A Model for Psychosocial Care Delivery:
A supplement for the implementation of the mhGAP Program in low resource settings

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"There are times in life when the question of knowing if one can think differently than one thinks, and perceive differently than one sees, is absolutely necessary if one is to go on looking and reflecting at all"

- Michel Foucault -

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Abstract

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Most individuals with mental, neurological and substance use disorders living in and low- and middle-income countries do not have access to appropriate mental healthcare, including psychosocial care. A call to governments and international agencies and other mental health key stakeholders to scale up mental health services in all countries, but specifically in low-resource settings, has been made by the international scientific community in order to reduce the overwhelming treatment gap. This study's objective was to develop a low-cost model for psychosocial care delivery that supports the implementation of the mhGAP Program in order to improve improves access to care in low resource settings; and to exemplify its use in real setting. The Model for Psychosocial Care Delivery was designed to assist program planners in the process of adapting and implementing the WHO's mhGAP Program in their local setting. The Model has eight interdependent components: Contextualization, Host's Needs, Host's Aspirations, Host's Human Resources, Host's Other Resources, Collaborator's Aspirations, Collaborator's Resources and Local Advocate; with subsequent decision point menus regarding for each of the components. The use of the Model was exemplified via recommended lines of action for the implementation of the psychosocial component of the mhGAP in Costa Rica's Public Health system.

Key words: *mental health, psychosocial care, scale up, mental healthcare delivery, low resource settings*

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List of Abbreviations

CCSS	Caja Costarricense de Seguro Social (Costa Rican Social Security Administration),
DALY	Disability Adjusted Life Years
DSM-V	Diagnostic and Statistical Manual of Mental Disorders V
EBAIS	Equipos Básicos de Atención Integral de Salud (Basic Provision Units of Integrated Healthcare)
IAFA	Instituto sobre Alcoholismo y Farmacodependencia (Institute for Alcohol and Substance Abuse=
ICD-10	International Classification for Diseases 10
LAMICs	Low- and Middle-Income Countries
mhGAP	Mental Health GAP Action Program
mhGAP-IG	Mental Health GAP Intervention Guide
MNS	Mental Neurological and Substance Abuse
MoH	Ministry of Health
PHC	Primary Health Care
WHO	World Health Organization
WONCA	World Organization of Family Doctors
YLD	Years Lived with Disability

Introduction

Mental health or psychological well-being is defined in the constitution of the World Health Organization (WHO), as an integral part of health, which is understood as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 2013b, p. 7). A person's capacity to lead a fulfilling life; to form and maintain relationships with family, peers and society; and to make decisions about different aspects of daily life, such as employment, housing or education are key to maintaining good mental health (WHO, 2010b; 2013a, p. 1521). In this sense, people who suffer from Mental, neurological and Substance use disorders (MNS disorders), as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) and the International Classification for Diseases (ICD-10) in their most current versions, see their capacity to follow through with these basic activities impaired; leading to diminished functioning at the individual, household and societal level (WHO, 2013a, p. 7).

Furthermore, current evidence shows that MNS disorders are notable contributors of the global burden of disease, accountable for 30% of the total burden of non-communicable diseases (WHO, 2008, p. 6), and accountable for 7.4% (6.2–8.6) of the total disease burden in 2010, becoming the fifth leading disorder category of global Disability Adjusted Life Years (DALYs) and the leading global cause for years lived with disability (YLDs) worldwide (Whiteford & Baxter, 2013, p. 1579). The overwhelming burden of MNS disorders is unquestioned, however these findings must be translated into effective actions to help mitigate the burden.

Although mental health, just like any other aspect of health, can be affected by a range of socioeconomic factors that must be addressed through comprehensive strategies for promotion, prevention, treatment and recovery (WHO, 2013b); traditionally mental health has not figured among public health priorities of countries, and very often individuals with MNS disorders are treated with indifference and prejudice by the communities and societies they live in (WHO, 2013a, p. 7). Consequently, partly as a result of the global disregard to mental health as a public health matter, the world is facing a rather disproportionate relationship between disease burden and mental health expenditure which directly affect people in need of care (WHO, 2001a). This overwhelming treatment gap, becomes more burdensome at low-resource settings, such as low- and middle-income countries (LAMICs), where resources to scale up mental health services are very scarce and governments tend to have other public health issues that are usually considered more urgent. The WHO and the now renowned Movement for Global Mental Health have called the global health community, governments, donors, multilateral agencies, and other mental health stakeholders for immediate action to scale up access to mental health services in all countries, but

especially in LAMICs (Lancet Global Mental Health et al., 2007; WHO, 2001a). Furthermore, as an effort to assist LAMICs in the scaling up of mental healthcare, the WHO launched the mhGAP Program and Intervention Guide, a comprehensive program and easy-to-use tool especially designed for the integrated management of MNS disorders at non-specialized health settings. The mhGAP is considered to be the most comprehensive and well-grounded package of care available for the treatment of MNS disorders in low-resource settings.

