alliance in this setting. If this is the case there may be a need to develop interventions that can be delivered over one to three sessions, and to focus the sessions on what Kenyan patients find most useful. It may also be important to engage in task-shifting models to equip primary healthcare providers to deliver basic counselling or psychological first aid, in order to minimise the need for patients to travel long distances to get treatment.

Conclusions

When trying to improve the effectiveness of psychological therapies in non-Western cultures, there may be a risk of 'empirical imperialism' – that is, imposing on local practitioners theories and methods developed in Western cultures despite lack of culture-specific evidence of effectiveness. We set out an alternative strategy that utilises initial effectiveness data as information on which patient groups need improved treatments and on what practices are effective. With limited resources, we want time and money to be utilised effectively to develop evidence-based contextualised therapies, which can be delivered by the available staff in the minimum effective number of sessions.

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SPECIAL PAPER

Edawu: a journey from in-patient rehabilitation to community-based treatment and rehabilitation in Nigeria

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Community-based rehabilitation is the strategy endorsed by the World Health Organization and other international bodies to promote the inclusion of people with disabilities, particularly in low- and middle-income countries. In this article we trace the journey of Edawu, a mental health rehabilitation unit in a rural area of Benue State, Nigeria, from an in-patient rehabilitation unit to a community-focused service. The partnership of organisations from the UK with Edawu along the journey is also described. The authors set out learning points from the project and the principles behind sustainable overseas organisational partnerships.

The WHO-AIMS report (WHO & Ministry of Health, 2006) on mental health services in Nigeria states that information about the level of mental health services in Nigeria is difficult to assimilate. Systematic data gathering is non-existent. Government-funded services include stand-alone psychiatric hospitals and psychiatric units located in general hospital settings. Since the catchment areas are not strictly defined, it is impossible to determine the population for which the facilities cater.

This article concerns the Edawu community mental healthcare project, in a rural part of Benue State, in the south-west of Nigeria. Facilities for people who have a mental illness are sparse and reflect many of the findings from the WHO-AIMS

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report. There is a federal medical centre in the state capital, Makurdi, which has the geographically closest government-funded psychiatric beds. There are no community residential facilities in the local area funded by the government, yet community-based rehabilitation (CBR) is the strategy endorsed by the World Health Organization (WHO) and other international bodies to promote the inclusion of people with disabilities, particularly in low- and middle-income countries (LMICs) (Iemmi *et al*, 2015).

Government-funded mental healthcare in Nigeria consists of hospital-based services that cater for patients who are brought there, irrespective of their home location. There are no government-funded community residential facilities. Centres like Edawu have grown out of the initiative of religious organisations, with overseas support. These centres provide mental health services to a community that is far removed from the urban centres where the state-funded hospitals are situated.

The Nigeria Health Care Project (NHCP) was set up in 1992 by the Wesley Guild (Nigeria Health Care Project, n.d.). One of its projects was the Edawu Community Mental Health Care Project. NHCP provided funds to build this centre based on the 'Amaudo' model (London District of the Methodist Church, n.d.).

Established in 1996, the project aimed to provide assessment and treatment for individuals who had become homeless, due to mental health problems, at a rehabilitation centre for 16 residents (8 male and 8 female). Edawu oversees a community psychiatric programme (CPP), which includes clinics. The early days of Edawu focused on providing in-patient care and rehabilitation for homeless people, with follow-up after discharge in clinics.

Edawu has forged strong links with ACCEPT, a UK mental health charity, and Leicestershire Partnership NHS Trust (LPT).

In 2001 Aidan Lucas, an occupational therapist at LPT, took a sabbatical year to go and live in Edawu with his wife to oversee the project. He strongly recommended local leadership at the end of his tenure, the result being the appointment of the Very Reverend John Angwa, who lives on the campus with his family, having provided inspirational leadership to Edawu for more than 15 years. He is supported by a team that includes a qualified community psychiatric nurse, a community mental health extension worker, a community resettlement officer and a workshop manager.

Development of UK collaboration with THET

Back in the UK Aidan Lucas joined ACCEPT. LPT joined the NHS International Links scheme in 2004, sponsored by THET (Tropical Health & Education Trust) with the aim of encouraging the reciprocal transfer of knowledge and skills between UK-based health institutions and their counterparts in LMICs (THET, n.d.). Three projects, involving Nigeria, Ethiopia and India, were set up with LPT. Aidan Lucas was instrumental in setting up the Nigeria link, which remains involved with Edawu.

