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Disability Inclusion Helpdesk Report

Query	What works in mental health services and community interventions to support people with mental health conditions and psychosocial disabilities: a rapid evidence review
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Query	What works to develop quality services and community interventions to support people with mental health conditions and psychosocial disabilities and wellbeing for all, across the lifecycle? What are examples of effective interventions in this area?

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OVERVIEW

- **There tends to be a stark under-investment in mental health** in already under-funded healthcare systems in many low- and middle-income countries (LMICs). However, achieving universal health coverage, including mental health, is a key international commitment outlined in Sustainable Development Goal (SDG) targets.
- People with mental health conditions or psychosocial disabilities commonly **lack educational and employment opportunities** leading to negative impacts on human and economic development.

Evidence highlights several promising approaches to mental health in service delivery including:

- Increasing the **effective and meaningful participation** of people with psychosocial disabilities and/or service-users in service monitoring, planning and evaluation, and in research to improve quality, accessibility and availability of services and mental health system strengthening.
- Developing national mental health policies and action plans in collaboration with people with psychosocial disabilities.
- **Integrating health benefit plans** within healthcare systems to scale up mental health coverage in LMICs as part of progress towards Universal Health Coverage (UHC).
- **Incorporating mental health within existing health programmes** using a life course approach.
- **Integrating mental health across non-specialised health services** through a task sharing model.
- Supporting the **scale up of community-based mental healthcare** approaches to address health and social inequities by promoting social wellbeing and addressing the structural and social determinants of mental health.
- **Building coordination of providers and services** within and outside the health system (private sector, NGOs informal healers, peer support or traditional leaders etc.).
- Ensuring a **people-centred approach** to service delivery.
- **Promoting self-care and self-management**.

Key risks and enablers include:

- Understanding community dynamics to ensure effective implementation of community-based interventions. There are emerging avenues for resourcing and financing mental health through integrated approaches, such as in maternal health programmes.
- The lack of reliable data on mental health systems in LMICs greatly hinders workforce planning efforts.
- A task sharing plus supervision model requires tackling negative attitudes and biases of health workers themselves to encourage uptake of mental health services and to avoid causing harm.

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Summary[1] of issues and commitments

There is a stark under-investment in mental health within already under-funded systems of healthcare. Mental health systems in most low-middle-income countries (LMICs) are severely under-resourced in terms of skilled personnel, provision of psychosocial and community support, and continuous medication supply resulting in poor quality care. The World Health Organisation's (WHO) Mental Health Gap Action Programme (mhGAP) highlights that 14% of the global burden of disease is attributed to mental and psychosocial disabilities and most of the people affected - 75% in many LMICs - do not have access to the treatment they need (mhGAP)**.** The large treatment and quality gap[2] affect not only people with different mental health conditions and psychosocial disabilities and their families but also economic development, through lost productivity, low participation in labour and increased expenditure on health and social welfare (WHO, 2018).

People with mental health conditions or psychosocial disabilities lack educational and employment opportunities, as a result of numerous barriers including stigma and discrimination, leading to negative impacts on human and economic development. Cross-sectional global surveys (Lasalvia et al., 2013; Thornicroft et al., 2009) for example, have found consistently high rates of both anticipated and experienced discrimination of people with diagnoses of depression and schizophrenia, across countries – with finding and keeping a job, and applying for work, training, and education, identified as key areas of discrimination. A systematic review of epidemiological research in LMICs also found a very strong relationship between many indicators of poverty and common mental health conditions (Lund et al., 2011). The evidence of strong links between poverty and mental health provides weight to the argument that mental health and psychosocial disabilities should be an important concern for development strategies implemented by government, non-government organisations (NGOs), bilateral agencies, global partnerships, private foundations, multi-lateral agencies and other stakeholders.

Achieving universal health coverage, including coverage with high-quality services and financial protection for all, is target 3.8 of the Sustainable Development Goals (SDGs). The WHO states that to meet this goal throughout the world, prevention[3], treatment and care must be integrated into accessible, effective, affordable services in which the rights and dignity of everyone in the population are respected (WHO, 2018). In 2013, WHO developed a Mental Health Action Plan following extensive consultation with member states, outlining four main objectives and priority areas for global action on mental health: 1) to strengthen effective leadership and governance for mental health; 2) to provide comprehensive, integrated and responsive mental health and social care services in community-based settings; 3) to implement strategies for promotion and prevention in mental health; and 4) to strengthen information systems, evidence and research for mental health (WHO, 2013). The Plan is a key document proposing a systematic shift from long-stay psychiatric hospitals to community mental health services, particularly in low-resource settings.