Consequently, although investment in mental health relates to promotion and protection, and not only prevention and treatment of MNS disorders, this study focuses on finding affordable strategies to effectively improve access to mental healthcare in low-resource settings. The Model for Psychosocial Care Delivery aims to provide practical support to program planner's who find themselves making decisions regarding the implementation of the psychosocial component of the mhGAP program in low-resource settings. Furthermore, to better exemplify how the model can be used, a site visit to Costa Rica was carried to gather data regarding its health system, to subsequently use the Model to identify lines of action for scaling up psychosocial care in Costa Rica.

This document is divided in three chapters. Chapter one: Background & Rationale; introduces this study's scientific antecedents along with the conceptual rationale that were key to the development of the Model for Psychosocial Care Delivery. The implications of mental health as a public health issue will be broadly discussed and multiple strategies to scale up mental health services in low-resource settings will be described. Chapter two: Study Design & Methods; focuses on the description of the research question, objectives and scope along with an ample description of this study's phases. In broad terms, phase one was dedicated to the development of the Model and phase two entailed the exemplification of the model by identifying lines of Action for its implementation in Costa Rica. Chapter three: Results & Discussion; is divided in two sub-sections regarding each of the methodological phases. In the first section the Model for Psychosocial Care Delivery is described and discussed; and in the second section the lines of action for Costa Rica are presented. Finally, the conclusions to which this study has reached are described, along with limitations encountered and specific recommendations for action.

Chapter 1: Background and Rationale:

I. Mental Health as a Public Health Issue

1. The Global Burden of Mental Disease

Despite the overwhelming figures showing that as many as 450 million people worldwide suffer from Mental, Neurological and Substance use (MNS) disorders, and being accountable for 7.4% of the global burden of disease; mental health and MNS disorders are not given the same importance as physical health and have been historically neglected and marginalized from mainstream health and welfare services in many countries (Whiteford & Baxter, 2013, p. 1575; WHO, 2001a). The lack of prioritizing of mental health in the public health agenda of countries has enormous consequences, affecting budget, policy planning and service development.

According to the WHO, the majority of countries spend less than 1% of their health budgets on mental health (WHO, 2001b, p. 3). "In low income countries, the typical per capita expenditure on mental healthcare is as low as $0.10-$0.20; that is $100,000-$200,000 per year for a population of 1 million. The required expenditure to meet target coverage levels is estimated to be around $1.50-$2.00 per capita in low-income countries, and $3.00-$4.00 in middle-income countries" (Lancet Global Mental Health et al., 2007; as cited by Eaton, De Silva, Rojas, & Patel, 2014, p. 304). In addition, "the logarithmic trend line shows that mental health in low-income countries faces a double disadvantage: the poorest countries spend the smallest proportion of their already scarce resources on mental health" (Saxena, Thornicroft, Knapp, & Whiteford, 2007, p. 881)

The publication of the World Development Report in 1993, which included the initial findings of the Global Burden of Disease, Injuries and Risk Factors Study (GBD), introduced a new metric that helped address the imbalance between the great attention paid to infectious diseases worldwide and the disregard to non-communicable and chronic diseases, amongst which figure mental illnesses and behavioral disorders (as cited by M. Prince, Rahman, Mayston, & Weobong, 2014, p. 103). The Disability Adjusted Life Years metric (DALYs) is a single integrated measure of disease burden that includes the sum of Years Lived with disability (YLD), and Years Life Lost (YLL). One DALY equals one year loss of healthy life. Its development helped to better understand the global burden of disease due to morbidity that was not being taken into consideration with the customary statistics that focused on measures of mortality (V. Patel, Minas, & Cohen, 2014; Whiteford & Baxter, 2013, p. 1575).

