



The 40+ Per Month Evaluation Report

Impact of the YouBelong Uganda Pre and Post discharge Intervention on Relapse and Readmission among Persons in Recovery



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YOUBELONG UGANDA 2026

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Impact of the YBU Pre- and Post-Discharge Intervention on Relapse and Readmission Among Persons in Recovery

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Table of Contents

LIST OF ACRONYMS	iv
OPERATIONAL DEFINITIONS	iv
LIST OF TABLES AND FIGURES.....	vi
1. EXECUTIVE SUMMARY	1
2. BACKGROUND AND INTRODUCTION.....	2
3. PURPOSE OF THE EVALUATION.....	4
3.1 Objectives	4
4. METHODOLOGY	5
4.1 Study Design	5
4.2 Study Site.....	5
4.4 Sample Size	6
4.5 Questionnaire Development	6
4.6 Data collection procedure	7
4.7 Data Analysis	7
4.8 Evaluation Benchmarks.....	8
4.9 Ethical considerations	8
5. FINDINGS.....	9
5.1. Demographics	9
5.2. Relapse & readmission.....	11
5.3 Access to follow up mental health services (continuity of care).....	13
5.4 Useful components of 40+ per month intervention	14
5.5 Program performance against benchmarks	15
5.6. Key performance indicators (KPIs).....	15
5.7. Qualitative analysis	16
6. DISCUSSION	17
7. RECOMMENDATIONS.....	21
8. LIMITATIONS	21
9. CONCLUSION.....	22
REFERENCES.....	23
APPENDICIES.....	26
□ Appendix 1 – Consent Script	26
□ Appendix 2 – Evaluation Questionnaire	27

LIST OF ACRONYMS

YBU YouBelong Uganda

YBH YouBelongHOME

MOH Ministry of Health

SUD Substance Use Disorder

SMI Severe Mental Illness

SPSS Statistical Package for the Social Sciences – IBM Version 29.0.2.0 (20)

IEC Information, Education and Communication

M&E Monitoring and Evaluation

BNRMH Butabika National Referral Mental Hospital

OPERATIONAL DEFINITIONS

1. **Relapse.** Re-emergence or worsening of mental health symptoms after a period of improvement, as reported by the caregiver or person in recovery.
2. **Readmission.** Re-hospitalization of a person in recovery at a mental health facility following relapse.
3. **Person in recovery.** An individual discharged from a mental health facility who is continuing recovery from Severe Mental Illness and /or Substance use disorder within their community.
4. **Caregiver.** A family member or individual responsible for providing day-to-day support, supervision, and care to the person in recovery.
5. **Follow-up services.** Mental health services accessed after discharge, including clinical reviews, medication refills, counselling, or outreach support.
6. **Medication adherence.** The extent to which a person in recovery consistently takes prescribed medication as directed.
7. **Substance use relapse.** Return to the use of alcohol or drugs after a period of abstinence, contributing to deterioration in mental health.
8. **Early warning signs.** Observable behavioral or emotional changes that indicate the onset of relapses (e.g., insomnia, withdrawal, irritability).
9. **Continuity of care.** Ongoing engagement with health services after discharge to support sustained recovery.

10. **Reintegration.** The process through which a person in recovery resumes normal roles and responsibilities within the family and community.
11. **Home-based management.** Management of symptoms or relapse within the household without escalation to hospitalization.
12. **Structural barriers.** External factors such as transport costs, distance, and medication shortages that limit access to care.
13. **Kobo Toolbox.** Digital data collection platform used for surveys
14. **YBH team.** The YouBelongHOME multidisciplinary team of social workers, psychiatric nurses, psychiatric clinical officer, and Occupational therapist.
15. **40+ per month intervention.** It's a 3-week pre and post discharge intervention focusing on reintegrating 40+ persons with SMI discharged from BNMH into community mental health support.

LIST OF TABLES AND FIGURES

A. LIST OF FIGURES

Figure 1: The 40+ per month pre and post discharge process	3
Figure 2: Map of Wakiso and Kampala showing YouBelong Uganda catchment area.	5
Figure 3: Age Distribution of Participants (n = 120)	9
Figure 4: Gender distribution of persons in recovery under 40+ per month intervention	9
Figure 5: Pie chart showing distribution of persons in recovery by district.....	10
Figure 6: Distribution of persons in recovery by diagnosis.....	10
Figure 7: Comparison of relapse and readmission	12
Figure 8: Time to Readmission (n = 18)	12
Figure 9: Relapse patterns by diagnosis.....	12
Figure 10: Program performance against benchmarks.....	15

A. LIST OF TABLES

Table 1: Benchmark targets for project evaluation	8
Table 2: Breakdown of Diagnoses of Alcohol and substance use disorder (n = 59)	10
Table 3: Duration of illness	11
Table 4: Number of previous admissions	11
Table 5: Duration at Hospital Before Discharge	11
Table 6: Relapse and Readmission Outcomes (n=120)	11
Table 7: Duration of Hospital stay vs Relapse Risk (n = 120).....	13
Table 8: Drivers of Relapse (n = 51)	13
Table 9: Access to Referred Services.....	13
Table 10: Services Acquired (n = 43).....	14
Table 11: Pattern of non-utilization of health services (n = 77)	14
Table 12: Useful components of the YBH intervention	14
Table 13: Program Performance Against Benchmarks.....	15
Table 14: Key Performance indicators.....	15

1. EXECUTIVE SUMMARY

This evaluation assessed the impact of the YBU 40+ per month pre- and post-discharge intervention on the readmission rate of persons in recovery from severe mental illness, 3–6 months after discharge from Butabika National Referral Mental Hospital. Specifically, it examined relapse and readmission patterns, access to follow-up services, and the contribution of key intervention components to maintaining recovery in the community. The evaluation also assessed program performance against predefined recovery, relapse and readmission benchmarks to determine how well the intervention supports sustained recovery and contributes to reducing hospitalization. A census approach was adopted, with all eligible persons considered for participation. Of the 282 individuals supported under the YBH intervention, 190 met the eligibility criteria, and 120 (63.2%) were successfully contacted and interviewed after spending 3–6 months at home following discharge and post discharge support by YBH team. Using a mixed-methods approach, the study examined these outcomes among 120 individuals with severe mental illness and substance use disorders

The study population comprised persons in recovery with diverse demographic and clinical characteristics. Most participants (68.3%) were aged 26–45 years, reflecting the economically productive age group most affected by severe mental illness and A/SUD. Males accounted for 60.8% of respondents, while females represented 39.2%. Participants were drawn from Kampala (39.2%) and Wakiso (60.8%), the primary districts where the intervention is implemented. Clinically, substance-related disorders were the most common diagnosis (49.2%), followed by schizophrenia spectrum and other psychotic disorders (24.2%) and bipolar disorder (20.0%), with other diagnoses accounting for 6.6% of cases. Overall, the findings indicate that the intervention was implemented among a population with complex mental health needs including high risk of relapse and readmission.

The intervention is impactful in maintaining recovery in community for persons with severe mental illness and substance use disorders, with up to 85% remaining at home without readmission post discharge. These findings are despite the study population being comprised largely of individuals with long-standing mental illness (49.5% with ≥ 5 years duration), multiple prior admissions (73.2% with ≥ 2 admissions), and a high prevalence of substance-related disorders (49.2%); all factors typically associated with increased risk of relapse. Although 42.5% experienced relapse, only 15.0% required readmission, indicating that most relapse episodes were identified early and managed at the household level through caregiver support and phone support by YBU team.

Risk of relapse was highest among individuals with substance use disorders (49.2%), compared to those with schizophrenia spectrum /psychotic disorders (24.2%) and bipolar disorder (20.0%). These findings indicate that substance use is the most prominent risk factor for relapse to SMI, alongside other drivers such as medication non-adherence and limited follow-up care. Additionally, the first month post-discharge accounted for 55.6% of readmissions, making it the most critical risk period for relapse.

Continuity of care remains a significant challenge, with only 35.7% of participants accessing follow-up mental health services after discharge. Participants who accessed follow-up services received early support when symptoms re-emerged, maintained medication adherence, and managed relapse at household level before it escalated. These findings suggest that continuity of care plays an important role in reducing the severity of relapse and supporting recovery after discharge, highlighting the need to strengthen linkage to community-based mental health services.

Components of the YBH intervention considered most useful to families were follow-up phone calls (81.7%), medication adherence support (76.7%), and psychoeducation (70.8%), which strengthened caregiver capacity to provide home care and enabled early intervention.