What works

[1] Please note this short report is based on a light-touch, rapid review of the publicly available evidence, involving 3 person days (2 researcher days, 1 expert day). It is one of four similar reviews examining the evidence on the four outcome areas articulated in DFID's draft theory of change on mental health: rights and participation, leadership and governance, services and community interventions, FCAS and humanitarian contexts. The reviews provide a snapshot of some of the key issues and focus on summarising findings from systematic reviews, evidence syntheses and key global thematic reports, including frameworks and guidance.

[2] It should be noted that the idea of a treatment gap has been problematised from multiple perspectives, including that it is based on a narrow biomedical approach to treatment and burden of disease estimates which have been found to be unreliable and exaggerated. Studies have also shown unregulated supply of medicines in some contexts challenging the notion of lack of availability. Finally, focusing on the economic burden of mental health places support within the biomedical model which can then be co-opted for commercial gain. See the following references: Brhlikova P, Pollock AM, Manners R. Global Burden of Disease estimates of depression—how reliable is the epidemiological evidence? *J R Soc Med.* 2011; 104: 25-34; Ecks, 2014 "'We Always Live in Fear': Anti-depressant Prescriptions by Unlicensed Doctors in India." Special Issue on Psychopharmaceuticals, *Culture, Medicine and Psychiatry* 38:197-216; Cosgrove et al., (2019) Global Mental Health, in the Lancet Correspondence, Vol 394, no. 10193, P117-118; and Jansen et al., (2015) The "treatment gap" in global mental health reconsidered: sociotherapy for collective trauma in Rwanda, in European Journal of Psychotraumatology, vol. 6, no. 10.

[3] Prevention includes looking upstream to address social determinants as outlined in the UNCRPD.

Increasing the effective and meaningful participation of service-users in service monitoring, planning and evaluation, and in research to improve the quality, accessibility and availability of services and mental health system strengthening (Sweeney et al., 2010; Carroll et al., 2016). Positive examples include research in four LMICs, by the World Psychiatric Association (WPA), in collaboration with people with mental health conditions and psychosocial disabilities, service users and carers (Wallcraft et al., 2013). The recommendations on best practices in working with service users and family carers' include: respecting human rights as the basis of successful partnerships for mental health; developing legislation, policy and clinical practice relevant to the lives and care of people with mental and psychosocial disabilities in collaboration with users and carers; promoting and supporting the development of user and carers' organisations; improving the mental health of all sectors of the community as a fundamental condition for formulating policies to support economic and social development; recognising that the best clinical care of any person in acute or rehabilitation situations is done in collaboration between the user, the carers and the clinicians; and enhancing user and carer empowerment (Wallcraft et al., 2013).

Developing national mental health policies and action plans. There are some promising examples showing countries developing and approving new national mental health policies, such as India, China, Ethiopia and South Africa (de Menil, 2015). For example, in 2014, India approved its first National Mental Health Policy, following evidence of high rates of suicide. The policy has moved India away from criminalising suicide, with the aim of improving discussion and interventions, with a focus on crisis intervention centres and training community leaders and media in risk factors and responsible communication around suicide. The policy takes a **life-course approach and addresses the needs of vulnerable groups** including the elderly, children and people affected by natural disaster or other emergencies. The policy **targets a wide cadre of workers from health and non-health backgrounds** for scale up. The mental health workforce is to include: "lay and community-based counsellors, psychiatric social workers, development workers, psychologists, occupational therapists and other mental health professionals" (Government of India 2014). The policy **targets families rather than individuals** by recognising that most mental health care is given in the home (Government of India, 2014).

Integrating health benefit plans in healthcare systems, to scale up mental health coverage in LMICs, as part of progress towards Universal Health Coverage (UHC). An ongoing challenge in implementing mental health policies has been the absence of explicit financial flows to back up new policies, with some experts arguing that cost-effective mental health services and products should be included as part of the set of interventions to be publicly subsidised under UHC schemes (de Menil, 2015). These are sometimes known as health benefits plans or essential medicines lists. Although health benefits plans are more common in middle-income than in low-income countries, there are nonetheless examples of growing service coverage through benefits plans in countries such as Uganda and Ghana (de Menil, 2015).

