# Scaling Up Mental Health Services

## In Low and Middle Income Countries

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# Learning objectives

- Why we need to scale up services
- Broad Principles of good services
- What is meant by ‘scaling up services’
- Contextual issues to consider
- Motivation for change among stakeholders
- Translating a policy into a plan

# Why we need to scale up services

- Needs are high, but access to services is very low
- We know what works to improve symptoms, functioning and quality of life *(interventions/treatments level)*
- We are getting better at knowing how to provide these interventions *(implementation/services level)*
  - Low cost, practical interventions
  - Costed at population level (US$2 pppy in LIC)

# Social Costs

- Stigma and discrimination against people with mental illness and their families means that they suffer a double burden
- Often excluded from society; find it difficult to find work, to marry. Can be physically abused, chained or imprisoned
- Myths make this worse (eg that epilepsy is contagious) or that people are to blame for their condition
- Often first access traditional / religious options, which can be ineffective or even harmful. Less vulnerable to abuse if have access to effective services.
- High costs to the economy; many people affected at age of high economic productivity

# High prevalence and high treatment gap

- So at least **1** out of **4** people will have some kind of mental disorder in their lifetime
- There are high social and economic costs as well as personal suffering
- A large WHO multi-country survey found that 36–50 % of serious cases in developed countries and 76 –85 % in less-developed countries had received no treatment in the previous year

# Broad Principles

What is the current consensus on what we think services should look like?

Brainstorm…

# Broad Principles

- A mix of services to match local population needs
- Decentralised; into Primary Health Care /other local services
- Accessible;
  - local, affordable, few barriers and simple pathways
- Integrated into existing (Government) systems
- Adequate financial and human resources; feasible
- Task-sharing/shifting and core competencies
- Evidence-based; ideally locally relevant research
- Culturally adapted; understood and accepted by local people
- Inter-sectoral linkages; able to refer people in and out to other (non-health) services

# History

- Why did we come to think these were good ideas?
  - Learning from what has been done before
  - Evidence-base of effectiveness
  - Ethical considerations
    - Human Rights
    - (Global) Equity and the treatment gap

# What does scaling-up services mean?

"Deliberate efforts to increase the impact of health service innovations successfully tested in pilot or experimental projects so as to benefit more people and to foster policy and programme development on a lasting basis"

- The most widely accepted definitions of scaling up include 5 main components:

Simmons R, Fajans P, Ghiron L, (Eds). Scaling up health service delivery: from pilot innovations to policies and programs. Geneva, World Health Organization, 2007:vii–xvii

Mangham LJ and Hanson K. Scaling up in international health: what are the key issues? Health Policy and Planning 2010; 25:85-96

Eaton J, McCay L, Semrau M, Chatterjee S, Baingana F, Araya R, Ntulo C, Thornicroft G, Saxena S. Scale up of services for mental health in low-income and middle-income countries. The Lancet 2011; 378 (9802): 1592-1603

# Components of service scale-up - 1

- Increase the number of people receiving services.
  - This might be through greater geographical spread, a wider range of services (e.g., adding psychosocial care to biomedical services), or addressing more conditions or demographic groups
  - ‘Coverage’ is a concept that covers the above increase plus measurement of/ensuring a minimum level of quality

# Components of service scale-up - 2

- Use the best available scientific evidence to design health care interventions and services
  - Following the principle that the most likely way of achieving the intended impact is to rely on the best evidence of effectiveness and cost-effectiveness of interventions, and how they can be delivered sustainably
  - Must take care to match evidence from most appropriate setting

# Components of service scale-up - 3

- Use a service model shown to be effective in similar contexts
  - The evidence of effectiveness is not transferable to all contexts, so need to test interventions and service models in a pilot phase in a similar setting prior to scaling up
  - This is particularly important because a high proportion of research is done in places that are unlike where the greatest treatment gaps exist
  - While there are significant similarities between cultures, it is easy (for convenience) to assume universality where there is diversity, eg in the way people describe mental symptoms ('idioms of distress'), or make decisions about accessing care

# Components of service scale-up - 4

- Integrate mental health services into existing health systems, at all levels of healthcare
  - This leads services in the evidence-based direction of deinstitutionalisation, decentralisation, and PHC-based services
  - reduces the stigma and exclusion associated with psychiatric services
  - ‘Health systems’ are not only services, but the structures and processes that support them, eg management structures, financing and health management information systems

# Cont'd

- Embedding mental health in the programs of organisations working in other sectors, e.g., education and justice, is an effective way of reaching many people with needs who do not present to health services, and mobilising resources towards promoting good mental health

- Most people first access the informal sector to access support that fits in with their ideas of what will best resolve their problems. These traditional systems must be engaged

# Components of service scale-up - 5

- Ensure sustainability of mental health services through policy formulation, implementation and financing
  - A major challenge and cause of failure
  - The science and practice of implementation encompasses engagement with political processes
  - Must be a priority from the start if scaling up is to be successful

# Context

*People are not the same everywhere*

*Health systems are not the same everywhere*

*Resources are not the same everywhere*

- BUT there are important similarities across countries that justify common approaches
  - Eg WHO mhLAP which provides standard materials ('normative') which are then locally adapted

– Is a global approach to mental health justified?

- There a risk of cultural imperialism in scaling up services in a similar model globally, but the key is to improve CHOICE, so that people can have the option of using new or not

# Best Practice Principles

- **At patient level**: Patient-centred, multi-disciplinary working

- **At services level**: Multi-sectoral approach to organisation of systems. Within health, good integration of services at every level
- Integration of MH into programmes and services (government and NGO) – particularly important in LAMI countries

# Health sector reform

- Drivers for reform, top-down and bottom-up
  - The WHO system
  - The growing influence of service users
- Levers for change, nodes of influence
  - Individuals who have an impact , both officially an unofficially who can be utilised (change agents)
- Broader influences on direction and content of reform
  - eg MDGs and the lack of a MH MDG (a problem or an opportunity?)
  - News, media and natural events/war

- Evidence that MH has performed badly in influencing reform
  - In specific mental health policy and legislation development (and **implementation**)
  - In ensuring that MH is an integral part of general health reforms