The GBD 2010, published in The Lancet in December 2012, is the most recent version of the study. It is significantly broader in scope than previous GBD studies and was expanded to include 20 MNS

disorders as described by the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) and the International Classification of Diseases (ICD-10). It consists of a comprehensive reanalysis of premature death and disability due to 291 diseases and injures, 1,160 non-fatal health consequences and 67 risk factors for 20 age groups and both sexes. Data was analyzed for 187 countries in 1990, 2005 and 2010 and confirms the rapid transformation of the global health landscape that has occurred in the last two decades: instead of premature mortality there is now an increasing disease burden due to disability (IHME, 2013b, p. 6).

According to the GBD 2010, MNS disorders are notable contributors of the global burden of disease; representing 30% of the total burden of non-communicable diseases (WHO, 2008, p. 6), and accountable for "183.9 million DALYs (95% UI 153.5 million-216.7 million), or 7.4% (6.2–8.6) of total disease burden in 2010" (Whiteford & Baxter, 2013, p. 1579), becoming the fifth leading disorder category of global DALYs and the leading global cause years lived with disability (YLDs) worldwide (Ibid.). "These disorders were responsible for more of the global burden than were HIV/AIDS and tuberculosis, diabetes, or transport injuries" (Whiteford & Baxter, 2013, p. 1582).

Furthermore, it has been found that MNS disorders affect 10 - 20% of children and adolescents worldwide and are accountable for a large proportion of the global burden of disease (Kieling et al., 2011, p. 1515). Data from Latin America and the Caribbean, show trends that reflect what has been observed globally: a drop in rank of DALYs due to most communicable, newborn, maternal, and nutritional causes and a rise in rank due to non-communicable causes. (IHME, 2013a, p. 17) For example, "Depression is the leading cause of disease burden in Brazil and the second leading cause in women in Chile" (Brazil Country Management Unit, 2005; Ministerio de Salud, 2005; as cited byV. Patel et al., 2007, p. 994).

GBD's groundbreaking findings showcase the evidently disproportionate relationship between disease burden and mental health expenditure (Saxena et al., 2007, p. 878). "This rising burden imposes significant challenges on health-care systems, on the individuals who rely on these systems, and on mental healthcare providers world-wide" (Rebello, Marques, Gureje, & Pike, 2014, p. 308). This evidence, highlighting the great burden of mental disorders worldwide and the growing mental health crisis in low-income countries, has been used as an effective tool to influence policy-makers, researchers and academics around the world (V. Patel et al., 2014, p. 110).

In addition, major connections between mental and physical health have been demonstrated, confirming mental disorders as risk factors for the development of communicable and non-communicable diseases, and various physical health conditions as risk factors for MNS disorders (M.

Prince et al., 2014, p. 106; WHO, 2001a, p. xiv) (WHO, 2001a, p. xiv). "For example, in population based studies, depression is a prospective risk factor for cardiovascular diseases (CVD), including angina, myocardial infarction and stroke" (Larson et al., 2001; Everson et al.,1998; a cited by M. Prince et al., 2014, p. 106). Also, HIV infection is consistently associated with an increased prevalence of affective disorder, both in populations treated with Antiretroviral therapy and not treated (Ciesla & Roberts, 2001; as cited by M. Prince et al., 2014, p. 106) "Comorbidity is also important because it complicates help-seeking behavior, diagnosis and treatment; it also affects the outcomes of treatment for physical conditions, including disease related mortality" (M. Prince et al., 2014, p. 107).

Mental and behavioral disorders, such as depressive and anxiety disorders, and drug use, are the primary drivers of disability worldwide and caused over 40 million years of disability in 20 to 29 year olds (IHME, 2013a). Clinical depression alone is estimated to be the leading cause of disability globally (WHO, 2001a) and is accountable for the highest proportion of disease burden attributable to mental and substance use disorders across all regions considered in GBD 2010 (IHME, 2013b, p. 6; WHO, 2001a). Anxiety is another one of the top ten causes of disability in all regions, ranking highest in Latin America and the Caribbean and the Middle East and North Africa *(Whiteford & Baxter, 2013, p. 1582).* According to the GBD 2010:

> *"Depressive disorders accounted for 40·5% (31·7–49·2) of DALYs caused by mental and substance use disorders, with anxiety disorders accounting for 14·6% (11·2–18·4), illicit drug use disorders for 10·9% (8·9–13·2), alcohol use disorders for 9·6% (7·7–11·8), schizophrenia for 7·4% (5·0–9·8), bipolar disorder for 7·0% (4·4–10·3), pervasive developmental disorders for 4·2% (3·2–5·3), childhood behavioral disorders for 3·4% (2·2–4·7), and eating disorders for 1·2% (0·9–1·5)." (Ibid.)*

Despite this breakthrough in terms of access to information, there are many other varieties of burden caused by mental disorders that aren't covered by the DALY metrics, such as the economic burden to families, governments and society itself.

