and maternal and child health programs. Consequently, very limited health promotion efforts have been conducted for MH issues.

*“In PHCs, a lot of MH cases reported only in the severe stages....because there is no regular health promotion activities for MH issues since it is not considered as a “sexy” program as compared to the others such as HIV prevention and maternal and child health” (IDI\_01)*

### Workforce organization

All respondents consistently mentioned that workforce organization was the main obstacle for providing MH services at PHCs, including insufficient

health workers needed for the high workload. The high number of patients at the general polyclinic leads to too little time for exploring MH patients' problems. Almost all GPs reported that exploring psychological problems is not possible if there is no additional in-charged staff.

*“We only have 2 doctors in charge in the polyclinic...Psychiatric patients need more time for counselling and examination...we must work very quickly...I often work alone while my colleagues have to attend several training sessions... We also don't have psychiatric nurses... the nurses only help in doing administrative things, such as reporting...There are about 80-100 patients per day...too many for a 5 hour service time.. ” (IDI\_02)*

The Head of Denpasar City Health Office and program managers confirmed that PHC staff have a high workload due to managing multiple programs. In addition, not all PHCs have MH nurses for monitoring MH cases, thus they rely on the family of the patient to take care and following up the adherence of patient in taking their medication. If there are new cases, the community will call a team which usually consisted of local community guard, ambulance from mental health hospital, doctors and in-charged mental health nurses at PHC.

*“This is a classical problem that we have a lack number of human resources, poor competencies and they have to handle more than one program. Not all PHCs have MH nurses so PHCs rely on the community MH monitoring team” (IDI\_03)*

Another important concern is the lack of competence of program managers in organizing MH services at PHCs. All program managers were nurses and midwives with no educational background in MH. However, the head of the Denpasar City Health Office mentioned that some program managers had been invited to a workshop on managing a MH program in May 2015.

*“I am not a nurse, but a midwife and I am supposed to be in charge in the Maternal and Child Health program, so when I was asked to fill the report form about patient with mental illness, I do not understand what I should write.” (FGD\_PM2)*

*“Recently... we have trained the program managers of all PHCs... it was about their task and function ” (IDI\_03)*

Program managers indicated that this training was not given to the right persons, since not all MH

program managers could attend the training due to their employment status. Some MH program managers in PHCs were not employed by the government but were outsourced workers instead, while the training had been organized only for those employed by the government. Therefore, some PHCs sent a government employee to the workshop although he/she was not involved in the MH program, and workshop outputs were not adequately transferred to the MH program managers.

*“I heard there was a training for the program managers a few months ago, but my nurse could not join the training at that time since she was still an outsourcing employee... so the head of PHC sent the other nurse to join the training...” (IDI\_04)*

CHWs elaborated that they had been involved in MH services, however, their role remained limited to reporting cases with MH disorders, not in providing treatment and monitoring patients. CHWs were initially working for dengue larvae detection and control but then they were appointed to help in reporting MH disorder cases to the MH program manager in PHC. It was stated that treatment monitoring was mainly done by the patients’ family; however, the family mostly found difficulties in taking care of aggressive patients.

*“...reporting yes.....but not treatment nor monitoring.....treatment mainly by the family” (FGD\_CHW1)*

*“For the aggressive patients, none of the family member are able to manage the patient and usually helps are needed from the local safety guard” (FGD\_CHW3)*

### Funding and budget allocation

PHCs in Bali are funded by the national and local government based on a proposed budget submitted each year. The head of the Denpasar City Health Office explained that no specific budget was allocated for MH services, but that these costs were covered by the general polyclinic budget.

*“The MH budget is included in the basic health service and we only provide the available medicine. There are various cases to be treated and the money is not specifically allocated for MH program”. (IDI\_03)*

Additional funding incidentally came from projects of the Indonesian Ministry of Health or non-governmental organizations. Obviously, this

was not sustainable and only covered specific needs such as injectable long acting medicines and health promotion programs.

*“..... it was not from APBN (national funding), but from the ministry of health... sometimes the funding is from global fund, only once in a year, not regular, we received some medicine but it was dropped through an NGO, also from pharmaceutical company.” (IDI\_01)*

MH program managers mentioned that there was an operational budget for conducting home visits to follow up patients with MH disorders, but allocated only for three patients per month in one PHC.