# Context issues to consider in developing services

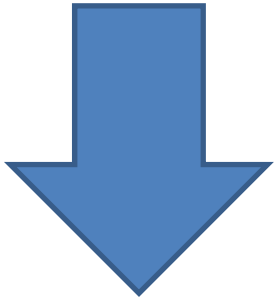
- Needs – any epidemiological or other evidence, demographic makeup
- Resource availability – human and financial
- Strength of existing health infrastructure
- Cultural beliefs and how these can effect pathways to care
- Geographical, transport
- Attitude of key decision-makers

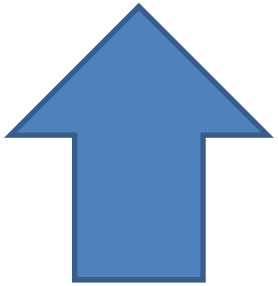
# Motivation of stakeholders for change

- Motivation for change
  - Why now, what are the driving factors?
  - Different motivations for different people
  - Need to understand *their* reasons for action

- Global Drivers
  - Better evidence, better presented
  - Global MH Action Plan/mhGAP

- Local drivers
  - Advocacy from stakeholders in country
  - More funding available
  - Personal benefit/profit





# Planning stakeholder engagement

- List all possible stakeholders
- Plan a process of engagement with the relevant stakeholders listed towards your stated task
- Consider;
  - Different strategies that might be needed to engage with each
  - What resources might be needed
  - Time-lines
  - Natural opportunities, events
  - Need for awareness-raising or capacity building
  - Risks of engagement

# Stakeholder Analysis

| | Stakeholder | Interest in the project | Attitude towards project | Influence: 1 (low) – 5 (high) | Ideal involvement of Stakeholder | Next steps |
|---|---|---|---|---|---|---|
| 1 | | | | | | |
| 2 | | | | | | |
| 3 | | | | | | |
| 4 | | | | | | |
| 5 | | | | | | |
| 6 | | | | | | |
| 7 | | | | | | |
| 8 | | | | | | |
| 9 | | | | | | |

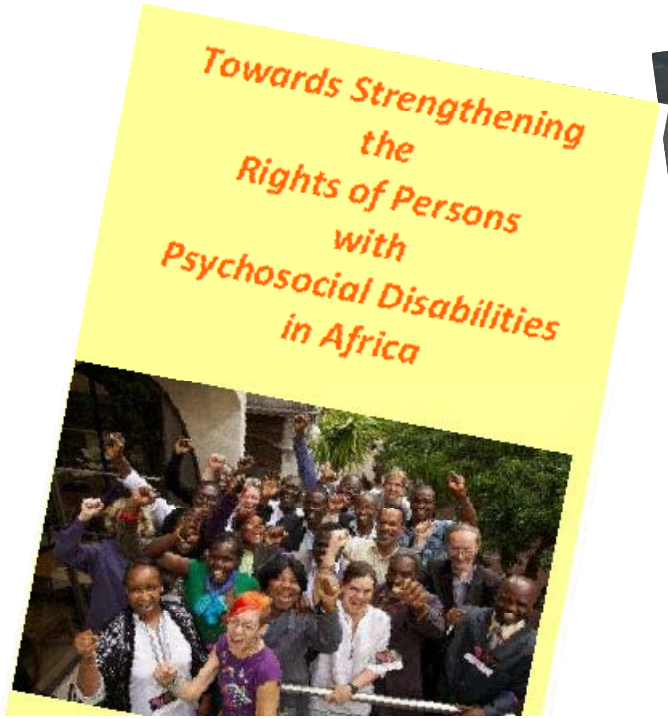
## Strategies for scaling up services - 1

# People are the most important factor

- Stakeholder analysis to understand actors
- Relationships are very important
- Make key decision-makers feel Involved
- Co-ordinate activities using representative group , with input from all stakeholders, especially service users
- Be careful of people who have perverse incentives

# Empowerment of stakeholders

- The most relevant stakeholders
- Different levels of involvement
- *'Nothing about us without us'*
- Must ensure meaningful participation, not just tokenistic consultation




# Strategies for scaling up services - 2

## Know your context

*"The hand that dips into the bottom of the pot will eat the biggest snail"*

Wole Soyinka, Nigeria

- Situation analysis in development of programme/service
- Contextualise international guidelines, research evidence to make it relevant
- Be ready to review things that are not working and change taking local advice

# Strategies for scaling up services - 3

## Use a systemic and strategic approach

- Consider all issues that might affect services
  - Trained personnel need a lot of follow- up, support and supervision, especially if isolated
  - Significant training needs to be followed by change in grade and pay
  - Time, infrastructure and equipment are essential to do work (clinic space, transport, records etc)
  - Medication availability is essential
  - Referral systems that work
  - Task shifting and other aspects of work may require a supportive policy framework and perhaps legislation change
  - Resources need to be sustained. Find ways of embedding funding in systems

## Strategies for scaling up services 4

## There usually needs to be a radical re-organisation of roles

- Make model as simple and efficient as possible (but also holistic)
- A high proportion of need can be met with simple packages of care delivered in non-hospital settings by non-specialists. Task sharing
- A service model needs to address questions of the specific roles they should have, the training and supervision they need, and the way that they relate to the overall health system
- This is often the hardest change to achieve

# Task-sharing/shifting

- In sub-Saharan Africa, the ratio of psychiatrists to population is typically < 1 per 1 million
- It is impossible to conceive of replicating a high income country model of care delivered by specialists in these circumstances

- Task shifting/sharing involves;
  - Providing basic evidence-based interventions at local level through less specialist personnel
  - Clearly defining tasks for specific cadres of staff
  - Clear guidelines defining interventions
  - Training them to deliver their roles
  - Providing supervision and continued learning for them
  - Defining when specific cases are appropriate for referral (stepped care)

## Strategies for scaling up services 5

# Decentralised services need local expertise

- Decentralisation of any mental health expertise to district level (rather than only the very largest cities) would have an enormous effect on access to care.
- Specialist mental health staff (eg psych nurses) are needed at the district level to supervise PHC
- Staff should not only provide clinical services, training, and supervision for non-specialist staff in primary care, but also a managerial function to ensure that the health system facilitates integration of mental health services.

