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Policy Actions To Achieve Integrated Community-Based Mental Health Services

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ABSTRACT Globally, the majority of people with mental health problems do not receive evidence-based interventions that can transform their lives. We describe six mental health policy actions adopted at the World Innovation Summit for Health in 2013. For each policy action, we offer real-world examples of mental health innovations that governments and health care providers can implement to move toward universal health coverage for mental health. The six policy actions are empowering people with mental health problems and their families, building a diverse mental health workforce, developing collaborative and multidisciplinary mental health teams, using technology to increase access to mental health care, identifying and treating mental health problems early, and reducing premature mortality in people with mental health problems. Challenges to implementing these policy actions include the lack of recognition of mental health as a global health priority and the resulting lack of investment in mental health, the difficulties of integrating mental health into primary care health services because of a scarcity of human and financial resources, and the lack of evidence on the effectiveness and costs of taking innovations to a national scale.

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Mental health, defined by the World Health Organization (WHO) as "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and is able to make a contribution to her or his community,"[1] is an indispensable component of health. Mental health problems refer to a set of medical conditions that affect a person's thinking, feeling, mood, ability to relate to others, and daily functioning.

In this article mental health problems are those listed in the WHO Mental Health Gap Action Programme intervention guide,[2] which are priority disorders that can be addressed by health care providers working in nonspecialized health care settings. The priority conditions included are depression, psychosis, bipolar disorders, developmental and behavioral disorders in children and adolescents, dementia, alcohol use disorders, drug use disorders, and self-harm or suicide. A description of these mental health problems can be found in online Appendix 1.[3]

We recognize that there are challenges involved in using diagnostic classifications at a global level when presentations of some disorders may vary across settings. We therefore have used the pragmatic classification of disorders defined by the WHO, which is of more practical relevance in nonspecialist settings.[4]

The priority conditions were also selected because they represent a large burden globally in terms of mortality, morbidity, or disability; have high economic costs; are often associated with violations of human rights; and can be treated using evidence-based interventions.[5]

Mental health problems are highly prevalent

and have a substantial human cost. As many as 700 million people around the world were estimated to have been affected by mental health problems in 2010.[6] Mental health problems are responsible for 7.4 percent of the world's total burden of disease, as measured in disability-adjusted life-years.[6] Of all health conditions, mental health problems are the largest contributor to years lived with disability, estimated to account for 22.9 percent of those years in the 2010 Global Burden of Disease report.[6]

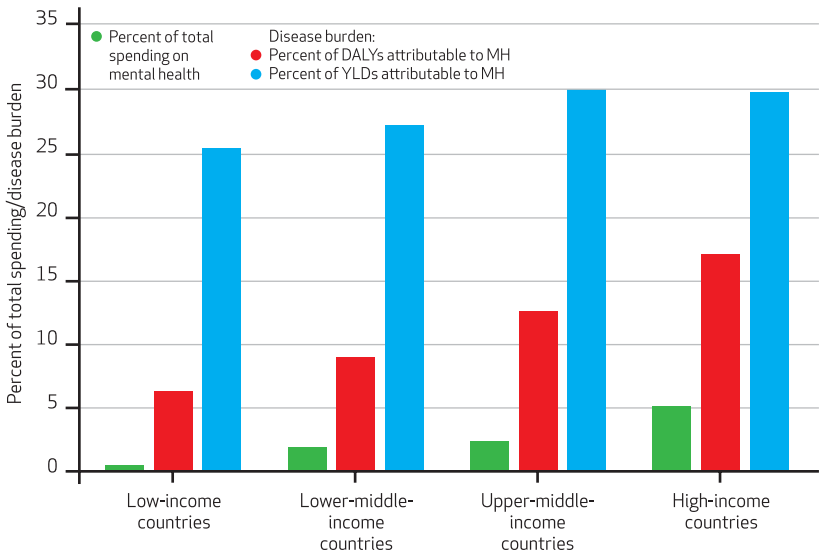
Mental health problems also impose a tremendous economic cost in all societies that places a brake on progress in economic development. In a study commissioned by the World Economic Forum, the global cost of mental health problems was estimated to be $2.5 trillion in 2010 and was predicted to rise to $6.0 trillion by 2030.[7] About two-thirds of the costs attributed to mental health problems are related to lost productivity and income—the consequences of untreated mental health problems.[7]

The lack of public understanding of mental health problems, high levels of discrimination against people with these problems, and inadequate political attention to the need for resources for mental health have led to a chronic underinvestment in mental health care in almost all countries. Currently, most low-income countries allocate about 0.5 percent of their already small health budgets to the treatment and prevention of mental health problems (Exhibit 1).[8] The total spending on mental health is far less than the percentage of DALYs and YLDs attributable to mental health.