From 2004 to date, LPT and ACCEPT have made arrangements for several teams of multidisciplinary mental health professionals to visit Edawu regularly for around 2 weeks, approximately annually.

Edawu – a 20-year journey, 1996–2016

During visits to Edawu we have seen how common it is for people who are mentally ill to be whipped, chained, confined or found wandering homeless. Professionals from the UK have helped Edawu raise awareness of mental illness and the project itself locally. They have trained Edawu staff in comprehensive assessments, key-working, interviewing skills, maintaining data registers, developing care pathways and setting goals for their own development. Visitors attend team meetings, ward rounds, evening workshops, volunteer meetings and meetings with local stakeholders.

The Benue State Comprehensive Community Mental Health Care Project is in its second phase, involving a partnership between the Methodist Church and the Nigerian government. Edawu is a key centre for further development of community-based mental healthcare across Benue State, which is led by CBM, an international non-governmental organisation (NGO) that focuses on disability.

Until 2013, Edawu focused on identifying homeless people with serious mental illness who had been found wandering the streets in the area. Such people were brought to the centre, cared for and treated. Efforts were made to locate their families, following which there was an encouraging discharge ceremony and a church service that saw them reunited with their families. Education focused on the importance of understanding that mental illness is treatable; it is not the result of demonic possession or punishment for sins. Ex-residents returned to the centre to participate in a monthly patient group. Support was given for vocational rehabilitation.

In 2013, staff identified the need for cases to be picked up early in the community and for patients to be treated within their homes. They reasoned this would lead to less stigmatisation, and it would give the family a better idea of the patient's journey to remission. It would also be less distressing for the patient and could promote community-based rehabilitation.

In October 2015, Edawu organised a community programme on World Mental Health Day which saw staff garner greater local support for the timely and humane treatment of people who are mentally ill. They devised a strategy of discharging four residents at one time to the same village and holding community talks at the same time, with the aim of raising awareness of mental illness. Their aim was to help the community to identify patients as soon as possible after the onset of their mental health disorder, before the symptoms became more severe, and before the affected

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individual would be at risk of becoming homeless. They also wished to encourage community-based rehabilitation.

In 2016, three mental health professionals – a psychiatrist (N.C.) and an occupational therapist (A.L.) from the UK and a psychiatrist from Lagos (A.E.) – visited Edawu over a 2-week period. They facilitated staff workshops which focused on developing a community mental health awareness programme, and they delivered lectures on mental illnesses, psychiatric history-taking, diagnosis and treatment plans; they also encouraged role-play to consolidate staff skills.

The staff who were trained gained knowledge about the different types of mental illness. They became more skilled in identification and treatment. Participants also became more confident in relaying their knowledge to the local community.

The trainers formulated guidelines on distinguishing criteria so that the local staff could identify people with mental disorders who were likely to require in-patient treatment, as well as those who could be treated in the community. They had a clear time-limited agenda for delivering a mental health awareness programme that would promote greater acceptance of mental illness. Their overall objectives were to foster de-stigmatisation and to encourage the rehabilitation of people with mental illness with the participation of local communities.

Future directions

Community-based rehabilitation was initiated by the WHO following the Declaration of Alma-Ata in 1978. The recommended approach aimed to enhance the quality of life of people with disabilities and their families, to enhance the delivery of their basic needs, and to ensure their inclusion and participation in society (WHO, n.d.). At the moment CBR is far from being integrated into the infrastructure of health services in the national context of Nigeria (Adaka *et al*, 2014).

The Benue State Comprehensive Community Mental Health Care Project is entering its second phase. Edawu is at a crucial point in its journey. It has shifted the focus of mental health management from in-patient treatment to identifying mentally unwell people in the community, with the assistance of a psychiatrist from Nigeria. The next 5 years will chalk out its course for the foreseeable future. Our vision for the partnership at the end of that period is to see it completely supported by Nigeria and Nigerian professionals in terms of staff training and supervision. We plan to have a stable group of trained staff in Edawu, so that skills gained from participation in our training programmes are not lost. We aim to move the focus of treatment from in-patient rehabilitation to intervention in the community. The link with LPT should continue as a partnership that provides advantages at both ends.

Key learning points from the journey

Partnerships between organisations in the UK and LMICs are rewarding in promoting the exchange of ideas, improving resources and increasing staff morale.