## Strategies for scaling up services 6

## Mental health professionals and practitioners need to broaden their roles

- Besides being traditional clinicians, specialist staff also need to accept responsibility for planning, training, supervision, and advocacy with decision makers
- To achieve this goal, specialists themselves may need access to relevant training in these skills

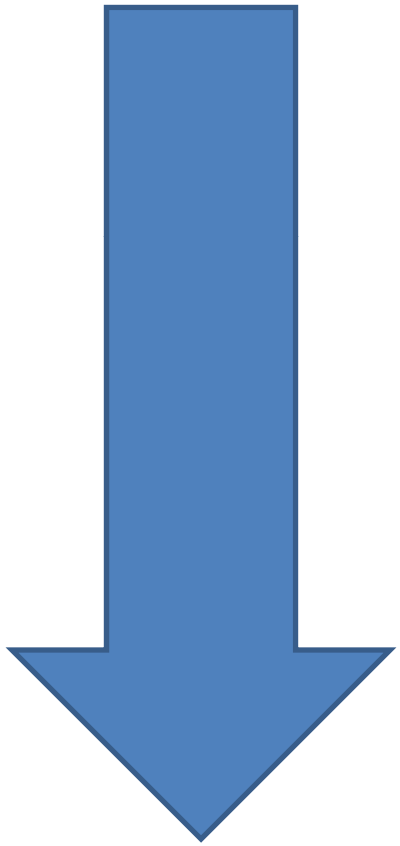
## Strategies for scaling up services 7

## Services need to maintain a high profile

- Scaled up services need to be monitored and evaluated
- What can't be measured won't get done (or noticed)
- Basic data from services needs to be fed into routine Health Management Information Systems (HMIS) if the extent of need is to be recognised and services sustained
- Regular advocacy, appearances in media, becoming a popular agenda, are important for sustainability