The result is a severe shortage of workers who are trained to provide mental health care. For example, almost half of the people in the world live in countries where the ratio of psychiatrists to the total population is no more than one per 200,000 residents.[8] For more severe disorders, the mental health workforce shortage in low-income countries has resulted in a large treatment gap—that is, the difference between the prevalence of the disorder and the rate of treatment for it. For example, for schizophrenia, the treatment gap is as large as 98 percent in Nepal and Eritrea. Even in high-income countries such as Japan and Italy, as few as 4 percent of people with mental health problems access services.[9]

EXHIBIT 1

Percent Of Total Health Spending On Mental Health (MH) Compared To The Burden Of Disease For All Mental Health And Neurological Conditions Relative To All Disease, By Country Income Level, 2010 And 2011



SOURCE Authors' analysis of data from the following sources: (1) 2010 data from Institute for Health Metrics and Evaluation. Search GBD data [Internet]. Seattle (WA): IHME; [cited 2014 Jul 21]. Available from: http://www.healthmetricsandevaluation.org/search-gbd-data. (2) 2011 data from World Health Organization. Mental health atlas (Note 8 in text). **NOTES** Income levels are based on those defined by the World Bank (see Note 24 in text). Burden of disease is stated in terms of DALYs (disability-adjusted life-years) and YLDs (years lived with disability).

Policy Action Through Innovation

Mental health is increasingly recognized by governments as an area of emerging priority. In 2013 all 194 of the countries whose health ministers attended the WHO World Health Assembly adopted the Comprehensive Mental Health Action Plan.[10] And in January 2014 mental health was included for the first time as a significant theme at the World Economic Forum meeting, held in Davos, Switzerland.[11] The WHO plan has four objectives that all countries should aim to achieve by 2020: strengthening effective leadership and governance for mental health; providing comprehensive, integrated, and responsive mental health and social care services in community-based settings; implementing strategies for promotion and prevention in mental health; and strengthening information systems, evidence, and research related to mental health.[10]

This article draws in part on a report and panel discussion on mental health at the World Innovation Summit for Health (WISH), in Doha, Qatar, in December 2013, which recommended six policy actions to operationalize mental health and social care services in the community (objective 2 of the WHO Mental Health Action Plan).[12] The policy actions were generated through consensus among the members of the WISH Mental Health Advisory Forum, a panel of twenty-two experts in mental health policy, research, and funding from thirteen countries.

We highlight how each policy action could be achieved through the use of innovative mental health programs that have been successfully delivered on a national scale in a range of settings. The innovations were identified through system-

For more severe disorders, the mental health workforce shortage in low-income countries has resulted in a large treatment gap.

atic reviews of the evidence on scaled-up innovations globally[13] and in low- and middle-income countries.[14,15] Additional innovations were identified through interviews with forty-seven experts—all twenty-two members of the WISH Mental Health Advisory Forum and representatives of sixteen nongovernmental organizations (NGOs).

All of the innovations, along with references to the evidence base of their impact, are listed in full on the Mental Health Innovation Network's website, which hosts a Web-based database of more than sixty mental health innovations.[16] The database will be expanded to serve as an open-access resource that policy makers, researchers, and practitioners can use to access and implement knowledge about mental health innovations. Full details of the innovations discussed in this article, along with the challenges to their implementation and the key drivers of their success, are available in online Appendix 2.[3]

Recommended Policy Actions

EMPOWER PEOPLE WITH MENTAL HEALTH PROBLEMS AND THEIR FAMILIES Mental health problems are associated with profound social and economic disadvantage in all countries, but particularly in low- and middle-income countries. People with mental health problems are more likely than others to experience social exclusion, violent victimization, and human rights abuses. This includes being chained to their beds or kept in isolation in psychiatric institutions, being incarcerated in prisons, being chained and caged in small cells in the community, and being abused by traditional healing practices.[17] In Indonesia, for example, the Ministry of Health estimates that 18,800 people with mental health problems are currently restrained, a practice known locally as *pasung*.[18] These human rights abuses have been described as a failure of humanity[17] and constitute a global emergency that requires immediate and sustained action.