Staff from the UK have used their own clinical expertise to train unqualified personnel in Edawu. They have helped those personnel to deliver mental healthcare in remote areas where no infrastructure previously existed. Qualified staff are a precious resource in Nigeria. Mental health systems in rural areas will have to depend on unqualified staff with training and supervision from mental health professionals for the foreseeable future. UK staff on the Edawu project have observed that the presence of professionals from the UK gives Edawu more prominence in the local area. Local community leaders have often commented that if people from the UK find it worthwhile to visit Edawu and give their time, the local community owe it to their own mentally ill citizens to work together with Edawu and to invest in it.

UK staff have been able to fund-raise for Edawu through the LPT. The presence of UK staff in this Nigerian project has facilitated meetings between government officials and Edawu management. Not all the government promises made in these meetings have been kept, but a part of the salary of the community psychiatric nurse is now funded by the government.

UK staff from Leicester recount that their experiences in Edawu have left a deep and lasting impression on them. Their discovery of how far limited resources can be stretched, by working within this impoverished community, has been a revelation to them. Staff say they have benefited from their experiences of interacting with a culturally different community, and from trying to understand that community's different traditions and perspectives. They have come back from Nigeria feeling more holistic in their views and with a more complete understanding of mental health in different settings.

It has taken time to learn what works and what does not work in the context of rural Nigerian culture, but the passion and willingness of the Edawu staff to learn is encouraging; the empty promises of many government officials have been disappointing.

Such international partnerships are sustainable only with the commitment of key individuals from both sides. An organisational 'contract' may be useful, but our experience is that the link between Leicester and Edawu has survived because of the interest and passion of people in both communities. Our success has been mediated by the benefit perceived by both parties, by having a common agenda and by the partners sharing similar expectations about the aims and objectives of the project.

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MENTAL HEALTH LAW PROFILE

Mental health and the law: a South African perspective

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Mental health law in South Africa has been dominated in recent times by the Mental Health Care Act 2002. This paper provides selective insights into specific aspects of that Act and highlights its impact on clinical practice within a broad clinical setting and in so doing suggests areas for review and revision.

Historical context, current legislation

The Mental Health Care Act 2002

The Mental Health Care Act 2002 (Act no. 17 of 2002), hereafter referred to as 'the Act', together with its regulations ushered in a new era for South African psychiatry by replacing the Mental Health Act of 1973. The Act was assented to on 28 October 2002, but commenced on 15 December 2004, taking many clinicians by surprise. In the wake of the implementation of the Constitution of the Republic of South Africa (promulgated in 1996, implemented in 1997) it was incumbent on law makers to ensure that all Acts of Parliament were amended and written so as to accord with the new Constitution (Constitution of the Republic of South Africa, 1996).

It has been noted that the Act is founded on the ten basic principles set out by the World Health Organization (WHO) guiding mental healthcare law (WHO, 1996; Landman & Landman, 2014). In essence, the era of a human rights-driven ethos in patient care had arrived. This is not to say that human rights were never previously a consideration, but the revised Act brought with it a raft of changes, not least of which was an explicit orientation towards what one might view as a more 'patient centred' approach to psychiatric care.

Challenges

In the aforementioned scenario, the patient became a 'user', more specifically a 'mental healthcare user', and the psychiatrist became a 'mental healthcare practitioner' (MHCP), together with other professionals, given that the procedures accompanying the Act permit medical practitioners with experience in psychiatry together with a range of allied health professionals (e.g. nurses, social workers and psychologists) a potential role in the assessment of mental state contributing to need for admission. The term 'user' has somewhat negative connotations, yet in attempting to be seemingly more egalitarian in the approach to care it was clearly felt that the word 'patient' conferred a status not befitting an individual seeking and requiring care. However, the word 'patient', derived from the Latin *patior* (to suffer), would appear to be precisely what a person seeking care is experiencing – suffering – with the medical practitioner's obligation being to assist in alleviating such suffering.

A further requirement of the Act was that 'users' be treated in the least restrictive manner possible and ultimately with the least discomfort and inconvenience, and so as close to their place of domicile as possible. This is a noble sentiment which no self-respecting practitioner would disagree with. It is hard to recall any South African psychiatrist wanting to have a 'user' stay in hospital care for one day longer than absolutely necessary, not least of all given the limited resources that characterise state psychiatry in South Africa.

The structure of mental health services in South Africa

The Act

Acute beds are at a premium, and longer-stay beds even more so. This of course raises a critical qualifier in the Act, namely that everything is dependent on resources (i.e. funding). In an ideal scenario the 'user' is assessed and treated locally, as envisaged by the Act .

Challenges

The requirements of the Act presume there is a functional primary healthcare clinic, with an appropriately trained family practitioner, who if

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