Overall, the YBH intervention demonstrates strong impact by reducing dependence on tertiary hospital services and enabling home-based management of relapse. Strengthening post-discharge follow-up, community service linkage, and targeted substance use interventions will be critical to reducing relapse and sustain recovery among persons with severe mental illness and substance use disorders.

2. BACKGROUND AND INTRODUCTION

Mental health conditions remain a major public health concern worldwide, contributing significantly to disability, poor quality of life, and premature mortality (WHO, 2022). For people living with severe mental illness, the period following discharge from hospital is often one of the most vulnerable stages of recovery, with increased risk of relapse, treatment interruption, and readmission if adequate support is not available (WHO & UNICEF, 2023).

These challenges are particularly evident in low- and middle-income countries, where community-based mental health services and continuity of care remain limited. (WHO, 2022; WHO & UNICEF, 2023). In Uganda, many persons in recovery continue to face barriers such as medication non-adherence, substance use, stigma, unstable family environments, and limited

access to follow-up services, all of which increase the risk of relapse and readmission. (Semakula et al., 2020). In addition, Mental health services continue to be concentrated at referral facilities, while community-based mental health systems remain underdeveloped, creating challenges in continuity of care following discharge (National Planning Authority, 2025). Substance use remains an important concern, given its strong association with poor treatment outcomes and recurrent episodes of illness (Biribawa et al., 2025).

In response to these challenges, YBU implements the 40+ per month pre- and post-discharge intervention at BNRMH (Figure 1) as part of the YBH program, a community-based mental health intervention developed to support the transition of ready to discharge persons from hospital to home through structured follow-up, caregiver engagement, and community-based recovery support (Cappo et al., 2023). Drawing on lessons from the YBH program, the 40+ per month intervention was designed to strengthen continuity of care for a larger number of persons in recovery each month, with a focus on supporting safe reintegration into families and communities, promoting treatment adherence, and reducing the risk of relapse and readmission following discharge while supporting the decongestion of BNRMH.

THE 40+ PER MONTH MODEL

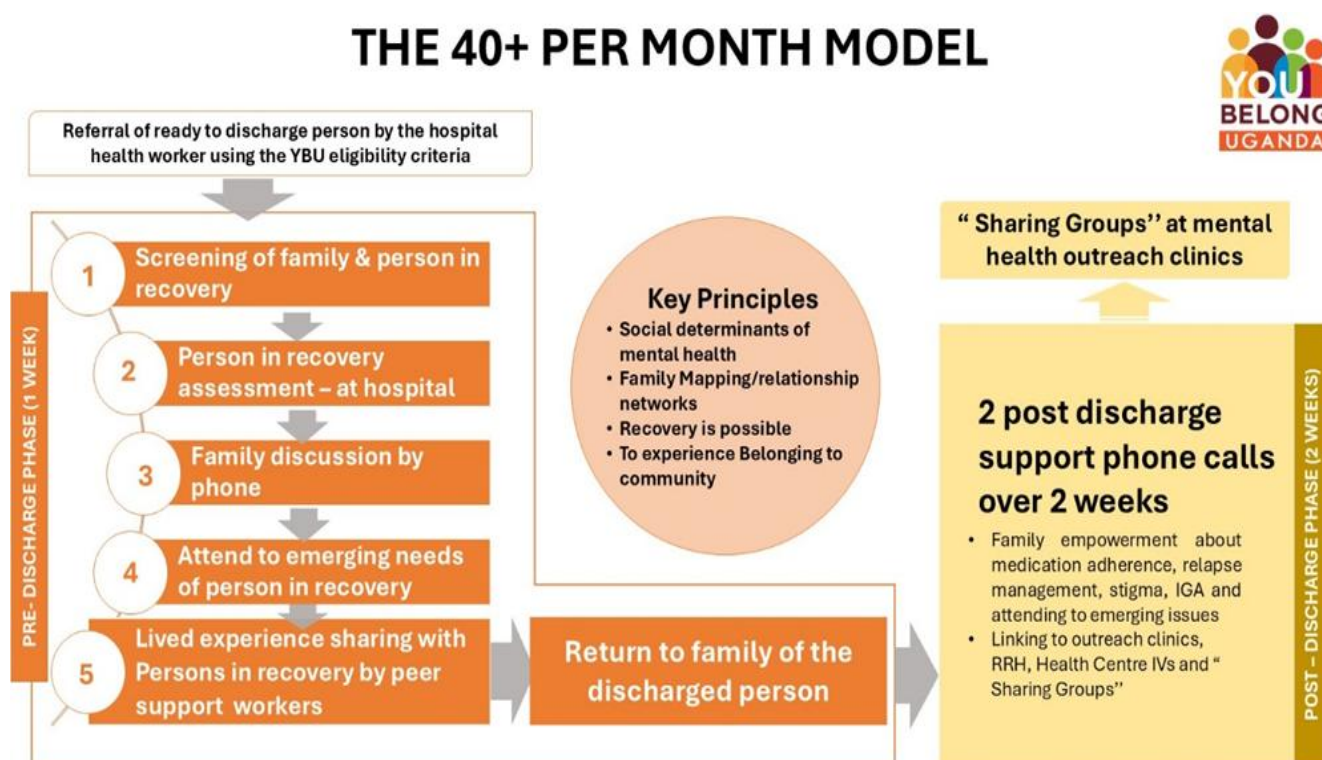


Figure 1: The 40+ per month pre and post discharge process

The intervention comprises three structured phases delivered over a three-week period. An initial pre-discharge phase consist focusses on assessment of the individual and their family , following five sequential steps: (1) screening of the family and the person in recovery following referral by the hospital health worker using YBU eligibility criteria; (2) an in-hospital

assessment of the person in recovery; (3) a family discussion conducted by phone; (4) follow-up on any emerging needs of the person in recovery; and (5) a lived-experience sharing session facilitated by peer support workers, conducted within a week before the person returns to their family. On return home, the YBU team coordinates and prepares the person in recovery on the day of return, transporting them in the YBU van back to their family and community. On arrival, the family/caregiver receives the person in recovery, and the YBU team delivers psychoeducation on the illness covering diagnosis, signs and symptoms, management, medication adherence, and early warning signs together with the next review date and post-discharge engagement plan. The post-discharge phase is delivery of two structured support phone calls, spaced over two weeks, with a focus on family empowerment on medication adherence, relapse management, stigma, income-generating activities (IGA), and any emerging issues, together with active linkage to outreach clinics, Regional Referral Hospitals, Health Centre IVs, and community “Sharing Groups.” The intervention is based on four key principles: attention to the social determinants of mental health, family mapping and relationship networks, the belief that recovery is possible, and helping the person in recovery experience belonging to their family and community

3. PURPOSE OF THE EVALUATION

The evaluation assessed outcomes related to recovery among persons living with SMI and substance use disorders supported under the YBH 40+ per month intervention who had remained at home for 3–6 months after discharge from BNRMH. The findings are intended to support program learning, strengthen service delivery, and guide policy initiatives to improve continuity of care and recovery outcomes for persons transitioning from hospital to community-based care.

3.1 Objectives

1. Determine the relapse and readmission rates of persons supported under the 40+ per month intervention.
2. Assess clinical and social outcomes, including mental stability, functioning, and symptom profile.
3. Analyse demographic and clinical profiles associated with relapse risk.
4. Examine access to health services post-discharge and their influence on outcomes.
5. Identify which YBH 40+ per month intervention components were most useful in preventing relapse.

6. Explore experiences of persons in recovery and caregivers through individual narratives.

4. METHODOLOGY

4.1 Study Design

This was a mixed-methods cross-sectional evaluation combining both quantitative and qualitative approaches.

4.2 Study Site

The study was conducted in Kampala and Wakiso districts (Figure 2), which constitute the primary geographical areas where YBU implements the YBH pre- and post-discharge intervention. They urban and peri-urban districts located in central Uganda, with district populations of 1,507,080 (Kampala) and 1,997,418 (Wakiso).

