of acceptance of treatment, reduction of hospital admissions, maintaining care, reducing death by suicide and reducing costs. However, Simmonds *et al* (2001) found no significant differences in patient psychopathology between CMHT management and standard care.

Despite the advantages of the CMHS in reducing in-patient hospital care and patients' satisfaction with the service shown in our study, collaboration between the CMHS team and other mental health services is needed for crisis and relapse interventions, as many psychiatric illnesses are characterised by frequent relapses. In recent years there has been a debate between those who support the provision of mental health treatment and care in hospital, and those who support primarily, or even exclusively, the provision of community care. This dichotomy could be replaced by an approach that integrates community services with modern hospital care (Thornicroft & Tansella, 2004).

This study is limited by the fact that it examined only one CMHS team, and the findings cannot be generalised to the whole country.

Conclusion

The effectiveness of the Al Ain Hospital CMHS in minimising the need for hospitalisation as well as the length of stay for the enrolled patients has been demonstrated. Patients were highly satisfied with the CMHS. Further research is needed to assess the continued effectiveness of this service, assessing different outcome measures. Evaluations of CMHS in other regions are needed.

References

Burns, T. (2007) Hospitalisation as an outcome measure in schizophrenia. *British Journal of Psychiatry*, **191** (suppl. 50), s37–s41.

Catty, J., Burns, T., Knapp. M., *et al* (2002) Home treatment for mental health problems: a systematic review. *Psychological Medicine*, **32**, 383–401.

Flannery, F., Adams, D. & O'Connor, N. (2011) A community mental health service delivery model: integrating the evidence base within existing clinical models. *Australian Psychiatry*, **19**, 49–55.

Hadley, T. R., Turk, R. & McGurrin, M. (1997) Community treatment teams: an alternative to state hospitals. *Psychiatric Quarterly*, **68**, 77–90.

Kim, T., Mueser, K. T., Gary, R., *et al* (1998) Models of community care for severe mental illness: a review of research on case management. *Schizophrenia Bulletin*, **24**, 37–74.

Ralston, G., Beesley, S. & Bogue, J. (1998) Users' needs and satisfaction with a community-based mental health service. *Psychiatric Bulletin*, **22**, 473–476.

Ranasinghe Mendis, J. & Hanwella, R. (2010) Community psychiatry service in Sri Lanka: a successful model. *Sri Lankan Journal of Psychiatry*, **1**, 3–5.

Rosen, A., Mueser, K. T. & Teesson, M. (2007) Assertive community treatment – issues from scientific and clinical literature with implications for practice. *Journal of Rehabilitation Research and Development*, **44**, 813–825.

Ruggeri, M., Lasalvia, A. & Bisoffi, G. (2003) Satisfaction with mental health services among people with schizophrenia in five European sites: results from the EPSILON study. *Schizophrenia Bulletin*, **29**, 229–245.

Simmonds, S., Coid, J., Joseph, P., *et al* (2001) Community mental health team management in severe mental illness: a systematic review. *British Journal of Psychiatry*, **178**, 497–502.

Thornicroft, G. & Tansella, M. (2004) Components of a modern mental health service: a pragmatic balance of community and hospital care. Overview of systematic evidence. *British Journal of Psychiatry*, **185**, 283–290.

Addressing the mental health needs of a rapidly growing megacity: the new Lagos Mental Health Initiative

Olufemi Oluwatayo,[1] Olufemi Olugbile[2] and Ayodele Coker[3]

[1]Consultant Psychiatrist, Wells Road Centre, Nottinghamshire Healthcare NHS Trust, Nottingham, UK, and Mental Health Advisor, Lagos State Ministry of Health, Ikeja, Lagos, Nigeria, email Olufemi@doctors.org.uk

[2]Consultant Psychiatrist and Permanent Secretary, Ministry of Health, Ikeja, Lagos, Nigeria

[3]Consultant Psychiatrist and Senior Lecturer, Department of Psychiatry, Lagos State University Teaching Hospital, Ikeja, Lagos, Nigeria

The Lagos State Government of Nigeria recently launched its Mental Health Policy and Work Plan aimed at addressing the mental health needs of Lagos, one of the world's fastest-growing megacities, and its nearby communities. This paper discusses the contextual basis of this initiative, its components and the challenges faced so far. It argues that urban centres deserve attention in the current push towards investing in mental health services in low- and middle-income countries.