*“In PHC there is an operational budget [BOK] only for home visit.....not for all patients, only for three patients per month” (FGD\_PM3)*

### Governance, management and leadership problems

Program managers mentioned a poor recording system as an important factor for low MH service performance at all PHCs. This resulted in problems such as unregistered patients, loss to follow-up of cases, and cases registered twice at different PHCs.

*“In the border area for example, the border of PHC coverage is confusing, people tend to go to the closest place. Also in the area where the mobilization of the people is higher, like in Denpasar, one patient may come to two different PHCs...” (IDI\_01)*

Insufficient recording system was also caused by confusion regarding the use of a new reporting form provided after the first workshop. This confusion applied particularly to classifying new and old cases, establishing the treatment objective and calculating the coverage of services. Poor documentation also affected medicine procurement, as there was no accurate data on the number of patients with mental illness.

### Coordination and supervision

Another issue that emerged was the lack of coordination between PHCs and the referral hospital. Almost all GPs and program managers explained that specialists hardly ever provided back referral letters to PHCs, while this information was crucial for making a follow-up treatment plan, planning medicine procurement and completing the medical record.

*“When we send the patients to the district hospital, the back referral letter is usually taken at the registration desk and may be it was not received by the psychiatrist in the hospital’s polyclinic.” (FGD\_PMI)*

Psychiatrists said the mental hospital in Bangli District provided back referral letters only to particular PHCs which could provide psychotropic medicines, while patients from Denpasar were referred back to Wangaya Hospital and not to PHCs. Although there was a back referral system, many patients did not show up, and referral letters were rarely forwarded to the appointed PHCs or Wangaya Hospital.

*“We only referred back to particular PHCs where we knew the medicines were available like to Gianyar and Badung...in Denpasar there is Wangaya Hospital, we did not refer to PHCs as there is no medicine...” (IDI\_01)*

*“Hospital in Bangli referred back patients to us, but many patients did not come and we do not know their condition now....” (IDI\_08)*

### Physical infrastructure and supporting facilities

The need for a special room at PHCs to provide MH services appeared to be a controversial issue. GPs at all PHCs argued that a special room or space for assessing psychiatric problems was required.

*“Yes...there’s supposed to be one special room to explore the problems of the patient... So far we only can give regular medicines, and after that it is hard to give psychotherapy... we also would not be able to counsel in an holistic way.” (IDI\_02)*

Psychiatrists and most program managers, however, did not agree. Psychiatrists argued that skills of health workers to identify and treat patients were essential requirements, rather than a special room. This was supported by program managers stating that having more room meant having more duties. This issue was strongly linked with the limited number of health workers previously discussed in the Workforce Organization Section.

*“If we were asked to provide special polyclinic for mental illness, it would be hard, because we usually have only one polyclinic, if there 2 or 3 more, when a colleague is absent ... who will be in charge in that room? That is stressful, we also don’t have enough doctors...” (FGD\_PM2)*

In addition, CHWs rated the idea of providing a special room negatively, because it might make patients feel uncomfortable to be recognised as psychiatric patients. Despite the controversy, one PHC in East Denpasar managed to provide a space around the corner of the general polyclinic room, and a special schedule was provided assigning particular days for patients with MH illness. These initiatives resulted in an increased number of cases identified and treated.

### Availability of psychotropic medicines

The limited availability of psychotropic medicines is another concern in providing MH services at all PHCs in Denpasar. Contributing factors were the lack of competence in planning medicine procurement; a poor registration system; the complex process of medicine procurement, involving prior approval from the Health Department authority, and medicine supply frequently not matching the demand. The most common medicines available at PHCs were diazepam, chlorpromazine, and haloperidol.

*“May be only psycho-somatic drugs are available. For the severe cases, the medicine is not available. The proposal is usually submitted to the health department who will then check it, some may be reduced or added. It depends on their budget and supply not always similar with what we proposed...” (IDI\_02)*

The Head of the Denpasar City Health Office confirmed that medicines would not be distributed without request from PHCs. This related to the new policy requiring strict monitoring of psychotropic medicine distribution. The competence of program managers, therefore, was crucial in planning the medicine procurement. One PHC demonstrated success in providing a wide range of medicines owing to the presence of capable program managers in planning medicine supply requirement. A further positive result was the increase in service coverage, as explained by program managers from the PHC in East Denpasar.