Map of Wakiso and Kampala Districts

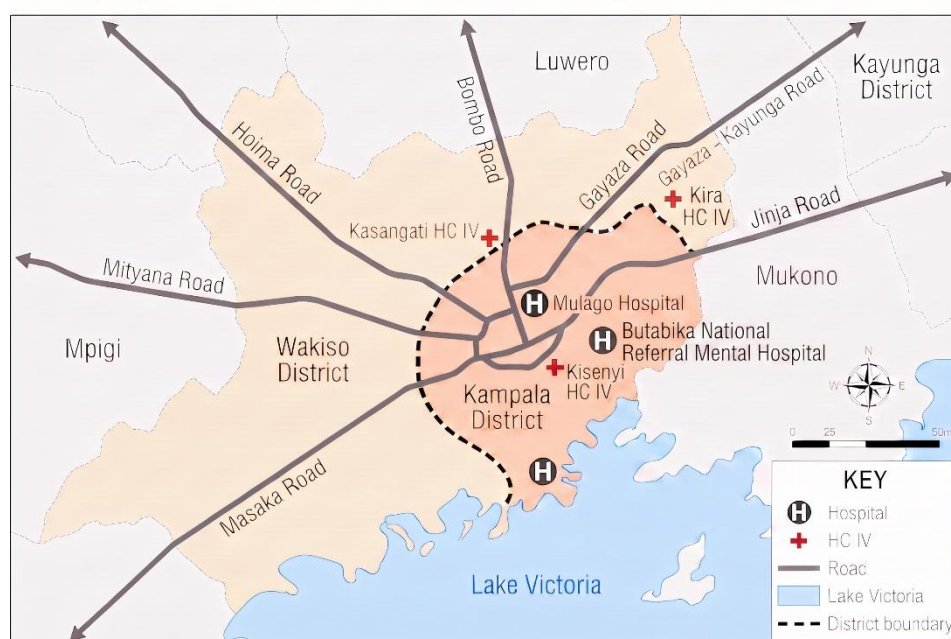


Figure 2: Map of Wakiso and Kampala showing YouBelong Uganda catchment area.

4.3 Study population

The study focused on persons with lived experience of SMI and Substance use who had received support from the YBH 40+ intervention to return home during the study period.

4.3 Evaluation Period

The evaluation was conducted between March 2026 and April 2026. Data collection was undertaken during this period through structured phone interviews with eligible persons in recovery and their caregivers.

4.4 Sample Size

The evaluation used a census approach, where all persons in recovery who met the inclusion criteria were considered for participation, rather than selecting a random sample. The sample size therefore included all 190 individuals from a population of 282 persons supported under the YBU 40+ per month intervention who had spent 3–6 months at home after discharge. From a total of 282 persons supported, 190 met the eligibility criteria. All eligible individuals were then contacted using available phone records. Of these: 120 persons in recovery, representing 63.2% of the eligible population (120/190) were successfully contacted.

Inclusion Criteria

- Supported under YBU's 40+ per month intervention
- Returned home by YBU after hospital discharge
- Spent 3–6 months at home
- Provided informed consent by self or their caregiver (Appendix 1)

Exclusion Criteria

- Less than 3 months at home
- No valid phone contacts
- Declined or unable to provide consent
- Severe current illness preventing engagement

4.5 Questionnaire Development

A structured data collection questionnaire including both qualitative and quantitative aspects was developed by the YBH team based on the objectives of the evaluation and the key components of the YBH 40+ per month intervention.

The quantitative aspect was designed to collect information on socio-demographic characteristics, clinical history, relapse and readmission patterns, access to follow-up services, and utilization of intervention components. The qualitative aspect focused on experiences of recovery, relapse triggers, caregiver roles, continuity of care, and barriers to accessing services after discharge. (Appendix 2).

The draft questionnaire was reviewed by the study supervisor to assess its relevance, clarity, and alignment with the evaluation objectives. The revised questionnaire was further discussed by the YBH team and refined to improve question flow, wording, and suitability for phone-based interviews. The final version was programmed into Kobo Toolbox and used for data collection.

4.6 Data collection procedure

Data collection was conducted by the YBH team through telephone interviews with eligible respondents identified from program records. During the initial phone contact, the evaluation team introduced the purpose of the study, sought verbal informed consent from the person in recovery and/or their caregiver, (Appendix 1) and confirmed whether they were available to participate immediately or preferred to schedule the interview for a more convenient time. Interviews were then conducted by trained members of the evaluation team using the Kobo Toolbox questionnaire.

Where respondents could not be reached on the first attempt, or requested a different interview time, multiple follow-up calls were made until contact was established or all reasonable attempts had been exhausted. Completed interviews were submitted electronically and reviewed regularly for completeness and consistency throughout the data collection period. Respondents included:

- The person in recovery together with their caregiver; or
- The caregiver alone, where the person in recovery was unable to participate.

4.7 Data Analysis

Quantitative data were exported from Kobo Toolbox and analysed using SPSS (Version 29.0.2.0. (20)) and Microsoft Excel (Microsoft 365). Descriptive statistics, including frequencies, percentages, and cross-tabulations, were generated to summarize participant characteristics, relapse and readmission patterns, service utilization, and perceptions of intervention components. Determination of relapse was by self-report of symptoms and signs of illness experienced by the person in recovery and/or their caregiver, during the structured phone interview. Date of readmission was inquired into during the interview and later verified from hospital records.

Qualitative data were analysed using thematic analysis. Responses from the open-ended interview questions were reviewed and organized into meaningful codes based on recurring ideas and experiences reported by persons in recovery and caregivers. Similar codes were then grouped into broader categories and themes. Both pre-determined themes linked to the evaluation objectives and new themes emerging from the data were considered during analysis.

The coding process resulted in four major themes: (i) Improved functioning and maintenance of recovery in community, (ii) Improved caregiver capacity to recognise relapse patterns and early warning Signs, (iii) Caregiver Burden and Responsibility, and (iv) Structural Barriers to Sustained Recovery. These themes were continuously reviewed and refined to ensure they

accurately reflected the experiences reported by respondents. Illustrative quotations were used to support the interpretation of findings.

4.8 Evaluation Benchmarks

To interpret program performance, key outcomes were assessed against predefined benchmarks developed by the YBU team based on program objectives and practical expectations for post-discharge recovery. These benchmarks served as reference points for evaluating the effectiveness of the intervention rather than as formal national or international standards. The benchmarks included:

Table 1: Benchmark targets for project evaluation

No	Benchmark	YBH Target
1	Relapse rate	< 30%
2	Readmission rate	< 30%
3	Maintaining recovery in the community (participants remaining at home without readmission)	≥ 70%
4	Uptake of key intervention components (follow-up support, medication adherence support, psychoeducation, and family involvement)	≥ 70% of participants reporting each component as useful

Observed results were compared with these benchmarks to identify areas of success and opportunities for program improvement.

4.9 Ethical considerations

Participation in the evaluation was voluntary. Before each interview, the evaluation team read a structured verbal consent script (*Appendix 1*) to the person in recovery and/or their caregiver, by phone. This script introduced the interviewer and YBU, explained the purpose of the follow-up survey, the topics to be covered (recovery, relapse, readmission, and related experiences), and the expected duration (15–20 minutes). Respondents were told that participation was voluntary, that they could decline to answer any question or stop the interview at any point, and that their responses would remain confidential and would not affect any support they received from YouBelongHOME or any health facility. Where the person in recovery was able to participate, both they and their caregiver were asked to consent; where they were not able to, consent was sought from the caregiver alone. Consent was recorded directly in the Kobo Toolbox questionnaire (*Appendix 2*) before any substantive questions were asked, distinguishing whether the person in recovery, the caregiver, or both had consented. Interviews proceeded only where consent was given; where it was declined, the survey ended immediately

and no further questions were asked. Respondents were assured of confidentiality, data were collected and stored securely, and findings are presented in aggregate form to protect the identity of participants.

5. FINDINGS

5.1. Demographics

This section presents the demographic and clinical profile of the 120 persons in recovery who were successfully interviewed. These characteristics provide context for understanding relapse patterns, readmission risk, and post-discharge outcomes.