An alternative promising approach is to incorporate mental health within existing health programmes using a life course approach. This includes programmes from early infancy (nutrition, stimulation, parent-child bonding) through to adolescence (reproductive health, life skills) young adulthood (prevention of suicide and substance abuse), and into older age (early detection and planning). Evidence shows the interaction between poor mental health and poor reproductive, maternal, newborn child and adolescent health outcomes (de Menil, 2015). As a result, the WHO recommends that mental health should be added to the screening in reproductive health services (an example is provided in the following section of this paper).

Integrating mental health across non-specialised health services through a task sharing plus supervision model. In resource-poor settings, the model focuses on improving the recognition and services for people with mental health conditions and psychosocial disabilities within primary health care clinics, alongside services at specialised institutions. This approach, however, requires time and resources for building the competencies of non-specialist health care providers (family doctors, clinical officers, nurses, midwives and other general para-professionals) in mental health care, as well as the **support and supervision from mental health specialists** in a collaborative and **stepped approach to care**. Social and relational norms and dynamics impact on the delivery of services and these must be taken into account when designing and implementing task sharing approaches. A case study from South Africa highlights this in the case of mental health services for HIV-affected rural women: **power dynamics**, which shape relationships within multidisciplinary teams; **stigma**, which limit the efficacy of task-shifting strategies, and **gender norms**, which shape how health professionals engage with male and female service users (Burgess, 2016). Case study findings highlight that "the establishment of training programmes that focus on **sensitising practitioners** to issues of gender, alongside safe spaces for practitioners to tackle their own stigma will be valuable for communities" (Burgess, 2016, p. 19).

Supporting the scale up of community-based mental healthcare approaches to address health and social inequities by promoting social wellbeing and addressing structural and social determinants of mental health. For example, Rwanda's post-genocide mental health agenda has largely focused on individualised and psychiatric approaches that have helped some but cannot be provided at scale. As a result, there have been increasing calls for community-based approaches to mental health. A study in 2016 (Mahr and Campbell., 2016) evaluated one such approach: The Life Wounds Healing workshops offered by the African Institute for Integral Psychology. The psychosocial workshops offered to the community are continuously adapted based on needs e.g. there may be sessions on rights, domestic violence, poverty, depending on the context. The aim is "not to just heal individuals but to create supportive contexts and communities that facilitate health enhancing attitudes and behaviours" (Mahr and Campbell, 2016 p. 4). The evaluation found that participants went through a process of reflection that gave them a deeper understanding of themselves and others which in turn facilitated behaviour change; they became more capable of responding to adverse experiences and negative behaviours; and became more aware of their rights (Mahr and Campbell, 2016). The workshops succeeded in improving mental health by establishing a safe social space for people to open up, increasing peoples' critical understandings of the processes of pain - and potential for healing - that informs behaviour change, generating bonding social capital and offering participants income generating possibilities (Mahr and Campbell, 2016). This approach is in line with the **social contact model** proposed by many specialists (Henderson and Thornicroft, 2013).

Building coordination of providers and services within and outside the formal and informal health system (private sector, NGOs informal healers or traditional leaders etc). This is important especially as mental health is inextricably linked to the wider social environment. For example, a person may require support (for example, from peers) in dealing with distress, as well as support in having their human rights recognised, or accessing education, or finding affordable and safe housing. This requires a **coordinated referral system with the health system and to service points outside the health sector** (WHO, 2018). In many LMICs, there are also parallel health systems operating informally, where people go to traditional healers before or at the same time as visiting formal health services, which needs to be recognised when coordinating an effective response (Monteiro, 2015). Although this is a recommendation echoed in several documents, there is little evidence to show that this is taking place in LMICs.

Ensuring a people-centred approach to service delivery. Over the years, service user movements have called for more meaningful engagement in health care to ensure health systems can better respond to the needs of all health care stakeholders and constituencies in a holistic manner (WHO, 2007). This requires meaningfully involving people with psychosocial disabilities and their families in advocacy and in the design and delivery of policy, planning, legislation, service provision, monitoring, research and evaluation. It also requires empowering individuals by increasing knowledge of their rights, their health literacy and their capacity to self-manage. People-centred care is slowly being implemented across LMICs. In Rwanda for example, the government has taken steps to provide people-centred services for people with psychosocial disabilities. Mental health services are now decentralised, mainly to district hospitals and care plans are personalised. The aim is to ensure that health care is also provided as close to home as possible by specially trained nurses providing a broad range of mental health services under the supervision of a physician and mental health workers. In addition, families are viewed as key care partners, and community groups are engaged to raise awareness about the extent of mental disorders in the country and to dispel common misunderstandings about their causes and treatability (WHO, 2010). While for many, families and communities are key caregivers and sources of support, family and community dynamics are also shaped by social, economic and political determinants, and by differential power dynamics.