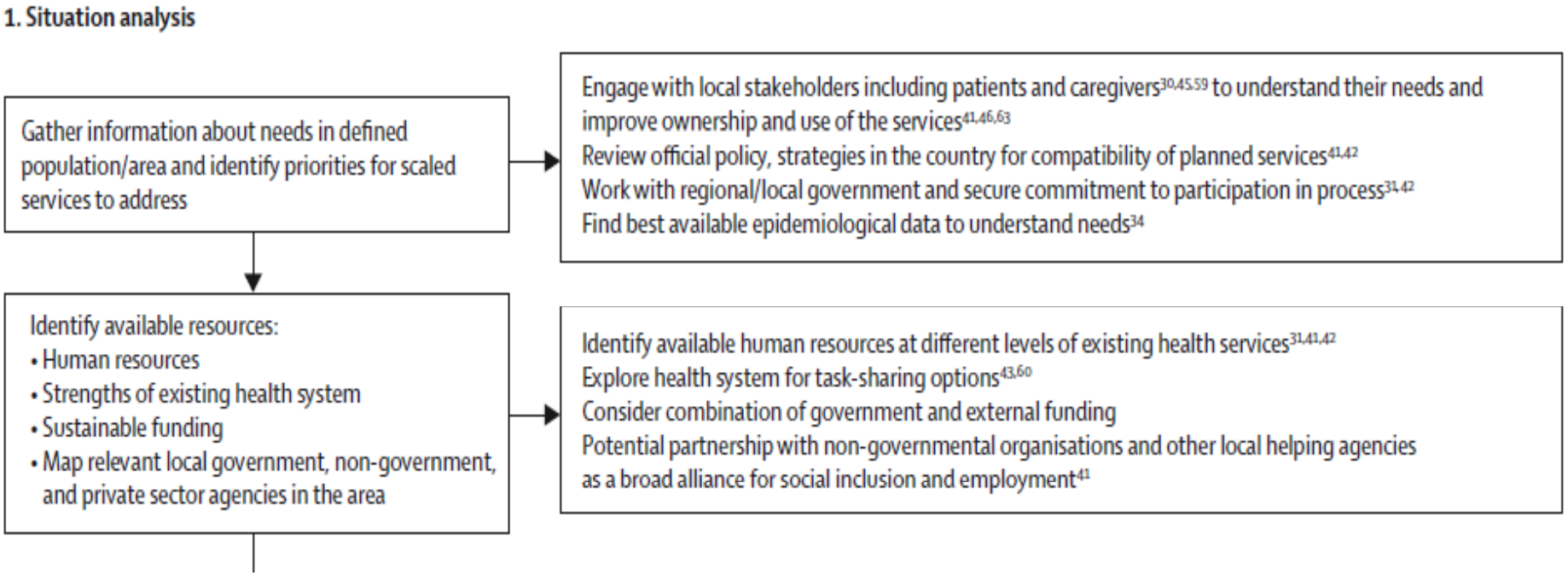
# Process of developing services

1. Situation Analysis
2. Planning
3. Implementation
4. Evaluation

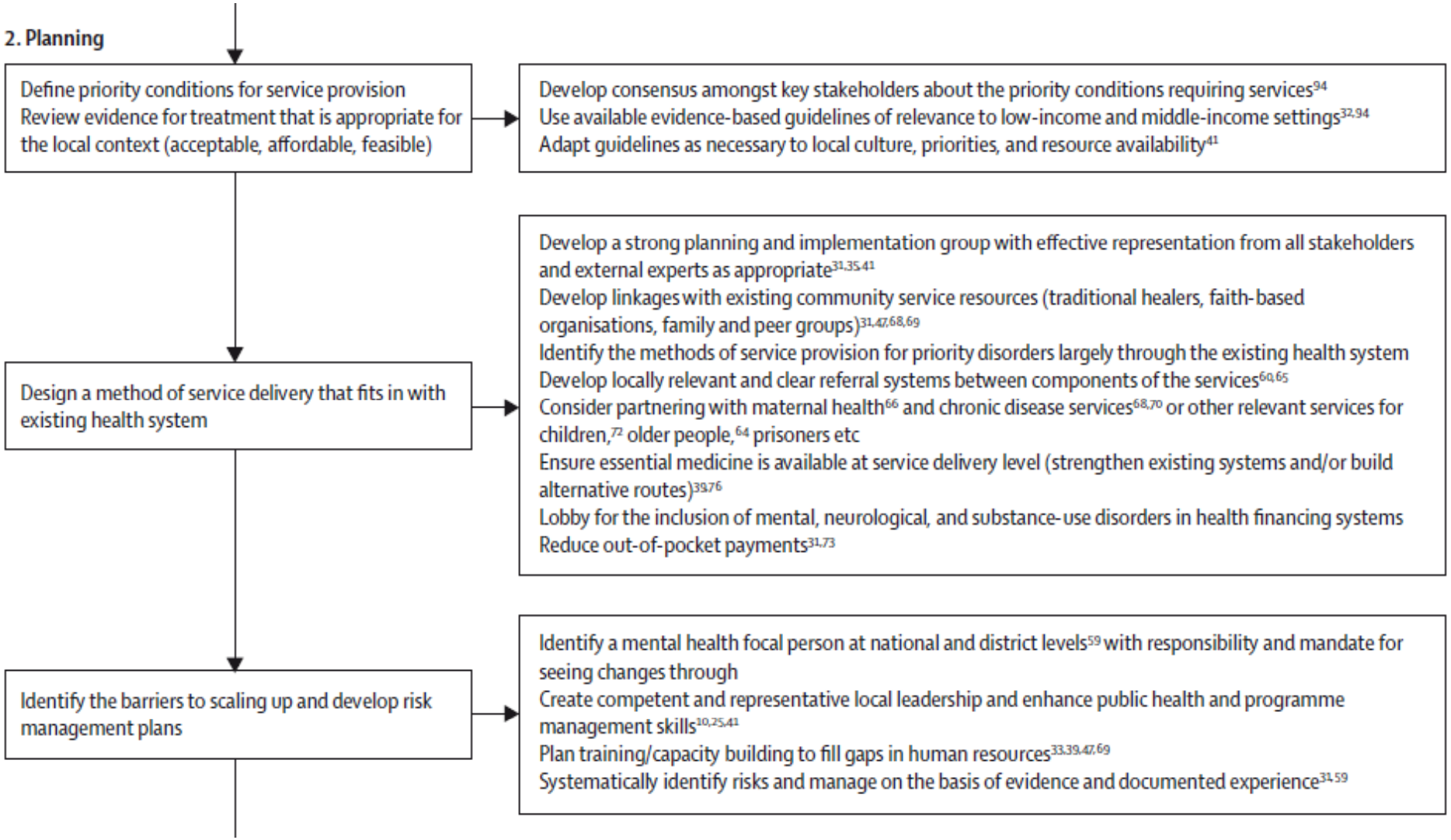


From: Eaton J, McCay L, Semrau M, Chatterjee S, Baingana F, Araya R, Ntulo C, Thornicroft G, Saxena S. Scale up of services for mental health in low-income and middle-income countries. The Lancet 2011; 378 (9802): 1592-1603