Age Group Distribution

The age distribution indicates that the majority of participants (68.3%) were between 26 and 45 years of age, with nearly two-thirds concentrated in the 26–35-year age group. (Figure 3)

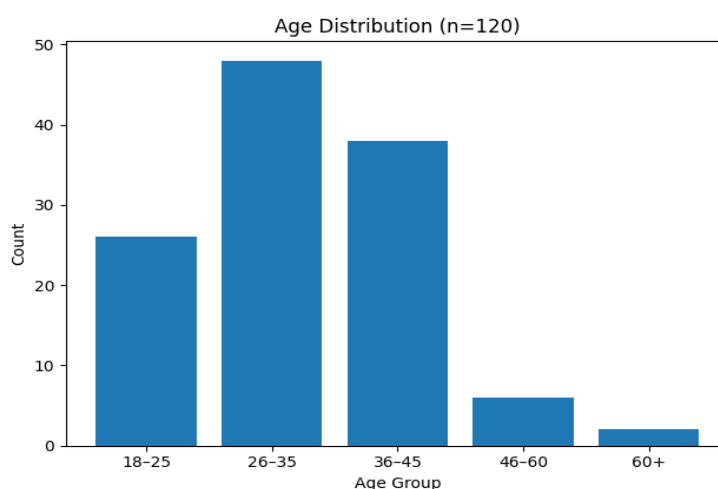


Figure 3: Age Distribution of Participants (n = 120)

Pie chart showing gender distribution

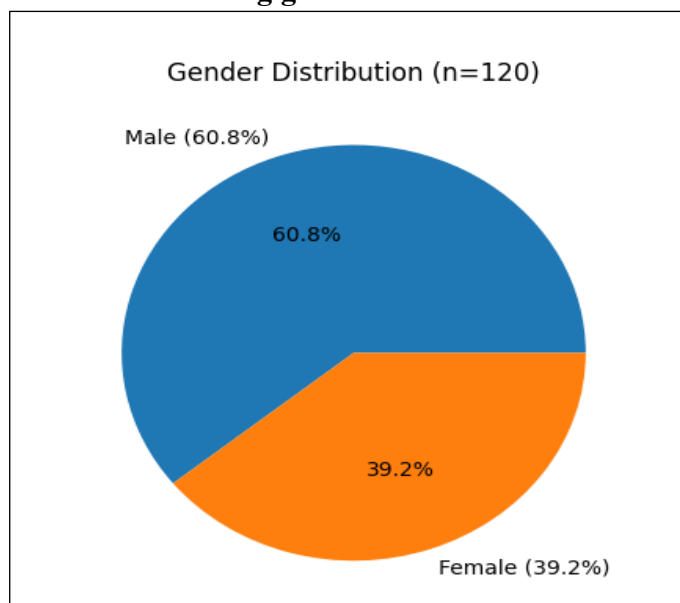


Figure 4 shows that the majority of participants were male (60.8%).

Figure 4: Gender distribution of persons in recovery under 40+ per month intervention

District Distribution

Majority of participants were from **Wakiso district (60.8%)**, reflecting the urban and peri-urban catchment of the study population. (Figure 5)

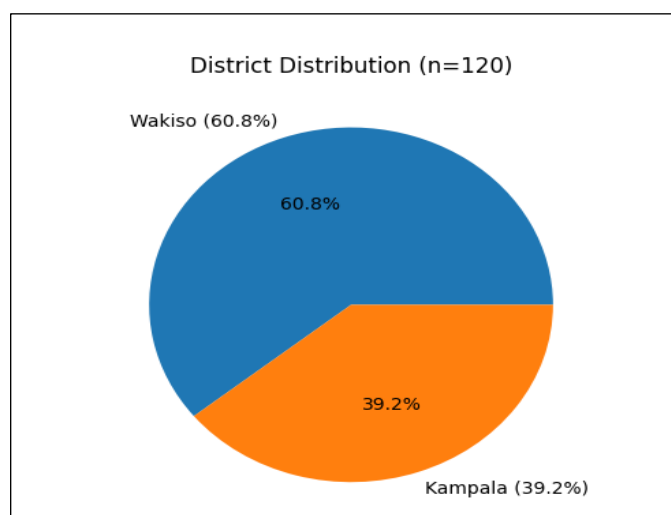


Figure 5: Pie chart showing distribution of persons in recovery by district

Diagnosis distribution

Alcohol and Substance use disorders (A/SUDs) accounted for 49.2% (n=59) of all cases (Figure 6), making them the largest diagnostic group. Schizophrenia spectrum and other psychotic disorders accounted for 24.2% (n=29) of cases, followed by bipolar disorder at 20.0% (n=24). Other diagnoses accounted for 6.6% (n=8) of respondents.

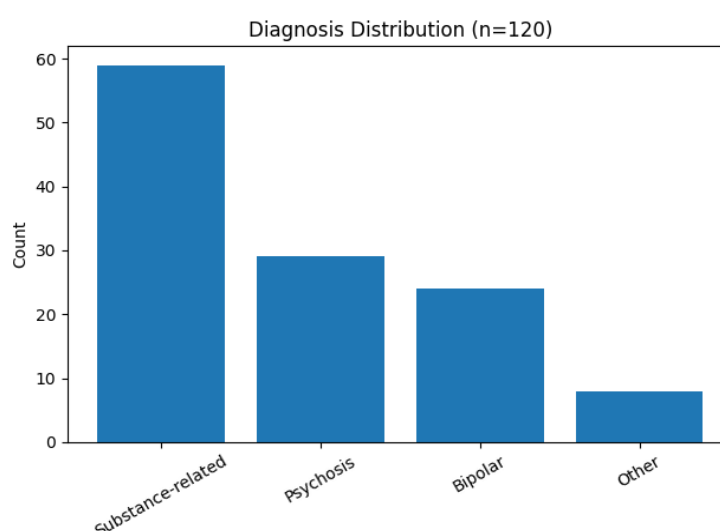


Figure 6: Distribution of persons in recovery by diagnosis

Table 2: Breakdown of Diagnoses of Alcohol and substance use disorder (n = 59)

Category of substance use disorders	Frequency (n)	Percentage (%)
Alcohol Use Disorder (AUD) only	6	10.2%
Substance Use Disorder (SUD) only	28	47.5%
Severe Mental Illness + SUD (Dual Diagnosis)	18	30.5%
SUD with Physical Comorbidity (e.g., HIV)	7	11.9%
Total	59	100.0%

Nearly half of the cases were primary substance use disorders (47.5%), while 30.5% involved co-occurring severe mental illness and substance use disorders. A smaller proportion comprised alcohol use disorder only (10.2%) and substance use disorders with physical

comorbidities, most commonly HIV (11.9%). This highlights the significant burden of substance use and dual diagnosis among the population supported under the intervention.

Duration of Illness

Nearly half of the participants (49.5%) had lived with mental illness for more than five years as shown on *Table 3*.

Table 3: Duration of illness

Duration	Frequency	Percent
≤1 year	24	19.3%
2–5 years	37	31.2%
≥5 years	59	49.5%
Total	120	100%

Number of Previous Admissions

A majority of participants (73.2%) had two or more prior admissions. (*Table 4*)

Table 4: Number of previous admissions

Admissions	Frequency	Percent
1 admission	32	26.8%
2–3 admissions	46	38.0%
4+ admissions	42	35.2%
Total	120	100%

Duration at Hospital Before discharge

Most participants (61.7%) had moderate-length admissions (1–3 months)

Table 5: Duration at Hospital Before Discharge

Duration	Frequency	Percent
<1 month	34	28.3%
1–3 months	74	61.7%
3–6 months	5	4.2%
Missing	7	5.8%
Total	120	100%

5.2. Relapse & readmission

This section presents findings on relapse (symptom recurrence) and readmission (hospitalization).

Table 6: Relapse and Readmission Outcomes (n=120)

Indicator	Frequency	Percent (%)
Relapsed	51	42.5%
Not relapsed	69	57.5%
Total	120	100%
Readmitted	18	15.0%
Not readmitted	102	85.0%
Total	120	100%

Figure 7 show that while 42.5% of participants experienced relapse, only 15.0% required readmission, indicating that a substantial proportion of relapses were successfully managed at home without escalation to hospitalization during the evaluation period.