*“I have the data about how many psychiatric patients that we have, also about how many patients have been treated and controlled in the hospital. They usually have back referral letter from the psychiatrists in the hospital that informed about the type of medicine and dosage. We calculate every year based on the number of patients that have been recorded and added by new cases that are found and treated by our GP. (FGD\_PM4)*

## DISCUSSION

Barriers identified in our study were the lack of dissemination of the national policy on MH services; the low prioritization of MH care in local policy; the lack of community support; insufficient number and competence of MH workers in PHCs; poor coordination and supervision; poor management and recording system; funding and budget allocation problems; and the lack of infrastructure, supporting facilities and psychotropic medicine management.

Our study shows that although a national policy to improve MH services has been established in 2014, this policy had not been adopted by all local governments due to the lack of its dissemination. In addition, for local stakeholders MH care has not been a priority like other diseases such as HIV, tuberculosis and dengue fever. In decentralized government systems like currently applied by the Indonesian Government, the authority of a local government is instrumental in prioritizing specific health programs. As shown by Hailemariam et al.,<sup>10</sup> inclusion of MH in the national health policy will encourage improvement of MH provision at the lower level. However, examples from other countries where similar resistance and counterarguments existed among local stakeholders, suggest that it does take time and effort to implement MH services at the primary care level. In Australia, five years were needed to ensure that the program became functional.<sup>11</sup>

Low prioritization of MH care also results in very limited funding for MH services. The existing budget is mainly spent for conducting active case finding, following-up patients and referring patients to the hospital. The lack of additional funding constitutes a significant barrier for improving the competence of the health workers and involving CHWs in MH services. Limited financial support was also reported as a barrier in other developing countries. Ngo et al.<sup>13</sup> argued that MH care is frequently underfunded, mainly in low- and middle-income countries. This is related to the commitment and priorities of both the national and local governments. In addition, there is less funding from international donors to scale up MH programs in lower middle-income countries as compared to other health issues.<sup>13</sup>

Furthermore, in this study, workforce organization came out as a key factor limiting the provision of MH services at PHCs. Health workers at PHCs are mostly overburdened with multiple tasks and responsibilities. PHC staff mostly do not only provide services for patients at polyclinics, but also have to be in charge for management

and administration duties. Moreover, all health workers mentioned an overload of polyclinic service provision due to the high rates of visiting patients. This finding is in line with statements by Ngo et al.<sup>13</sup> who elaborated on the challenges of sustaining and scaling up MH services in primary care. Work overload of health workers is one of the issues which could be overcome by promoting task shifting and task sharing from health workers to well-trained CHWs.<sup>14</sup> A study in Georgia found that by investing in workforce training, the knowledge and skills of the health workers can be improved by 67%.<sup>15</sup> Our study, however, found that the role of CHWs remained limited to reporting mental disorder cases; they were not involved in providing treatment and monitoring patients. Our study also showed that due to some employment status issues, trainings were conducted for PHC staff not responsible for providing MH services. Consequently, workshop outputs were not adequately transferred to MH program managers.

Another option to improve the performance of MH services in primary care as suggested by WHO and Wonca<sup>11</sup> is introducing psychiatric nurses combined with supervision by psychiatrist. In Belize, the hospitalization rate could be reduced by involving trained nurses in primary care.<sup>16</sup> A case study by Petersen and colleagues<sup>16</sup> states that while services can be provided at a lower level, a framework for supervision and referral pathways should be clearly established. MH professionals also have to be trained regularly in order to improve both clinical and management skills.<sup>17</sup> Task shifting in MH care to non-specialized health workers is supported by WHO's mgGAP Intervention Guide, which provides a flowchart for assessing and managing common MH problems.<sup>18</sup>

A lack of communication and collaboration between healthcare professionals has been reported to constrain the quality of care for MH patients in Canada. Interdisciplinary, collaborative models of primary care delivery (e.g. family health teams, PHCs) were suggested to increase the quality of care for individuals with complex health needs.<sup>19</sup> In this study, lack of communication and collaboration between health institutions was identified as the leading cause of poor registration and case recording. For instance, occurrence of double recording of cases resulted from a lack of coordination, while lost-to-follow-up cases were related to a poor back referral system. Moreover, the poor registration and recording system also resulted in the miscalculation of medicine supply and procurement, thus most PHCs had a limited number and variety of psychotropic medicines.

This study was conducted in 2015 and the current situation may have changed at some PHCs, therefore further studies are needed to explore the progress of MH services provision at PHCs in Bali.

## CONCLUSION

In order to overcome barriers in providing MH services at PHC level, findings of this study highlight the importance of better dissemination of the national policy and collaboration between local government, health providers and CHWs.

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