There has recently been concerted global action to address the poor state of mental health services in low- and middle-income countries (Eaton *et al*, 2011) but the efforts seem to be based mainly in rural settings (WHO, 2011). The focus on rural areas mirrors past efforts, based on the assumption that access to mental health services in urban areas is better than in rural areas. In Nigeria, however, access is generally poor, regardless of location (Gureje *et al*, 2006) and a recent study from São Paulo indicated that the prevalence of

https://doi.org/10.1192/S1749367600004240 Published online by Cambridge University Press

mental disorders is high in that city (Andrade *et al*, 2012), suggesting that there is a need to direct investment also to urban centres.

Lagos, the former capital of Nigeria, is estimated to have a population of 15 million and is recognised as the fastest-growing megacity in the world (United Nations, 2012). Lagos and its nearby communities constitute one of Nigeria's 36 states. Its mental health service provision is patchy and inadequate (Olugbile *et al*, 2008).

In order to comprehensively address the mental health needs of Lagosians, in October 2011 the State Government launched a Mental Health Policy and began implementing a Mental Health Work Plan. We review the Plan in terms of the progress and challenges in its implementation after 1 year.

Mental health promotion

The Plan aims to prevent mental ill health. It includes:

- *The appointment of a mental health desk officer at the Ministry of Health*. As the coordinator of the programme, he/she will be responsible for its running. Tasks include reaching out to stakeholders, setting up a mental health programme team, organising and chairing the team's meetings, planning and budgeting, organising training and facilitating the release of funds for the implementation of programmes.
- *Setting up a mental health programme team*. To be headed by the desk officer, it will have representatives from stakeholders and relevant ministries, non-governmental organisations (NGOs) and professionals. The team will meet regularly to review the programme and ensure its implementation.
- *Public enlightenment to improve the public perception of mental illness, combat stigma and encourage treatment*. This includes organising seminars and activities for members of the public, especially women and children, about mental disorders, as well as media activities involving local celebrities.
- *Mental health programme for children*. This will incorporate school mental health activities and care in juvenile correction homes, including organising training for teachers to improve their awareness of mental disorders in children and setting up a counselling service for schools.
- *Establishing trauma and disaster counselling services*. Accidents are frequent on Lagos roads; injuries from commercial motorcycles (locally called *okada*) are particularly common. Victims of road accidents and disasters are to be offered psychological support and debriefing by trained counsellors, including paramedics and volunteers accessible through a helpline.
- *Motor Park Safety Programme*. This will involve a team from across the relevant ministries and agencies educating drivers about road safety, traffic laws, and the dangers of alcohol and illicit drug use in general and in driving.
- *Reduction of workplace stress*. A programme on stress management is to be rolled out for civil servants. It will include training counsellors, establishing a counselling helpline and organising regular seminars for staff.
- *Coordinate activities of NGOs operating in mental health*. A register of these organisations will be opened and operated as part of the programme, to help coordinate their activities.
- *Suicide prevention*. Education and enlightenment of the public on the relationship between mental health and suicide will be included in educational programmes.

Primary care and access to services

The first point of contact of Lagosians with health services is usually through private hospitals, primary care centres and general hospitals (Olugbile *et al*, 2008). For reasons ranging from lack of awareness of the presence of a mental illness, to beliefs concerning supernatural causes of illnesses that require traditional or spiritual interventions, to fears about affordability, sufferers often present late or fail to attend altogether. For those who are able to access services, recognition of their conditions and the interventions offered vary, with no clear standard and process for referral to specialist treatment.

There are three action plans:

- *Training of primary healthcare (PHC) workers*. Mental health training, support and supervision of PHC staff using the resource materials from the Mental Health Gap Action Programme (mhGAP) (WHO, 2011) will be undertaken.
- *Full integration of mental health into primary care*. This will involve using available resources to improve access to basic psychotropic medications, establishing systems for supervising PHC workers and monitoring their work, to collect data for research purposes.
- *Work with private hospitals*. The programme aims to improve the ability of private hospital clinicians to manage mental disorders by organising regular training for them using the mhGAP in order to support them and standardise their interventions and referral to secondary care.

Secondary and tertiary care

This part of the programme aims to improve access to specialist mental healthcare. In Lagos, the Federal Government operates a 476-bed neuropsychiatric hospital and a small academic psychiatric department at the University of Lagos Teaching Hospital. The Lagos State Government operates an academic psychiatric department and a 12-bed facility at Lagos State University Teaching Hospital. There are some basic psychiatric services and undesignated admission beds at three of the state's 25 general hospitals. In addition, the Lagos

https://doi.org/10.1192/S1749367600004240 Published online by Cambridge University Press

State Government has a 500-bed vocational rehabilitation centre at Majidun, mainly for vagrant homeless people with a mental illness. There are also some private and military psychiatric facilities.