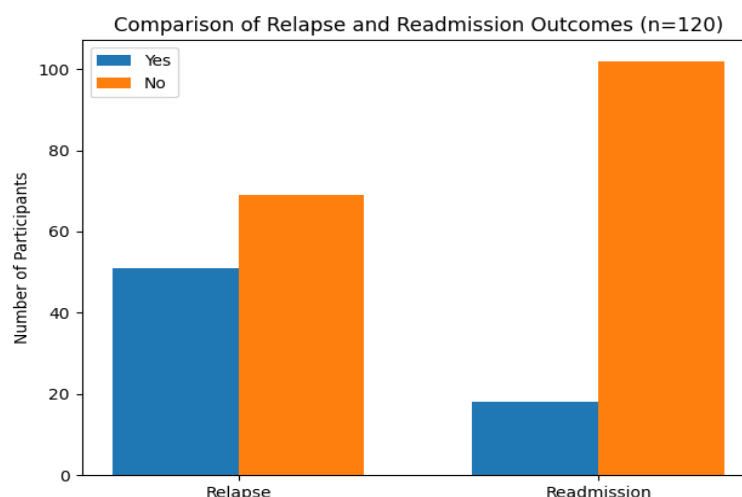


Figure 7: Comparison of relapse and readmission

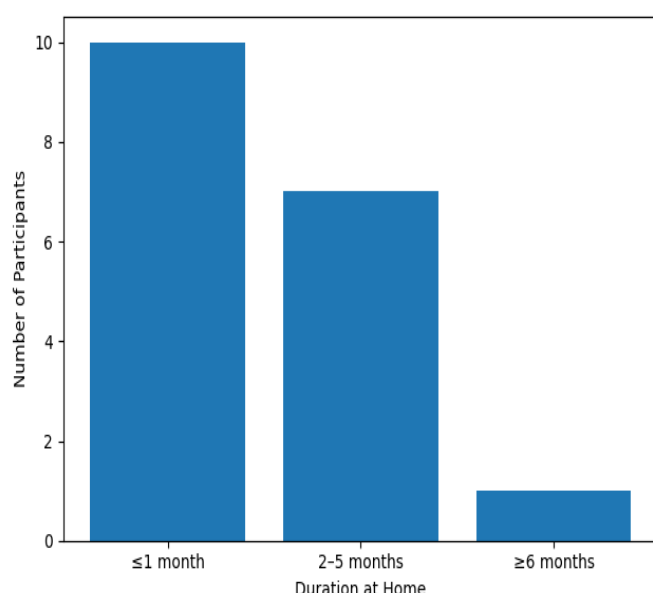


Figure 8: Time to Readmission (n = 18)

Figure 8 shows how long, after returning home, the 18 participants who were later readmitted stayed at home before readmission. This is a subset of the 51 who relapsed (Table 6) specifically those whose relapse escalated to hospitalization. Most readmissions occurred within the first month after discharge: 10 of the 18 (55.6%) were readmitted within that period, 7 (38.9%) between 2–5 months, and 1 (5.6%) at six months.

Relationship between Diagnosis and Relapse Risk

The relapse patterns by diagnosis show that relapse is not evenly distributed across diagnostic groups but is instead highly concentrated among a small number of high-risk conditions. The relapse patterns by diagnosis shows that relapse is high for persons with alcohol and substance use disorders.

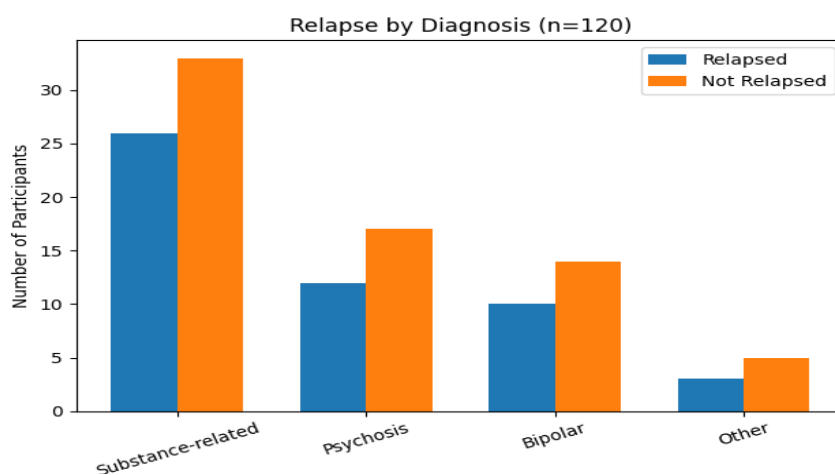


Figure 9: Relapse patterns by diagnosis

Relationship between duration hospital Stay and Relapse

Table 7: Duration of Hospital stay vs Relapse Risk (n = 120)

Duration at Hospital	Total (n)	Relapse Pattern
<1 month	34 (28.3%)	Higher relapse tendency
1–3 months	74 (61.7%)	Moderate relapse
3–6 months	5 (4.2%)	Lowest relapse

Participants discharged after shorter stay in hospital (<1 month) showed relatively higher relapse risk, while those with longer stay in hospital (≥ 1 month) had low relapses.

Key Drivers of Relapse

Relapse was associated with a combination of clinical factors including alcohol and substance use, medication non-adherence, and service-related barriers, including transport challenges, long distances to health facilities, medication shortages, and limited access to follow-up care, as identified through thematic analysis of responses from PWSMI and caregivers (n = 51 relapse cases).

Table 8: Drivers of Relapse (n = 51)

Driver	Frequency	Percent (%)
Alcohol and Substance use	32	62.7%
Medication non-adherence	28	54.9%
Limited access to follow-up care	21	41.2%
Influence to use substances	18	35.3%
Family stress/conflict, and limited family involvement	15	29.4%

5.3 Access to follow up mental health services (continuity of care)

Out of 120 participants, only 43 (35.7%) accessed mental health services at the facilities to which they were referred by the YBH team, while 77 (64.3%) did not access any follow-up services.

Table 9: Access to Referred Services

Response	Frequency	Percent (%)
Accessed services	43	35.7%
Did not access services	77	64.3%
Total	120	100%

Type of health services accessed post discharge (n = 43)

Among participants who accessed services post discharge, the majority received clinical review and medication support, with limited uptake of broader mental health services (Table 11).

Table 10: Services Acquired (n = 43)

Service Type	Frequency	Percent (%)
Review + medication refill	26	60.5%
Medication refill only	9	20.9%
Review only	2	4.7%
Mental health services (general/outreach)	3	7.0%
Counselling / psychotherapy	2	4.7%
Other services	1	2.3%
Total	43	100%

Pattern of non-utilization of health services (n = 77)

Non-utilization of services was primarily characterized by failure to attend referral health facilities by a majority (80.5%) of all participants who did not access any follow-up care.

Table 11: Pattern of non-utilization of health services (n = 77)

Pattern	Frequency	Percent (%)
Did not follow-through	62	80.5%
Preference for BNRMH	8	10.4%
Went once or twice	7	9.1%
Total	77	100%

5.4 Useful components of 40+ per month intervention

To assess the impact of the 40+ per month intervention, both persons in recovery and caregivers were asked to identify which components of the post-discharge intervention they found most useful in supporting recovery and preventing relapse. Responses were analysed and categorized into key intervention components.

Frequency of Reported Useful Components

Table 12: Useful components of the YBH intervention

Component	Frequency	Percent (%)	Description
Follow-up phone calls	98	81.7%	Weekly calls to caregivers/persons in recovery to monitor symptoms, provide guidance, and offer psychosocial support
Medication adherence support	92	76.7%	Guidance and reminders to ensure correct and consistent use of prescribed medication
Psychoeducation	85	70.8%	Education provided to caregivers and patients on illness, symptoms, triggers, and early warning signs
Family involvement	80	66.7%	Active engagement of caregivers in monitoring symptoms, supporting medication adherence, and participating in decision-making and follow-up care
Reintegration support	74	61.7%	Support to help the person adjust back into the home environment, including managing household

			roles, reducing conflict, and facilitating social and functional recovery
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Follow-up phone calls were the most valued component (81.7%), highlighting the importance of continuous post-discharge engagement. Medication adherence support (76.7%) was also critical, directly addressing one of the main drivers of relapse. Psychoeducation (70.8%) enabled caregivers and persons in recovery to recognize symptoms and intervene early. Family involvement (66.7%) strengthened caregiver confidence and capacity, while reintegration support (61.7%) facilitated smoother adjustment at home by reducing conflict and supporting social stability.

5.5 Program performance against benchmarks

Table 13: Program Performance Against Benchmarks

Indicator	Observed	Suggested Target
Relapse Rate	42.5%	<30%
Readmission Rate	15.0%	<30%
Maintained recovery at community	85.0%	>70%

Relapse was observed in 42.5% of persons in recovery, while 15.0% were readmitted. Among those who relapsed (n = 51), the most frequently reported factors were substance use (62.7%), medication non-adherence (54.9%), and limited access to follow-up care (41.2%). Overall, only 35.7% of participants accessed follow-up services.