These abuses must be combated by innovative programs that prevent abuse and promote the inclusion of people with mental health problems in their communities. In addition, people with mental health problems and their caregivers must be empowered to advocate for the services that best meet their needs and should be involved in delivering these solutions. Providing services in the community that are implemented by people with mental health problems is a realistic strategy to empower service users as well as to ensure accessible and affordable services.

A good example is Clubhouse International, an NGO that operates 330 community centers in thirty-three countries. Collectively, the centers are accessed by 100,000 people annually. The centers are run by people with mental health problems and provide employment programs; evening, weekend, and holiday activities; community support; outreach services; and education and housing support for people with mental health problems. A randomized controlled trial from the United States showed that Clubhouse members worked significantly longer and earned more, compared with people receiving assertive community treatment—a specialist model of community mental health care.[19] The cost of the Clubhouse centers has been shown to be lower than that of other models of community-based care such as supported employment, community mental health centers, or assertive community treatment.[20]

BUILD A DIVERSE MENTAL HEALTH WORKFORCE The lack of a skilled mental health workforce is one of the main reasons why most people with mental health problems do not receive treatment or receive poor-quality care. Even in high-income countries, the number of mental health workers is often inadequate. In low- and middle-income countries, the situation is dramatically worse, with an estimated shortage of 1.18 million workers.[21] Innovative solutions coupled with substantial investments are needed to increase human resources for mental health care.

There are two strategies for developing a mental health workforce with the right skill mix: building the capacity of nonspecialist health workers and building the capacity of specialists. In low- and middle-income countries, community and primary health care workers can be trained to perform a variety of roles, with adequate supervision. These roles include identifying and referring cases, delivering psychosocial therapies, and supporting medication adherence.[14]

For example, the Kintampo Project in Ghana

has created two courses to train two new cadres of community mental health officers.[22] By 2012 this project had trained 296 new practitioners, who work across all regions of Ghana. The result is an increase of more than 200 percent in the number of people treated for mental health problems in Ghana from 2011 (67,792 people) to 2013 (154,322 people).[23] Similar models are also being implemented in Liberia[24] and India.[25]

Mental health specialists also play crucial roles in building the capacity of nonspecialist workers and supervising them to ensure the quality of mental health programs and provide care for people with severe mental health problems. In high-income countries, mental health specialists can also be used to provide psychological therapies.

An example is the Improving Access to Psychological Therapies (IAPT) program in England. IAPT is a government program that has dramatically increased access to evidence-based psychological therapies by training over 5,000 new therapists to work through primary care and to provide services to over 1.7 million people.[26] The cost of the service is estimated to be fully recovered through savings related to incapacity benefits, lost taxes, and expenditures on physical health care.[27]

DEVELOP COLLABORATIVE AND MULTIDISCIPLINARY MENTAL HEALTH TEAMS The high burden caused by mental disorders is partly the result of high levels of comorbidity with physical health problems, the high prevalence of lifestyle risk factors, and social deprivation.[28] Collaborative care integrates mental health care into general health care to provide person-centered care that addresses all of the needs of individual patients.[29] It typically involves a partnership between mental health specialists, primary care providers, and nonspecialist health workers in routine health care settings such as primary care clinics.

A good example is TEAMcare in the United States and Canada. In this program a care manager (usually a nurse) serves as the conduit between the consultation team, the primary care team, and the service user to deliver holistic care for depression and comorbid noncommunicable diseases. The TEAMcare program has been shown to be effective in a randomized controlled trial.[30] During a twenty-four-month period, the program resulted in a cost saving per service user of US$600 in a capitated system and of US$1,100 in a fee-for-service system.[31]

USE TECHNOLOGY TO IMPROVE ACCESS TO MENTAL HEALTH CARE Technologies such as telemedicine and psychological therapies delivered via mobile phones and the Internet can help connect people affected by mental health problems to mental health specialists and evidence-based interventions. Interventions mediated through technology have low marginal costs, are accessible to populations with good access to the Internet, and have been shown to be very effective in randomized controlled trials in high-income countries.[32] The rapid expansion of mobile technology and Internet access increases their appeal for adoption in low-income countries.