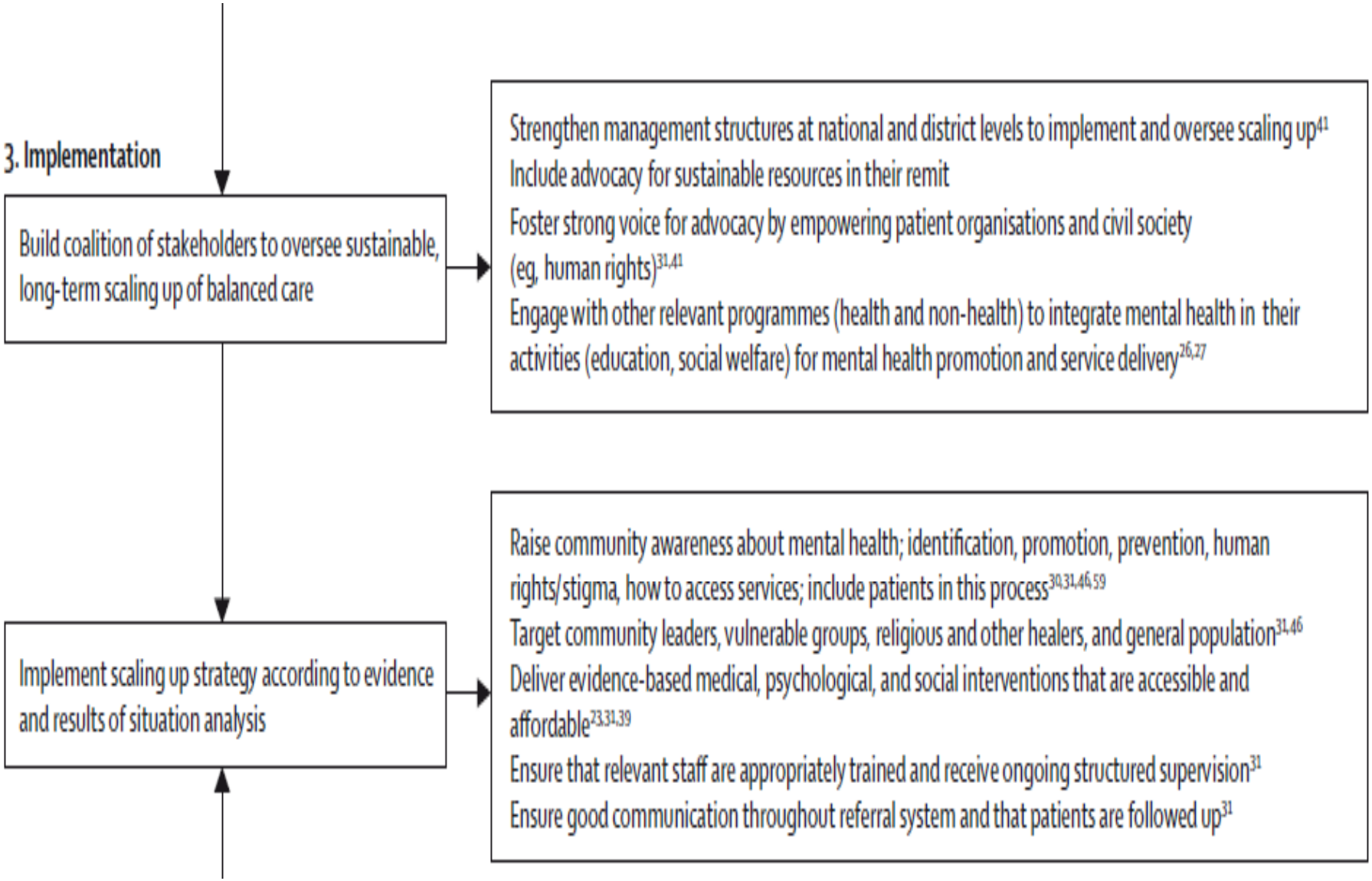
# 1. Situation Analysis



# 2. Planning


2. Planning
Define priority conditions for service provision
Review evidence for treatment that is appropriate for the local context (acceptable, affordable, feasible)
Develop consensus amongst key stakeholders about the priority conditions requiring services[94]
Use available evidence-based guidelines of relevance to low-income and middle-income settings[32,94]
Adapt guidelines as necessary to local culture, priorities, and resource availability[41]
Design a method of service delivery that fits in with existing health system
Develop a strong planning and implementation group with effective representation from all stakeholders and external experts as appropriate[31,35,41]
Develop linkages with existing community service resources (traditional healers, faith-based organisations, family and peer groups)[31,47,68,69]
Identify the methods of service provision for priority disorders largely through the existing health system
Develop locally relevant and clear referral systems between components of the services[60,65]
Consider partnering with maternal health[66] and chronic disease services[68,70] or other relevant services for children,[72] older people,[64] prisoners etc
Ensure essential medicine is available at service delivery level (strengthen existing systems and/or build alternative routes)[39,76]
Lobby for the inclusion of mental, neurological, and substance-use disorders in health financing systems
Reduce out-of-pocket payments[31,73]
Identify the barriers to scaling up and develop risk management plans
Identify a mental health focal person at national and district levels[59] with responsibility and mandate for seeing changes through
Create competent and representative local leadership and enhance public health and programme management skills[10,25,41]
Plan training/capacity building to fill gaps in human resources[33,39,47,69]
Systematically identify risks and manage on the basis of evidence and documented experience[31,59]

# 3. Implementation



# 4. Evaluation

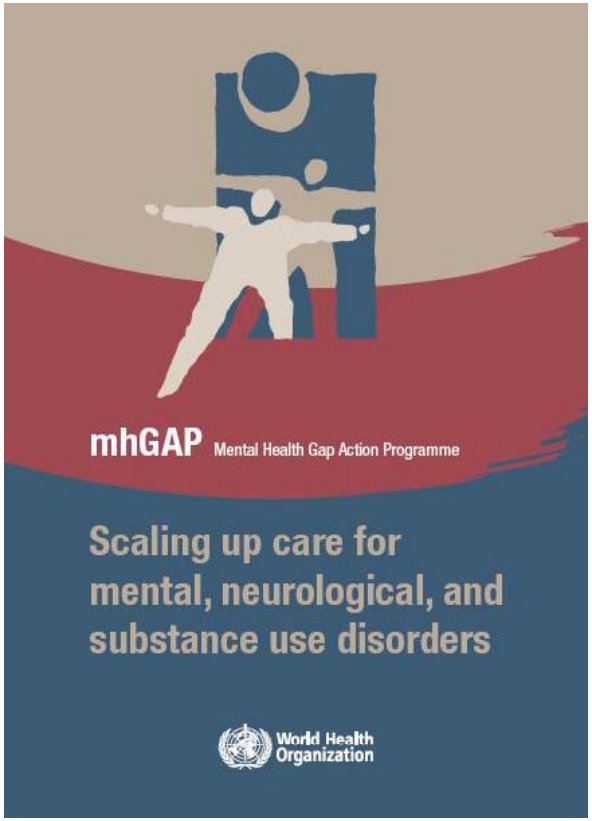

- Remember that this is a cycle; evaluation then feeds back into situation analysis and planning for future work

*What gets measured, gets done*

Margaret Chan, Director General WHO

# Overview mhGAP

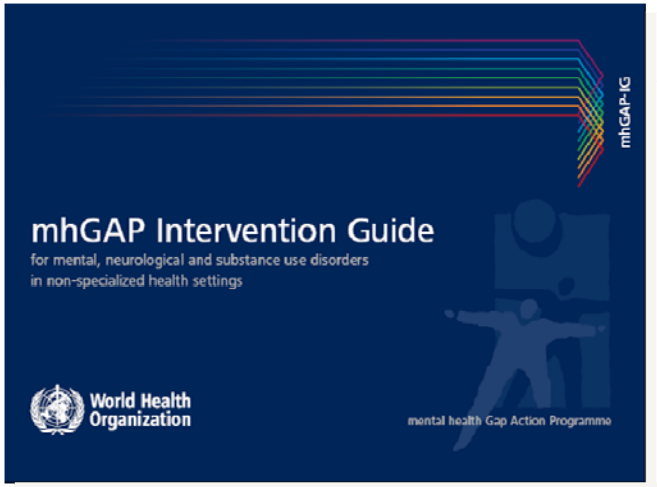
# Setting priorities




Criteria:

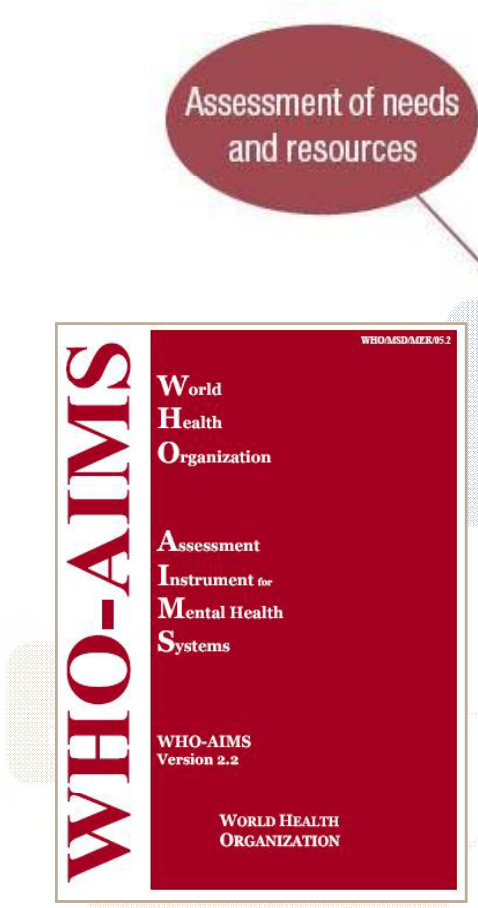
- High burden (mortality, morbidity, disability)
- Large economic cost
- Effective intervention available

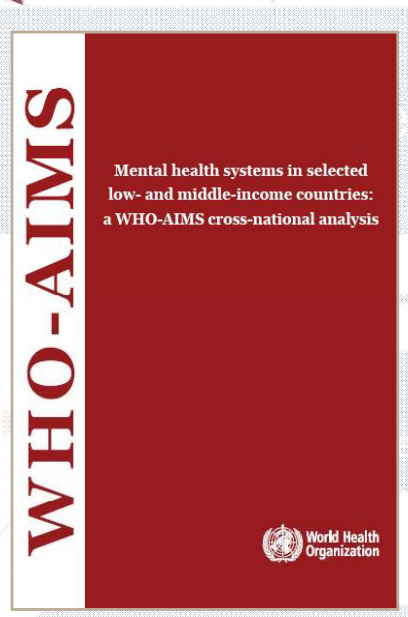
## Priority conditions:




- Depression
- Psychosis
- Suicide prevention
- Epilepsy
- Dementia
- Disorders due to use of alcohol
- Disorders due to illicit drug use
- Child mental disorders

# Technical support



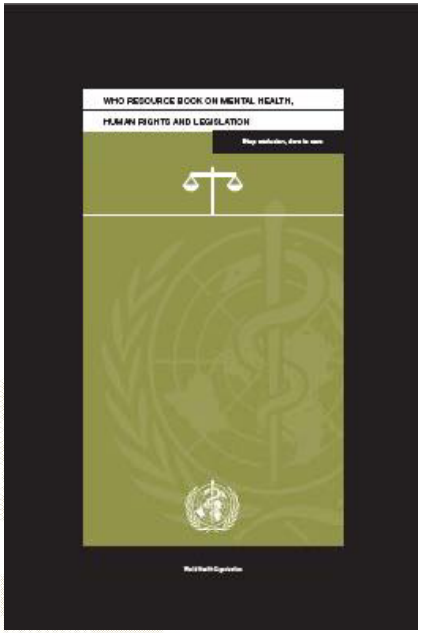




- Situation analysis:
  - Status of burden
  - Coverage of essential interventions
  - Reasons for low coverage

*WHO-AIMS: a useful tool for situation analysis*

# Technical support


*Mental health policy and service guidance package*

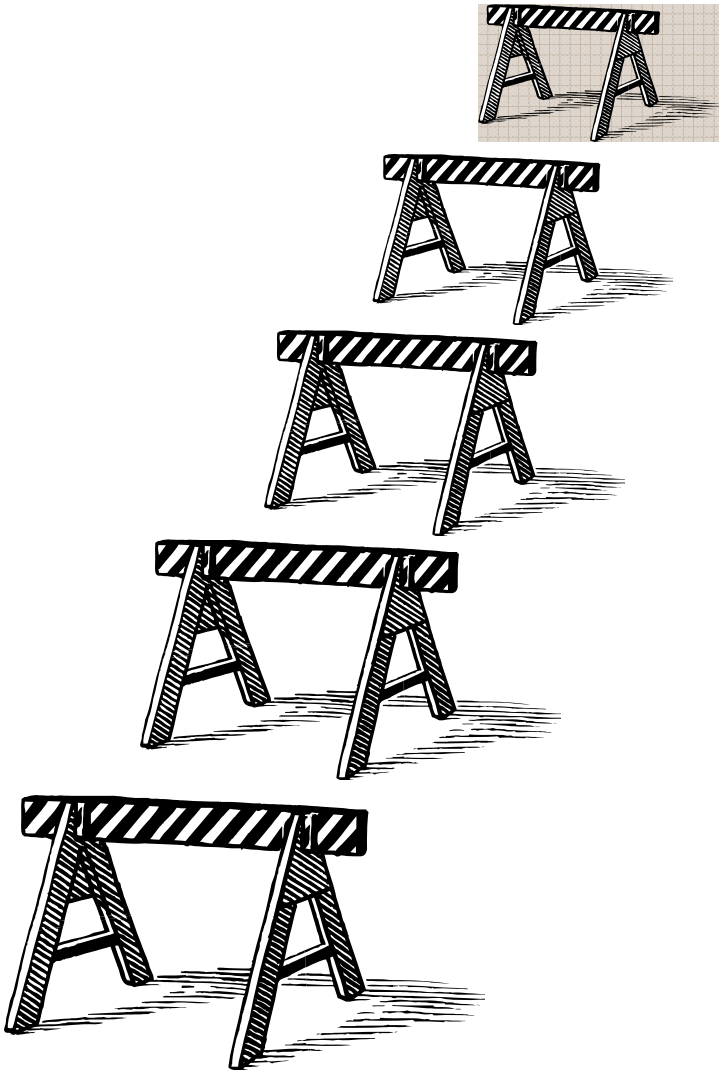

*Resource book on mental health, human rights and legislation*

# Strengths, Weaknesses, Threats, Opportunities

(SWOT Analysis)

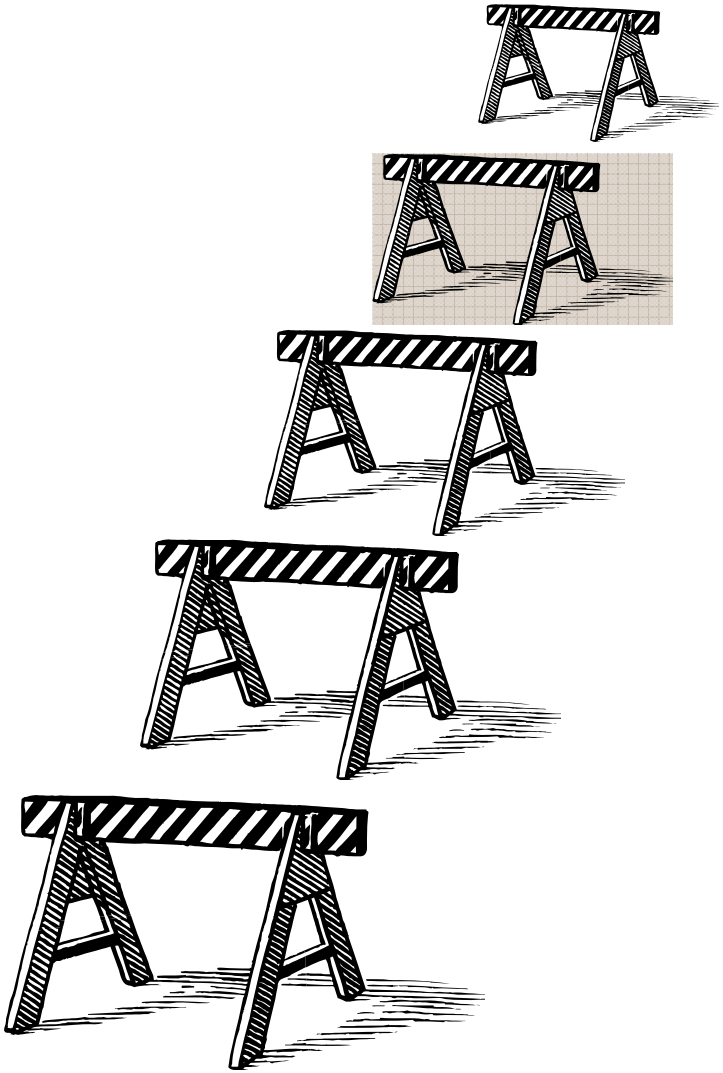
In reforming mental health services in Iran