Promoting self-care and self-management. Self-care and self-management strategies are tailored to maximize the individual's capacity to care for themselves. A 2013 systematic review including six studies from high income countries (HICs) (Houle et al., 2013) on self-management approaches for depression found that the application of self-management seems to be associated with reduced depressive symptoms and improved functioning. Evidence from a systematic review from LMICs also shows that school-based interventions indicate significant positive results on students' emotional and behavioural wellbeing including improved self-esteem and coping skills, promoting mental health and equipping young people with the life skills to fulfil their potential and overcome adversity (Barry et al., 2013). The rapid growth in **mobile telecommunications and internet access has also enabled access to an increased number of people with mental and psychosocial disabilities** and to bridge the mental health treatment gap (Patel et al., 2018). A randomised controlled trial of an mHealth self-care intervention by nurses for women living with HIV in rural India, for example, (Chandra et al., 2018) showed women were able to express and communicate effectively during the mobile phone intervention. Women shared worries about their own and their children's future, stigma, loneliness, financial difficulties and poor emotions such as sadness and guilt. A similar approach was used by the SHM Foundation in South Africa who launched a social support programme in 2013 called Khuluma. Research shows that

HIV positive adolescents are at increased risk of mental health conditions, meaning they have higher rates of depression and anxiety, and often stop taking their medication. The programme aimed to provide an integrated, cost-effective and scalable solution. Participants were placed in support groups of 10-15 peers for a three-month period. The groups are enabled by a digital platform where participants discuss, via text message, a range of issues related to their condition. Participants were also trained to deliver peer-to-peer psychosocial support in these digital support groups. Results from the programme include increased self-reported medical adherence, perceived levels of social support, decreased internalised social stigma and increased knowledge and access to services (SHM Foundation).

Examples of effective interventions

Example 1: Implementing the mhGAP programme to bridge the gap in mental health services in Uganda. To reduce the gap in treatment of depression, the non-governmental organisation (NGO) StrongMinds adapted a simple, cost-effective, evidence-based intervention. The psychological intervention included a structured, 12-week group interpersonal psychotherapy (GIPT) approach with community members to identify and manage their interpersonal difficulties. The approach is led by a facilitator to help group members identify and understand the root causes of their depression and formulate strategies to overcome triggers. A 2014 evaluation[4] reported positive results reducing symptoms; 94-95% of the 270 women who had participated in the programme reported being depression-free at the end of the formal sessions and having built strong social bonds with their peers. Most groups continue to meet after the formal sessions end, enabling women in the community to manage and prevent future depressive episodes. The evaluation also demonstrated the importance of continuous supervision of providers trained in psychological interventions to ensure quality (StrongMinds, 2014).

Example 2: Providing community-based mental health care in Ghana. A public-private partnership between Ghana Health Services and the NGO BasicNeeds Ghana has made mental health care accessible in primary care settings in Northern Ghana since 2002, using the Mental Health and Development model (de Menil, 2015). In addition to delivering medicines and counselling to people in their homes by community health workers, the programme offers livelihood opportunities to people with psychosocial disabilities and their families, through self-help groups (ibid.) at village, district and regional level with national representation through the Mental Health Society of Ghana. The Centre for Global Development (2015) identifies BasicNeed's public-private partnership as a "best practice" in providing community-based mental health care (ibid.). The groups gave people voice within communities and local Government, facilitating increased disability funds for healthcare from district assemblies and local NGOs (ibid.). According to BasicNeed Ghana's Annual Impact Report (2015), the organisation served 43,312 people with psychosocial disabilities and epilepsy and their caregivers and supported 253 self-help groups in 2014. The Mental Health and Development model now operates in 12 LMICs, including Kenya, where it has shown evidence of cost-effectiveness (de Menil, 2015).