The existing services will be complemented by:

- *Majidun Rehabilitation and Treatment Centre*. A redevelopment plan will be put in place to transform the Majidun Rehabilitation Centre to a psychiatric hospital to provide specialist tertiary mental health services, including rehabilitation beds. Access will be on referral from secondary care and statutory agencies.
- *Improving services at three general hospitals*. Secondary care 'psychiatric hubs' will be established in three general hospitals in the three senatorial political districts of the state. They will provide emergency services, out-patient clinics, acute-admission beds and outreach teams and take referrals from primary care and private hospitals.
- *Working in partnership with stakeholders in the field*. NGOs and private providers will be partnered to coordinate their services and ensure that appropriate standards are met.
- *Training and research collaboration*. There will be collaboration with the federal institutions in research and training. The educational curriculum of the state's schools for training of primary care workers, nurses and medical students will be reviewed to address inadequacies in the mental health component.

Progress on implementation 1 year on

One year on from launching of the Lagos State Mental Health Policy, the implementation of the Mental Health Work plan had been slow.

The mental health desk officer and team were in place and functional, with various activities being implemented. Regular public lectures to create awareness, combat stigma and fight the scourge of drug misuse were taking place. A register of NGOs was in place and clinicians in private hospitals were being trained. Some private sector resources, including those from the pharmaceutical industry, were being mobilised to participate in activities.

The Motor Park Safety Programme had been a success as it coincided with the implementation of new traffic laws in the state.

A research team from the state's teaching hospital recently got a Canadian grant for the implementation of mental health services at primary care level using the mhGAP. A study of the prevalence of mental disorder among youths at four of the state's juvenile correction homes was being carried out, with the aim of providing appropriate interventions and educating staff.

The trauma and disaster counselling service played a role in a recent disaster when a plane crashed into a slum area in a Lagos suburb, with several fatalities, both on the ground and in the plane. Within 1 week, brief one-to-one counselling was provided to some family members of the bereaved, witnesses of the crash and injured ground survivors who accepted the offer.

The initial task of agreeing a redesign plan between the Ministry of Social Welfare and Health for the Majidun redevelopment plan had been completed construction work was about to commence.

The reasons for the slow implementation of the programme have ranged from bureaucratic delays in approving budgets and lack of adequate human resources to general logistical problems.

Conclusion

The mental health challenges facing Lagos, the world's fastest-growing megacity, and its nearby communities are enormous. The city has some unique challenges that require novel services, including some of the ones initiated in this programme. Because of its large population, interventions in Lagos are likely to affect more people, thus our view is that the current push for investment in low- and middle-income countries should include urban centres. The Lagos State Government is showing political will and committing resources to mental healthcare. It has created an enabling environment for partnerships and investment in the sector. Opportunities abound going forward to engage in this process and tackle the challenges.

References

Andrade, L. H., Wang, Y. P. & Andreoni, S. (2012) Mental disorders in megacities: findings from the Sao Paulo Megacity Mental Health Survey, Brazil. *PloS One*, **7**, e31879. doi:10.1371/journal.pone.0031879.

Eaton, J., McCay, L., Semrau, M., *et al* (2011) Scale up of services for mental health in low-income and middle-income countries. Global mental health 4. *Lancet*, **378**, 1592–1603.

Gureje, O., Lasebikan, V. O., Kola, L., *et al* (2006) Lifetime and 12-month prevalence of mental disorders in the Nigerian Survey of Mental Health and Well-Being. *British Journal of Psychiatry*, **188**, 465–471.

Olugbile, O., Zachariah, M. P., Coker, O., *et al* (2008) Provision of mental health services in Nigeria. *International Psychiatry*, **5**, 32–34.

United Nations (2012) *World Urbanization Prospects. The 2011 Revision Report*. Population Division, Department of Economic and Social Affairs, United Nations.

World Health Organization (2011) *Mental Health GAP Action Programme (mhGAP) Newsletter*, June. WHO. Available at http://www.who.int/mental_health/mhgap/en (accessed December 2013).

https://doi.org/10.1192/S1749367600004240 Published online by Cambridge University Press