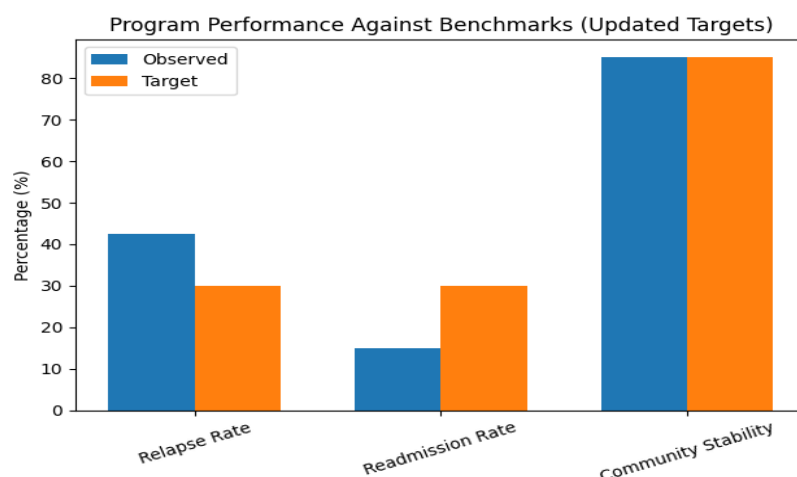


Figure 10: Program performance against benchmarks

5.6. Key performance indicators (KPIs)

Table 14: Key Performance indicators

Indicator	Result	Target
Relapse Rate	42.5%	<30%
Readmission Rate	15%	<30%
Stability at Home	85% not readmitted	>70%
Access to Services	35.7% attended follow-up	>50%
High-Risk Window	First 1 month	N/A
Most Effective Components	Follow up, Phone calls, medication support, psychoeducation	N/A

Table 14 reports outcomes against the evaluation's core benchmarks which feeds into Table 15 where service-access and design indicators are consolidated into a single summary. Relapse rate (42.5%) and access to services (35.7%) fall outside target; readmission avoidance (15%)

and community stability (85%) are within range. The first month post-discharge is the highest-risk window, and follow-up calls, medication support, and psychoeducation were the components most valued by participants.

5.7. Qualitative analysis

The qualitative aspect of the evaluation provides deeper insight into the lived experiences of persons in recovery and their caregivers following discharge under the 40+ per month intervention. Through thematic analysis of phone interviews, four major themes emerged, reflecting both progress in recovery and persistent challenges affecting long-term stability.

Theme 1: Improved Functioning and Stability

A dominant theme across responses was improved functioning and reintegration, with caregivers reporting that persons in recovery were calmer, more cooperative, and actively participating in daily activities such as household chores. There was a noticeable reduction in disruptive behaviours, alongside gradual return to family roles, often linked to medication adherence and structured post-discharge support. As one caregiver noted, *“She is now calm, helps with small chores at home, like washing utensils and sweeping, which she couldn’t do before.”* A person in recovery also shared, *“I feel better now. I can talk to people and stay at home well.”* These indicate that the intervention supported not only clinical stability but also meaningful functional recovery essential for long-term reintegration.

Theme 2: Improved caregiver capacity to recognise relapse Patterns and Early Warning Signs

Relapse was consistently described as a gradual and predictable process, with caregivers demonstrating strong awareness of early warning signs such as withdrawal, insomnia, mood changes, talking to oneself, and refusal to take medication. This reflects improved understanding from psychoeducation under the YBH program. As one respondent noted, *“We noticed she stopped sleeping at night and became restless that’s how we knew something was wrong.”* A person in recovery also shared, *“When I begin to feel confused or uncomfortable, I know I need help.”* These insights indicate a clear shift toward early detection and timely intervention, enabling families to manage relapse before it escalates.

Theme 3: Caregiver Burden and Responsibility

Caregiving remained emotionally and financially demanding, with families taking on continuous responsibility for medication supervision, behaviour monitoring, and daily support

with limited external assistance. Many caregivers reported feeling overwhelmed and strained, particularly due to transport costs, medication access, and reduced productivity. As one caregiver noted, *“It is not easy because you have to watch him all the time to make sure he is okay.”* Similarly, another shared, *“Sometimes we don’t have money for transport to take her for review, yet we know it is important.”* These accounts highlight that while families are central to recovery, they require sustained support and resources to effectively maintain this role.

Theme 4: Structural Barriers to Sustained Recovery

Structural barriers significantly limited continuity of care and long-term recovery, with participants highlighting long distances, high transport costs, medication shortages, and limited follow-up services as key challenges. These constraints often prevented families from accessing care even when willing to do so. As one carer noted, *“The health center is far, and sometimes we don’t have transport, so we just stay at home. If services were closer, it would be easier to manage him.”* Similarly, a brother to a person in recovery explained, *“We went to the health centre you sent us, but we didn’t get the medicine, so we had to return and find ways of buying.”* These findings underscore a critical gap between referral and actual service utilization, directly contributing to relapse risk.

In summary, the qualitative findings show that recovery under the 40+ per month intervention is both progressive and complex, with clear improvements in functioning, caregiver capacity, and early relapse detection, alongside persistent structural and socio-economic barriers that limit sustained recovery.

6. DISCUSSION

The socio-demographic and clinical profile of participants indicates that the 40+ intervention primarily supported young and middle-aged adults in their economically productive years. This finding is consistent with global and national evidence showing that severe mental health conditions often emerge during early and middle adulthood, with significant implications for productivity, family well-being, and social participation (World Health Organization, 2022; National Planning Authority, 2025). The predominance of male participants may reflect broader patterns in service utilization, consistent with global evidence that the disease and mortality burden of alcohol and substance use falls disproportionately on men (World Health Organization, 2024).

Many participants had experienced multiple prior admissions and prolonged illness duration, indicating a population with complex, recurrent mental health needs. This pattern is well-documented in literature, where substance use, treatment interruption, and limited community

support drive repeated relapse and hospitalization (Semakula et al., 2020; Cappelletti et al., 2022). This matters for how the relapse and readmission rates should be read: this population entered the evaluation already at an elevated risk of relapse and readmission independent of anything the intervention does because of the chronic nature of SMI and treatment history alone. The 42.5% relapse rate and 15.0% readmission rate should therefore be interpreted against that elevated starting point, not against a general population baseline.

Relapse in this population is better understood as an expected feature of recovery from severe, often recurrent illness than as a program failure: the gap between the relapse rate (42.5%) and the readmission rate (15.0%) is the central story of this evaluation. What distinguishes outcomes here is not whether relapse occurs, but whether it is managed within the family before it escalates to a hospital-level crisis. This echoes earlier work conducted on BNRMH's own convalescent wards, which found that the quality of family care for persons with severe mental illness is directly linked to hospital overstay and preventable readmissions (Verity et al., 2021) a finding that helped shape the YouBelongHOME model this intervention builds on. Caregivers in this evaluation reported growing confidence in recognizing early warning signs lack of sleep, irritability, withdrawal, medication refusal enabling them to intervene before crises developed. This aligns with an evolving understanding of recovery: not the absence of relapse, but the capacity to manage it without institutional readmission (The Lancet Psychiatry Commission on Psychosis, 2024; WHO & UNICEF, 2023). However, exploration of the specific factors that kept people out of hospital deserves further research.

Follow-up phone calls, medication support, and psychoeducation were consistently rated most helpful. This reflects more than convenience: each is delivered to the family as a unit, building the caregiver's capacity to detect warning signs, manage medication, and respond early, rather than following up with the individual alone. A Ugandan evaluation of a family involvement intervention for severe mental illness found this same family-centred approach improved medication adherence and reduced relapse and readmission compared with institution-based care (Turiho et al., 2024). Extending phone-call frequency or duration is therefore likely more effective and timelier than adding facility-based, individually oriented components.

Substance use disorders are both the largest diagnostic group (49.2% of 120) and the leading driver of relapse (62.7% of 51 relapses; Table 8) yet the model offers only basic motivational interviewing and partial peer-led sharing, since peer workers currently share lived experience of mental illness, not substance use. The mismatch deepens given composition: 30.5% of the 59-person SUD group (18/59) also has a co-occurring severe mental illness, and 11.9% (7/59) a physical comorbidity, mostly HIV (Table 1) nearly a third managing two conditions through

one generalist track. This matters because motivational interviewing alone rarely closes this gap: across Africa, SUD relapse stays high (23–92%) regardless of treatment type, driven more by social support than technique (Biribawa et al., 2025a). The implication: build dedicated SUD content, including a peer support pathway, into the model's existing family/community structure rather than treating substance use as secondary.

Critically, the 40+ per month model has no substance-use-specific component. This matters; substance use was the leading driver of relapse (62.7% of 51 cases, Table 8), and 30.5% of the SUD subgroup carries a co-occurring severe mental illness (Table 1). Both patterns match Ugandan evidence: SUD frequently co-occurs with and complicates treatment of primary mental illness (Rubega et al., 2025), and post-discharge SUD follow-up at Butabika's own Alcohol and Drug Unit is rarely sustained due to resource constraints, leaving relapse prevention underdeveloped (Biribawa et al., 2025). Adding a dedicated substance-use component would directly address both gaps.