In a project in one district in India, a bus with a telepsychiatry consultation room and a pharmacy visits sites such as villages that have Internet connectivity. Patients are referred to the bus by community health workers, who also perform home-based rehabilitation. The bus also shows films to raise awareness of mental health issues. In the first three years of the project, staff on the bus have treated 1,500 patients at a cost of US$12 per patient per month.[33]

IDENTIFY AND TREAT MENTAL HEALTH PROBLEMS EARLY Half of mental health problems begin in childhood or young adulthood, and a high proportion of these problems develop into adult mental health problems.[34] Many conditions can last for many years if they are not treated.

Intervening early to prevent mental health problems from developing or to stop them from progressing is key to reducing the burden of mental disorders. Innovative ways to do this include treating maternal depression to improve outcomes for mothers and their children and providing care and early intervention to at-risk young people.

The NGO HealthNet TPO has delivered a multitier psychosocial care package that combines mental health promotion (peer support groups, community sensitization, and psychological education), prevention (a structured group intervention for at-risk children), and treatment (for children with severe mental health problems) to address the needs of children and adolescents in five countries affected by conflict (Indonesia, Nepal, Sudan, Sri Lanka, and Burundi). Randomized controlled trials have shown that the program reduced psychiatric symptoms in Indonesia and Sri Lanka and promoted mental well-being in Nepal.[35] The program was subsequently rolled out to over 96,000 children in five countries, but lack of funding ended it everywhere except in Burundi.[36]

REDUCE PREMATURE MORTALITY IN PEOPLE WITH MENTAL HEALTH PROBLEMS In high-income countries, men with severe mental health problems die up to twenty years earlier than men without mental health problems; the figure for women is fifteen years earlier.[37] In low- and middle-income countries this life expectancy gap is likely to be much wider.[38] This excess mortality is a result of unhealthy lifestyles that include high

Until mental health is more widely recognized as a human right and an economic and social priority, lasting progress is unlikely.

smoking rates, poor physical health, poorer physical health care for people with mental health problems, and suicide.[37,39]

Globally, nearly a million people take their own lives every year,[40] which is almost double the number of people who are killed annually as a result of conflict-related or criminal violence.[41] Between half and three-quarters of suicides could be averted if mental health problems were treated.[42]

Providing integrated care such as that offered by the TEAMcare program for people with both mental and physical health problems is one strategy for reducing premature mortality. Another is suicide prevention programs that target high-risk people and restrict access to the means of suicide.

The European Alliance against Depression is a network of community-based programs to improve access to treatment and prevent suicide. It operates in ten European countries and Chile. The network conducts public awareness campaigns; encourages cooperation—both among community stakeholders such as the clergy, police, and media and between primary and specialist mental health care providers—through training for general practitioners; and it provides support for people at high risk of suicide and their relatives.

Researchers used population-based surveys to evaluate the alliance's program that was implemented in a district of Hungary. The evaluation found a sharp decline in suicide rates, from thirty per hundred thousand people in 2004 to twelve per hundred thousand in 2007. This decrease was significantly greater than that observed in the whole country or in the control region.[43]

Integrating Policy Actions To Reform Health Systems

Implementing all six of these policy actions would create a more holistic and responsive mental health care system and contribute to reducing the human impact of mental health problems. Choosing which policy actions to implement should be based on current gaps in mental health care in a particular context and on the priorities of policy makers and other stakeholders.

In rare cases, specific innovative mental health programs backed by strong evidence of cost-effectiveness have led to wide-scale policy change at the national level. For example, a series of randomized controlled trials in Chile in the 2000s demonstrated the effectiveness of a stepped care treatment program for depression. The program was subsequently adopted and funded by the Chilean Ministry of Health as a national treatment program for depression. One result has been a 344 percent increase in the number of full-time psychologists in primary care between 2003 and 2008.[44]

In India the District Mental Health Program in the 2012–17 government plan has greatly increased the financial allocation for mental health care for each district. The program has also relaxed the criteria for the recruitment of mental health specialists (for example, a candidate with only a bachelor's degree may be appointed as a psychologist if a candidate with a more advanced degree is not available) and added a new type of community-based nonspecialist worker to the human resource mix.[25]

The 2013 Qatar National Mental Health Strategy is another example of a mental health strategy that has the potential to create lasting positive change in a national health system.[45] This five-year strategy aims to design and build a comprehensive and integrated mental health system, giving people choice on how and where they receive their care. An important outcome of implementing it is to increase access to care.