# Five barriers to implementation



## Political will to address mental health is low:

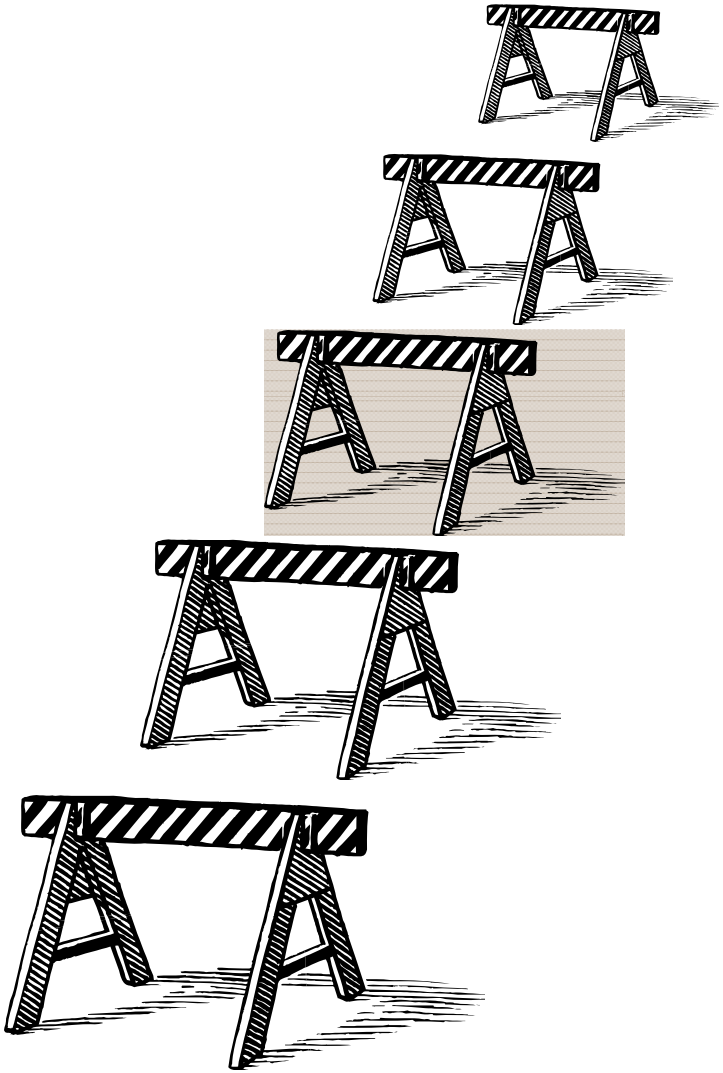
- Incorrect belief that mental health care is cost-ineffective
- Inconsistent and unclear advocacy between and within groups of mental health advocates (professionals, users, families)
- People with disorders are not organized into a powerful lobby in many countries



Political will to address mental health is low

## Mental health resources are centralized in urban areas and in large institutions:

- Need for extra funding to shift to community-based services
- Resistance by mental health professionals and workers, whose interests are served by large hospitals

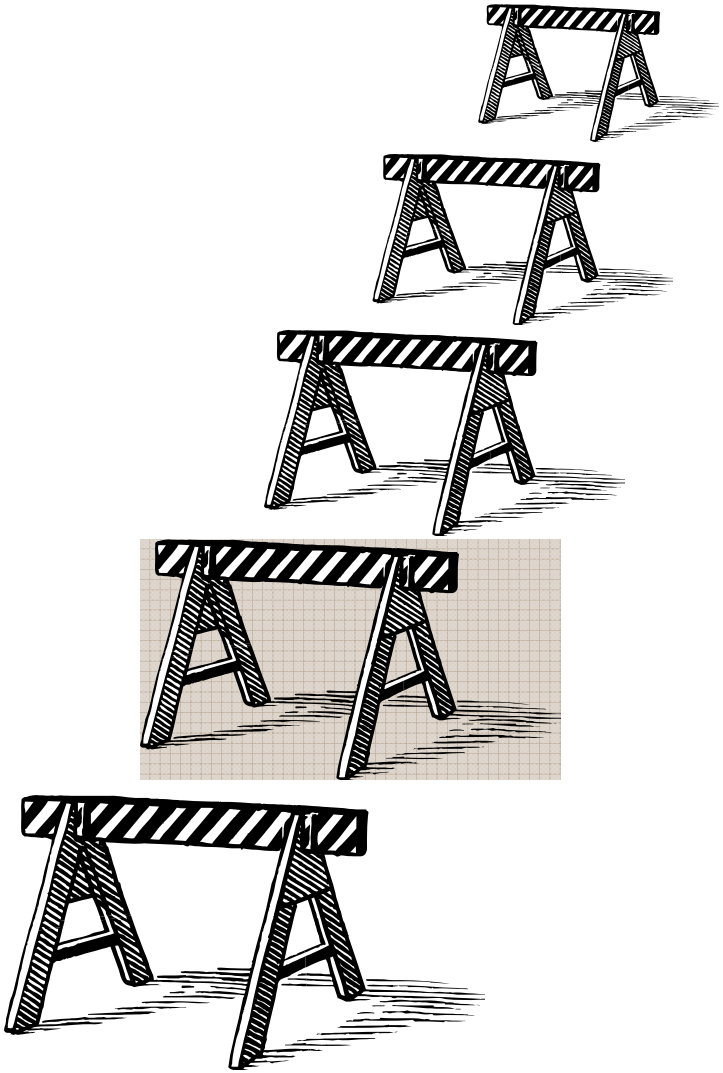


Political will to address mental health is low

Mental health resources are centralized in urban areas and in large institutions

Difficulties in integrating mental health care in primary health care services:

- Primary care workers are already overburdened
- Lack of supervision and specialist support after training
- Lack of continuous supply of essential psychotropic medicines in primary care in many countries



Political will to address mental health is low

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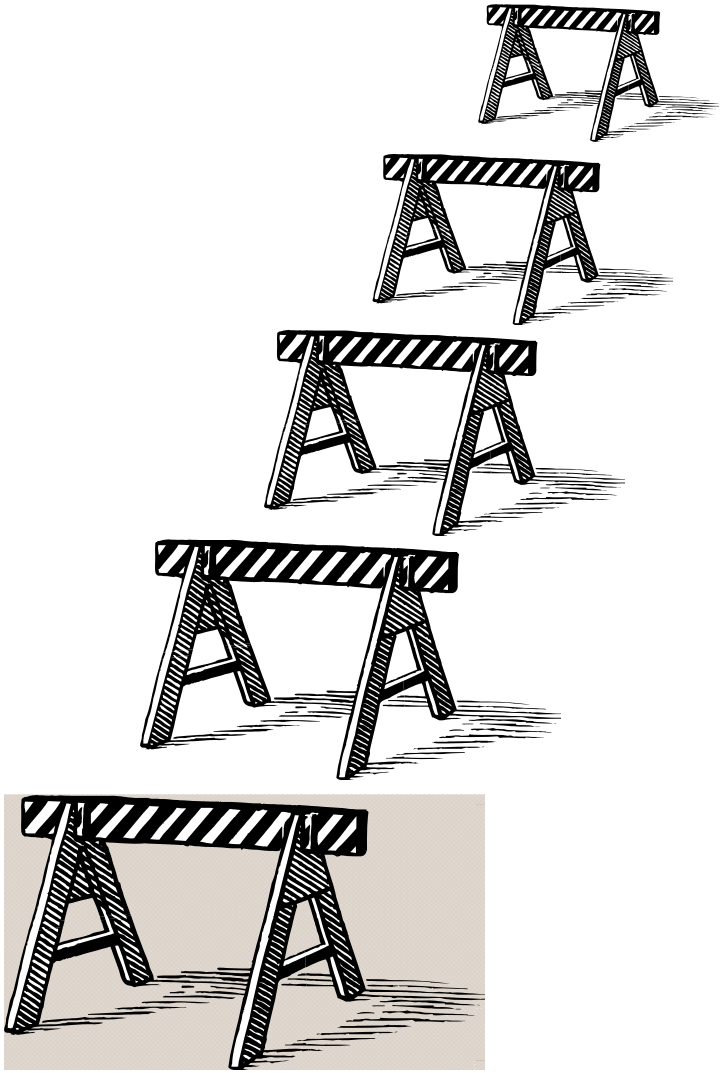
Difficulties in integrating mental health care in primary health care services

Mental health leadership often lacks public health skills and experience:

- Those who rise to leadership positions are often only trained in clinical management
- Public health training does not include mental health

# Mobilizing a global response:
## Five barriers to implementation



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Investment only in tertiary and (more recently) in primary care. Secondary care is essential

# Group Work

Development of a plan for introducing a package of care in a specific setting

Brainstorm

- policy changes towards community mental health care

Activity:

- Identify area (probably district) for reform
- List 3-4 major objectives
- Complete prepared logical-framework matrix to take policy to implementation

First, an example from DFID;

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **ORGANISATION NAME** | **CBM, WHO EMRO** | | | | | | |
| **PROJECT NAME** | **Improving Leadership Capacity for Mental Health Service Reform in EMRO Countries** | | | | | | |
| **IMPACT** | **Impact Indicator 1** | | **Baseline** | **Milestone 1** | **Milestone 2** | **Target (date)** | |
| Contribute to reduction of the mental health treatment gap in the Eastern Mediterranean Region through the scaling up of decentralised, evidence-based mental health services | Proportion of people in identified countries with access to mental health services (coverage) | **Planned** | | | | | |
| | | **Achieved** | | | | | |
| | | | **Source** | | | | |
| | **Impact Indicator 2** | | **Baseline** | **Milestone 1** | **Milestone 2** | **Target (date)** | |
| | Mean cost to access mental health services for 1 year for family with member with severe chronic mental illness (using modified 'Client Service Receipt Inventory') | **Planned** | | | | | |
| | | **Achieved** | | | | | |
| | | | **Source** | | | | |
| **OUTCOME** | **Outcome Indicator 1** | | **Baseline** | **Milestone 1** | **Milestone 2** | **Target (date)** | **Assumptions** |
| Leaders in mental health in the EMRO Region with increased knowledge and skills in mental health service reform. (Indicators of reform measured in key identified focus countries) | Number of new programmes (or new activities in national programmes) started through advocacy and technical input of graduates of the course | **Planned** | | | | | |
| | | **Achieved** | | | | | |
| | | | **Source** | | | | |
| | **Outcome Indicator 2** | | **Baseline** | **Milestone 1** | **Milestone 2** | **Target (date)** | |
| | Change in proportion of government health budgets allocated to mental health in countries sending participants | **Planned** | | | | | |
| | | **Achieved** | | | | | |
| | | | **Source** | | | | |
| **OUTPUT 1** | **Output Indicator 1.1** | | **Baseline** | **Milestone 1** | **Milestone 2** | **Target (date)** | **Assumption** |
| An up-to-date, evidence-based. Curriculum for a course that has involved participation of reevant stakeholder and includes lessons learnt from similar courses elsewhere in the world | Curriculum development workshop attended by relevant stakeholders facilitated by global leaders in the field | **Planned** | | | | | |
| | | **Achieved** | | | | | |
| | | | **Source** | | | | |
| | **Output Indicator 1.2** | | **Baseline** | **Milestone 1** | **Milestone 2** | **Target (date)** | |
| | A curriculum, independently validated for a course that will prepare leaders in mental health in EMRO countries to reform evidence-based services | **Planned** | | | | | |
| | | **Achieved** | | | | | |
| | | | **Source** | | | | |
| **IMPACT WEIGHTING (%)** | **Output Indicator 1.3** | | **Baseline** | **Milestone 1** | **Milestone 2** | **Target (date)** | |
| 10% | Acceptance of the proposed course (including curriculum and supporting documentation) by partner academic institution | **Planned** | | | | | |
| | | **Achieved** | | | | | |
| | | | **Source** | | | | **RISK RATING** |

*There is no health without mental health!*

*There is no wealth without mental health!*

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