Continuity of care remains a serious and unresolved gap. Only 35.7% of participants accessed follow-up services after discharge despite evidence that those who did were more likely to maintain medication adherence and receive timely support when symptoms returned. Transport costs, distance to facilities, and medication stockouts were the most commonly cited barriers. These challenges are not unique to this setting: they reflect broader failures in how mental health services are structured in low- and middle-income countries, where referral systems are weak and hospital-community integration is limited (Giebel et al., 2024; WHO, 2024). Uganda's own national data confirms that community mental health services remain thin and that care continues to be concentrated at referral-level facilities (National Planning Authority, 2025).

Furthermore, the other gap that deserves attention: is that uptake of counselling and psychotherapy was very low among those who accessed follow-up care. This reflects the limited availability of psychosocial services in Uganda, a pattern consistent with global analyses showing these interventions remain chronically underfunded, understaffed, and underutilized (WHO, 2024; Semakula et al, 2020).

More than half of all readmissions (55.6%) occurred within the first month after discharge, making this the single highest-risk window in the recovery pathway. Yet structured post-discharge phone contact ends at two weeks meaning some readmissions are occurring in the second half of that first month, after the two scheduled calls have already been completed. This is not simply a confirmation of a pattern reported elsewhere (Sarah Xiao et al., 2025; O'Donoghue et al., 2024); it points to a specific, fixable design gap the length of structured

support does not currently match the length of the period during which participants are most likely to relapse. Extending structured contact to cover the full first month, even briefly, would close that gap, particularly for those with recurrent illness, unstable home environments, or substance use challenges, who may need longer or more intensive support.

The observed association between shorter hospital stays and higher relapse patterns should be interpreted with caution. While participants discharged after shorter admissions appeared more likely to experience relapse, this evaluation cannot determine whether the duration of hospitalization itself influenced these outcomes. Other factors, such as illness severity, clinical stabilization, discharge readiness, caregiver preparedness, medication continuity, and access to follow-up care, may have played an important role. Consistent with recent evidence, effective transition planning and continuity of care are likely to be more important for sustained recovery than the length of hospitalization alone (The Lancet Psychiatry Commission, 2024; WHO & UNICEF, 2023). Further research is needed to explore the relationship between hospital length of stay, discharge processes, and post-discharge outcomes in this setting.

Beyond clinical management of illness signs and symptoms, caregivers described real improvements in day-to-day functioning. These included; better communication, participation in household tasks, and renewed social engagement. This matters. Recovery is increasingly understood not as symptom reduction alone, but as restored functioning, autonomy, and meaningful participation in community life (WHO, 2022; Melillo et al., 2025; Gamiieldien et al., 2025). The 40+ per month intervention contributes to this broader form of recovery.

Family caregivers were central to everything that worked. They supervised medication, monitored symptoms, identified warning signs, and held the recovery process together at home often at considerable personal and financial cost. This is consistent with what is known about mental health care in low-resource settings globally, where families carry the majority of long-term care responsibility (WHO, 2021; Verity et al., 2021; Cappo et al., 2022). Similar experiences have been documented among caregivers of persons with schizophrenia in Uganda (Namara et al., 2025). Caregiver wellbeing and capacity are not secondary concerns, they are structural requirements for community-based care to function, and Uganda's growing emphasis on this model makes that support even more urgent (National Planning Authority, 2025).

In addition, the intervention reflects global guidance calling for a shift away from institutional care toward family-centered, community-based systems that support recovery in everyday environments and reduce unnecessary hospitalization (WHO & UNICEF, 2023; WHO, 2022). It builds directly on the YouBelongHOME framework and demonstrates how structured follow-up and caregiver involvement can sustain recovery after discharge (Cappo et al., 2022).

National recommendations have similarly called for strengthening community systems through household follow-up, referral tracking, and community health worker engagement (National Planning Authority, 2025).

In summary, the findings show that the 40+ per month intervention supports sustained community recovery by building caregiver capacity, enabling early relapse detection, and improving continuity of support. However, substance use, limited follow-up access, and structural barriers continue to compromise outcomes for the most vulnerable participants. Strengthening community follow-up systems, expanding psychosocial services, improving outpatient linkage, and integrating substance use treatment are the evidence-based next steps toward reducing preventable readmissions and sustaining recovery at scale.

7. RECOMMENDATIONS

- Consider extending follow-up beyond the current two-week period, particularly for individuals at higher risk of relapse, including those with substance use disorders and multiple previous admissions.
- Improve referral tracking and referral to community health facilities to increase uptake of post-discharge services and continuity of care at community level.
- Continue caregiver education and follow-up support to promote consistent medication use and early response to adherence challenges while empowering carers to recognize their central role in sustaining recovery at home.
- Work with local health facilities and outreach services to address challenges related to transport, distance, and medication availability.
- Track recovery, relapse, and service utilization beyond six months to understand longer-term outcomes and inform program improvement.

8. LIMITATIONS

This evaluation was conducted through phone-based interviews, which limited opportunities for direct observation and in-depth probing of responses. The use of a standardized Kobo Toolbox questionnaire and trained interviewers helped to improve consistency and reduce variations in data collection.

Some eligible participants could not be reached during the data collection period, creating the potential for selection bias. To minimize this risk, multiple contact attempts were made at different times, and interviews were completed with a substantial proportion of all eligible participants.

We acknowledge that the 70 eligible individuals and their caregivers who could not be reached on phone may contribute to survivorship bias however, all attempts were made by the study team to contact them. We used a standard process to reach out to all potential participants, who were beneficiaries of the YBH 40+ intervention and hence shared similar characteristics to those enrolled . .

Determination of relapse and readmission status relied on self-report by the person in recovery and/or their caregiver, rather than use of objective and validated clinical assessments. This may have potentially introduced recall and social desirability bias, which may under- or over-estimate the true rates of relapse .

The evaluation focused on participants who had spent 3–6 months in the community after discharge. While this timeframe was appropriate for assessing early recovery and relapse, it did not capture longer-term outcomes. Longitudinal studies are needed to better understand sustained recovery and the long-term impact of the YBH 40+ per month intervention.

Finally, the evaluation did not include a control group, limiting the ability to attribute observed outcomes solely to the YBU 40+ per month intervention. We aim to conduct a controlled study as a follow up to this. To strengthen the interpretation of findings, the evaluation used a mixed-methods approach that combined quantitative and qualitative data, allowing for triangulation of results and a more comprehensive understanding of participant experiences and outcomes.

9. CONCLUSION

In conclusion, the YBU 40+ per month intervention demonstrates promising outcomes among a clinically complex population characterized by long illness duration, multiple prior admissions, and a high burden of substance-related disorders. Despite a relapse rate of 42.5%, the majority of participants remained in the community without requiring readmission, suggesting that many episodes of relapse were identified early and managed within the home through follow-up calls, medication support, psychoeducation, and caregiver involvement.

The findings highlight that recovery is a dynamic process largely sustained at the household level, where families play a central role in monitoring symptoms, supporting treatment adherence, and facilitating timely intervention. With strengthened support for medication adherence, follow-up care, and community linkages, many relapse episodes can be managed without hospitalization. However, substance use, medication non-adherence, and limited access to follow-up care continue to challenge sustained recovery, underscoring the need to strengthen continuity of care, extend post-discharge support, and improve access to specialized substance use services.