Such health system reforms are possible, as illustrated by the way in which some fragile states and countries affected by war and disaster have managed to "build back better" mental health systems.[46] In Afghanistan humanitarian programs have shown how mental health care can be successfully integrated into basic health care services and scaled up in selected areas of a country. Since 2001 more than a thousand health workers have been trained in basic mental health care, and close to a hundred thousand people have been diagnosed and treated, in Nangarhar Province.[47]

In Jordan mental health system reforms to establish community-based mental health ser-

vices and integrate mental health care into primary care were initiated in response to the Iraqi refugee crisis. These reforms were largely funded by international aid to support the refugees. This coordinated effort from the Ministry of Health, supported by international partners, has produced positive and lasting change, resulting in Jordan's first national mental health policy.[48]

Barriers To Policy Change

There are significant challenges to implementing these policy actions and to scaling up mental health programs to the national level.

First of all, until mental health is more widely recognized as a human right and an economic and social priority, meaningful and lasting progress is unlikely. However, establishing mental health as a global priority—for example, by including it in the post-2015 sustainable development goals of the United Nations—is proving difficult, as evidenced by the exclusion of mental health from the 2011 United Nations high-level meeting on noncommunicable diseases.[49]

In many countries, outdated laws that do not place the person with mental illness at the center of his or her care and the lack of a legislative structure are a big barrier to progress. Changing laws takes time and political willpower, but new laws alone are not enough. Strategies for change must be formalized into plans for action that are supported by adequate resources.

To overcome this problem, a human rights and antidiscrimination perspective must be promoted in mental health care. This can be achieved by ensuring that all mental health policies are consistent with internationally recognized human rights frameworks that are combined with initiatives designed to reduce the discrimination and pervasive stigma attached to mental health problems.

Second, as illustrated by the innovations highlighted in this article, there are challenges to creating and bringing integrated community-based programs to a national scale (online Appendix 1).[3] These challenges are linked to integrating mental health care into primary care and include barriers such as poorly organized existing services; scarce human and financial resources; and the general resistance to decentralizing specialist mental health services into community-based services, as well as the complexity of doing so.[50,51]

Other barriers are specifically related to achieving lasting policy change to improve mental health care. A "one size fits all" approach is not appropriate for scaling programs to a global level.[52] National contexts and cultures vary greatly. To be effective, mental health planners and policy makers must adapt innovations to take into account local social, economic, and cultural conditions.

The lack of political commitment is mirrored by a lack of financial investment in mental health.

Third, the lack of political commitment is mirrored by a lack of financial investment in mental health. The current level of resourcing is simply not enough to produce good mental health, and improved services will come only with additional resources.[53] Long-term commitments need to be made to supply adequate new financial resources for the implementation of policies and plans. International donors, such as the World Bank, need to lobby for these resources if they are not available in specific countries.

Existing weak and poorly organized health systems also present a barrier to scaling programs up to the national level. Such systems require significant political commitment, appropriate policy reform, and financial investment to ensure that they are robust enough to deliver mental health services that are integrated into existing health services.[50]

Last, the lack of investment in mental health research, especially in low-resource settings, hinders improvements in treatments and results in a lack of evidence upon which policy makers can act. Nonetheless, there is growing evidence that the treatment of some mental health problems is as cost-effective as other health treatments, such as antiretroviral treatment for HIV/AIDS,[54] and that the returns on investment in mental health may be considerable. For example, research has shown that in the United Kingdom, every £1.00 spent on early intervention for psychosis leads to a return on investment of £17.97, and every £1.00 spent on suicide training for general practitioners has a return on investment of £43.99.[55]

The potential costs of scaling up particular combinations of interventions have been modeled.[56] However, the cost-effectiveness of delivering whole mental health programs on a national scale has rarely been evaluated. A 2014 systematic review of all evaluations of the effectiveness of mental health care programs globally

found only 136 evaluations in peer-reviewed journals or grey literature.[13]

Thus, there is very little evidence to guide policy makers on the best way to integrate mental health into a general health care system and no overarching efforts to evaluate which type of integration is most cost-effective or suitable for particular contexts. Such studies, including research that estimates the returns on investment that could be expected from implementing mental health programs on a national scale, are urgently needed in all countries.

Conclusion

Moving toward comprehensive, integrated, and responsive mental health services in community-based settings is a huge challenge—one with which the field of global mental health is just starting to grapple. Implementing the policy actions recommended in this article and adapting or scaling up some of the innovative programs presented here would be an important step toward addressing the enormous global human, social, and economic costs of mental illness. ■

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3 To access the Appendix, click on the Appendix link in the box to the right of the article online.

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