Example 3: Integrating mental health into maternal health programming in South Africa. The Perinatal Mental Health Project (PMHP) in South Africa is a good example of how mental health has been integrated into antenatal care. The case is highlighted in an article that explores global perspectives on integrated mental health services (Rahman et al., 2013). The PMHP provided interventions to break the cycle of maternal mental distress by recognising that mental health services should be provided as part of health care at the primary level, not only at the specialist level. Women were referred to on-site counsellors who also acted as case managers or to on-site psychiatrists or specialists for secondary care. Over a 3-year period, 90% of all women attending antenatal care in the maternity clinic were offered mental health screening with 95% uptake. Of those screened, 32% qualified, of which 47% received counselling through the programme Important lessons include: (a) maternity health workers may be trained to screen for and refer women with mental distress in low-resource primary care settings; (b) training programmes that address and support the mental health needs of health workers can help staff manage their workload and prevent compassion fatigue and "burn out"; (c) on-site screening and counselling fosters the establishment of efficient referral mechanisms and access to mental health care often lacking in maternity settings in LMICs; (d) on-site, integrated mental health services can increase access for women who have scarce resources and competing health, family, and economic priorities; e) coordinating mental health visits with subsequent antenatal visits further facilitates access for women with insufficient resources (Rahman et al., 2013).

[4] Methodology was not always clear in this evaluation. It involved 270 women who had participated in the programme and a control group consisting of 36 women who experienced depression. The evaluation used mainly quantitative methods.

Example 4: Engaging whole communities to support people with mental health conditions. The Bapu Trust for Research on Mind and Discourse is a mental health organisation co-run with people with psychosocial disability, providing advocacy, community services and carrying out research in India (Bapu Trust, 2018). The organisation creates, pilots and monitors community inclusion programmes to enable the autonomy and independence of persons living with mental health conditions and psychosocial disabilities. The Bapu Trust has been running the *Seher* programme since 2004, scaled up in 2017 to provide direct service delivery across six low-income communities in India. It aims to create **emotionally sustainable and inclusive communities through the development of psychosocial self-care**, providing support services and building formal and informal care giving groups and networks (Bapu Trust, 2018). Initial work in each community begins with baseline research and community engagement to understand the 'whole mental health spectrum' of a community (asking questions such as, 'Who are the people at risk?'; 'How do they express their experiences?'; and 'What do they want?') (Bapu Trust, 2017a). **Information and education focus on mental health conditions as well as stress, distress, wellness, and 'being whole' as individuals, families and communities**. Arts-based and body practices are used where possible and any required service delivery is achieved through partnerships. The focus is on enabling communities to support and care for vulnerable people through circles of care, 'neighbourhood alerts', 'foster care' and community mental health volunteers. *Seher* also provides training modules across sectors on the inclusion of persons with mental health conditions and psychosocial disabilities. The Bapu Trust has reached about 200 people through enrolment in services in the two wellness centres and thousands of people through awareness raising activities in communities (Bapu Trust 2017b). An evaluation of the *Seher* programme found that the Bapu Trust's approach of providing support and services to persons with mental health conditions coupled with engaging the community to build a local support network has improved the situation of people with mental health conditions at relatively low cost (Natu, 2016).

Risks and enablers

Understanding community level dynamics to ensure effective implementation of community-based interventions. Several studies reinforce the interplay among mental health, interpersonal relationships, and social determinants of health, such as poverty, inequality and gender norms. There is limited literature available in LMICs showing sufficient analysis prior to community interventions. Increasing the risk that interventions fail and/or cause harm. Systemic monitoring and evaluation are also required to track impact on different groups, with regular risk analysis.

Investment in mental health could come from several new avenues. For example, non-communicable disease is an area receiving increasing attention and growing investment. There are also natural linkages between mental health and maternal and child health, an area that already receives significant funding with growing examples of integrating maternal and child health within the larger health system, e.g. the World Bank's Global Financing Facility (GFF) could provide an opportunity for financing mental health care (de Menil, 2015).

The lack of reliable data on mental health systems in LMICs hinders workforce planning. Almost one-fourth of the world's LMICs have no system for reporting basic mental health information (Brucker et al., 2011). Even when systems are in place, there is often limited accountability. This makes it difficult for countries to assess gaps in need and (Bruckner et al., 2011).

A task sharing model tackles negative attitudes towards mental health in primary health care workers. A qualitative study conducted in 2014 in Ethiopia, India, Nepal, South Africa and Uganda found that primary care workers with stigmatising attitudes towards people with mental health conditions can make them more reluctant to take on mental health care duties as part of an integrated approach (Mendenhall et al., 2014). This is also supported in a recent qualitative study undertaken in Sri Lanka (Palfreyman, 2018). Task sharing models thus need capacity building initiatives in place to tackle negative attitudes and biases of health workers themselves.

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