REFERENCES

1. Anthony, W. A. (2020). Recovery from mental illness: The guiding vision of the mental health system in the 21st century. *Psychosocial Rehabilitation Journal*, 16(4), 11–23.
2. Biribawa, C., Tumwesigye, N. M., Sinclair, D. L., Matovu, D. K., Swensen, G., De Meyer, F., Mukasa, M., Kalema, D., Mutamba, B. B., & Vanderplasschen, W. (2025). *Treatment outcomes for substance use disorders across the African continent: A systematic review*. <https://link.springer.com/article/10.1186/s40359-025-02978-5>
3. Biribawa, C., Vanderplasschen, W., Mutyoba, J. N., Mutamba, B. B., Kalani, K., Oyet, D., Kalema, D., Tumwesigye, N. M., & Simpson, V. (2025). *Service user and healthcare-worker perspectives on substance use disorder treatment journeys, relapse, and recovery in sub-Saharan Africa: Evidence from Uganda* [Preprint]. medRxiv. <https://doi.org/10.64898/2025.12.08.25341874>
4. Cappel, D., Mutamba, B., Ayesiga, K., Kebirungi, E., Chelangat, D., Fegan, G., Jacob, S. T., Nsangi, E., Ntabazi, I., Nalubwama, D., Nakasujja, N., Odoki, E., Odoi, P., Mpairwe, I., & Verity, F. (2022). YouBelong Home: A Ugandan community mental health intervention. *Community Mental Health Journal*, 59(4), 770–783. <https://doi.org/10.1007/s10597-022-01058-x>
5. Gamielien, F., Galvaan, R., & Silaule, O. (2025). Strengthening community-based recovery-orientated mental health services: Stakeholder insights on recovery from severe mental health conditions. *South African Health Review*, 27, 98–107. <https://doi.org/10.61473/001c.141584>
6. Giebel, C., Gabbay, M., Shrestha, N. et al. Community-based mental health interventions in low- and middle-income countries: a qualitative study with international experts. *Int J Equity Health* 23, 19 (2024). <https://doi.org/10.1186/s12939-024-02106-6>
7. Melillo, A., et al. (2025). Recovery-oriented and trauma-informed care for people with severe mental illness. *BMC Psychiatry*. <https://doi.org/10.1186/s12888-025-06473-4>
8. Ministry of Health Uganda. (2023). *Annual health sector performance report 2022/2023*. Ministry of Health Uganda.
9. Naamara, W., Twesigye, J., Mutamba, B. B., & Muhwezi, W. W. (2025). *Family caregivers' perceptions of schizophrenia and community members' attitudes toward patients and their family caregivers*. *Social Work in Public Health*. <https://doi.org/10.1080/19371918.2024.2448476>

10. National Planning Authority. (2025). *State of Uganda population report 2025: Mental health: A silent emergency—Addressing the psychological dimensions of Uganda's demographic dividend*. Government of Uganda.
11. O'Donoghue, B., Thompson, A., McGorry, P., & Nelson, B. (2024). *Early relapse and readmission following discharge from psychiatric care: Implications for continuity of care*. *The Lancet Psychiatry*, 11(2), 120–129. <https://www.mdpi.com/2227-9032/10/9/1808>
12. Patel, V., Saxena, S., Lund, C., et al. (2018). *The Lancet Commission on global mental health and sustainable development*. *The Lancet*, 392(10157), 1553–1598. <https://pubmed.ncbi.nlm.nih.gov/30314863/>
13. Sarah Xiao, Ann Tourangeau, Kimberley Widger et al. Exploring the quality of discharge planning processes in mental health care: The healthcare provider perspective, 04 March 2025, PREPRINT (Version 1) available at Research Square <https://doi.org/10.21203/rs.3.rs-6132690/v1>
14. Semakula, L., Mutamba, B., Rukundo, G., & Cappel, D. (2020). *Understanding mental health services for psychosis in Uganda: A report on current care, key gaps and challenges in the management of persons with psychosis in Uganda*. YouBelong Uganda https://youbelongcommunity.org/wp-content/uploads/2021/08/PSYCHOSIS-LANDSCAPE-REPORT_UGANDA-.pdf
15. The Lancet Psychiatry Commission. (2024). Psychosis in low-resource settings: Epidemiology, service gaps, and priorities for action. *The Lancet Psychiatry*, 11(4), 301–345.
16. Thornicroft, G., Deb, T., & Henderson, C. (2022). Community inclusion and supported reintegration after acute mental illness. *The Lancet Psychiatry*, 9(8), 635–646. [https://doi.org/10.1016/S2215-0366\(22\)00115-4](https://doi.org/10.1016/S2215-0366(22)00115-4)
17. Turiho, A. K., Musisi, S., Alinaitwe, R., Okello, E. S., Bird, V. J., Priebe, S., & Sewankambo, N. (2024). Perceived feasibility, acceptability and impact of the family involvement intervention for severe mental illness: A qualitative study in Masaka, Uganda. *International Journal of Mental Health Systems*, 18, 23. <https://doi.org/10.1186/s13033-024-00634-w>
18. UNICEF & World Health Organization. (2023). *Recovery and community reintegration for persons with mental illness: Best practice framework*. UNICEF & WHO.
19. Verity, F., Turiho, A., Mutamba, B.B. et al. Family care for persons with severe mental illness: experiences and perspectives of caregivers in Uganda. *Int J Ment Health System* 15, 48 (2021). <https://doi.org/10.1186/s13033-021-00470-2>

20. World Health Organization. (2022). *Comprehensive mental health action plan 2013–2030*. World Health Organization.
21. World Health Organization. (2022). *World mental health report: Transforming mental health for all*. World Health Organization.
22. World Health Organization. (2024). *Global status report on alcohol and health and treatment of substance use disorders*. Geneva: World Health Organization
23. Rubega, A., Muwanguzi, M., Nkola, R., Favina, A., Kirabira, J., Malinga, S., & Ashaba, S. (2025). *Substance use disorder among patients with primary mental illnesses in Southwestern Uganda*. *Journal of Dual Diagnosis*, 21(1). <https://doi.org/10.1080/15504263.2024.2434740>

APPENDICIES

- **Appendix 1 – Consent Script**

13/03/2026

YBH 40-Per-Month Intervention – Evaluation Survey

Consent Script

1. Introduction

Hello. My name is _____. I work with YouBelong Uganda. I would like to ask you questions based on your participation in YBH 40 per Month intervention briefly for about 15-20mins. You or your family member in recovery benefited from YouBelong Uganda's support during the 40-per-month intervention, and we are now conducting a brief follow-up survey to understand how things have been going since returning home. The information you provide will focus on recovery, relapse experiences, readmissions, and the factors influencing these outcomes, so that we can improve our support to others in the future.

Your participation is voluntary. You may choose not to answer any question, and you may stop the interview at any time. Your responses will be kept confidential and will not affect any support you receive from YouBelong or any health facility.

Do you understand the information provided, and do you agree to participate in this survey? (Ask caregiver and Person in recovery to both consent, and at least caregiver if person in recovery cannot).

☐ Yes, I agree

☐ No, I do not agree (End survey)

YBH 40-Per-Month Intervention – Evaluation Questionnaire

Please indicate who has provided consent for this survey:

Respondent Type	Yes	No
Person in recovery consented		
Caregiver / Family member consented		
Both the person in recovery and caregiver consented		

1. Demographic & Clinical Information of the Person in Recovery

- i. **Initials:** _____
 - ii. **Age:** ☐ 18–25 ☐ 26–35 ☐ 36–45 ☐ 46–60 ☐ 60+
 - iii. **Sex:** ☐ Male ☐ Female
 - iv. **District:** _____
 - v. **Sub-county / Village:** _____
 - vi. **Diagnosis:** ☐ Schizophrenia / Psychotic disorder ☐ Bipolar disorder ☐ Depression ☐ Epilepsy ☐ Substance use disorder ☐ Dual diagnosis (mental illness + substance use) ☐ Other (specify): _____
 - vii. **Duration of mental illness:** Years: _____ Months: _____
 - viii. **Number of previous hospital admissions (life):** ☐ 1 admission ☐ 2–3 admissions ☐ 4+ admissions
 - ix. **Duration spent at Butabika before discharge:** ☐ <1 month ☐ 1–3 months ☐ 3–6 months ☐ >6 months
2. How have you/person in recovery been (presentation of signs and symptoms, any changes in behavior, and compliance to medication, engagement in domestic/IGA) since the last engagement with YBU team?
 3. If no relapse was registered, what do they think helped them prevent relapses/maintain recovery?
 4. If they registered any relapse, what do they think were the reasons for relapse and how it was managed?
 5. Has the service user been readmitted since the last post discharged phone call with YBU team?
 6. How many times? How long did the service user spend at home before readmission after the 40 Per month interventions? For how long was the readmission and how did he/she return home?
 7. Have they been accessing mental health services to the referred outreach clinics or health centers?
 8. What support services have they acquired from referrals made by YBU team?
 9. What components of the YBH post discharge intervention were most useful? (*Tick all that apply*),

- ☐ Follow-up phone calls,
- ☐ Support with medication adherence,
- ☐ Psychoeducation for the family,
- ☐ Linking us to the nearest health facility/outreach clinic,
- ☐ Support in accessing medication,
- ☐ Emotional support and encouragement,
- ☐ Guidance on early warning signs and relapse prevention,
- ☐ Strengthening family involvement in care,
- ☐ Support with reintegration back into the household,
- ☐ Referral to community services,
- ☐ Peer support involvement,
- ☐ Other (specify): _____