The decision to invest or not in mental health systems can be based on three economic criteria: "the economic consequences of no investment; the amount of investment needed to address identified needs; and the cost-effectiveness of investment in relation to competing public health needs" (V. Patel et al., 2007). According to a study by the World Economic Forum regarding the economic burden attributable to MNS disorders, "the cumulative global effect of mental disorders in terms of lost economic output could amount to US $16 trillion in the next 20 years, equivalent to 25% of the global GDP in 2010 (Bloom et al.; as cited by Whiteford et al., 2013, p. 1582). "The burden to caregivers (time, financial resources, opportunity cost of caring for a sick relative), harm caused (a common consequence of alcohol and illicit drug use), and lost productivity at the individual, family

or society level" should also be accounted for (Eaton et al., 2014, pp. 303-304). An analysis for India found that half of the mental illness related expenditures out-of pocket expenditures came from loans, and further 40% from household income or savings (WHO, 2013a). Furthermore, MNS disorders can cause severe and sustained disabilities, which may result in decreased ability or even inability to work or attend school, representing a substantial economic and societal burden. "In terms of the impact on the national economy, mental disorders are associated with high rates of unemployment and also under-performance while at work" (Mahal et al., 2010; as cited by WHO, 2013a, p. 17). The loss of productivity due to disability and supplementary costs to support its care add up to drain the economies of poor countries, whether it's via out-of-pocket or public health expenditure (Eaton et al., 2014, pp. 303-304; WHO, 2001a, p. 20).

Lastly, although there is highly convincing epidemiologic and economic criteria to support the decision to invest in scaling up mental health services in low-resource settings, other non-economic criteria such as equitable access to healthcare, human rights protection, and poverty reduction, should be considered as equally important when setting priorities regarding mental health investment (V. Patel et al., 2007).

2. Social Determinants of Mental Health

In addition to the biological determinants of mental health, which take into consideration genes, physical health and reproductive history, a wide range of social determinants have been found to play a role in the mental health of populations (Lund, Stansfeld, & DeSilva, 2014, p. 116). "The social determinants of health are the circumstances in which people are born, grow up, live, work, and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies and politics" (Lund et al., 2014, p. 117).

Socioeconomic factors, especially poverty, influence mental health in powerful and complex ways (WHO, 2001a). Poverty and its associated psychosocial stressors (e.g. violence, unemployment, social exclusion, and insecurity) are correlated with mental disorders. Moreover, relative poverty, low education, and inequality within communities have been found to be associated with increased risk of mental health problems (WHO, 2008, p. 6). In this regard, consistent evidence across countries shows that MNS disorders are twice as common among the poorest sections of society without regards of the country's level of income (WHO, 2001a, p. 19). Epidemiological data from five studies in LAMICs showed that people with low education and low income were most vulnerable to common mental disorders and that relative poverty was a risk factor for common mental disorders (Saxena et al., 2007, p. 883). Studies have also shown that a range of mental disorders such as schizophrenia, depressive illness, substance abuse and personality disorders are associated with

less advantaged socioeconomic position (Dohrenwend, Levav & Shrout, 1992; as cited in Lund et al., 2014, p. 118).

The dual action of the "social drift hypothesis" and the "social causation hypothesis" is often referred to as the "vicious cycle" of poverty and mental illness (Patel, 2001; as cited by Lund et al., 2014, p. 124). The first hypothesis suggests that a person's health may determine their social position: a person who develops a mental illness suffers a social scale descent by becoming unemployed, withdrawing from social relationships and moving to a less expensive neighborhood (Dohrenwend et al., 1992; as cited by Lund et al., 2014, p. 124). "In this case, the social decline is secondary to the illness, and understood to be driven by reduced income and employment associated with the disability and stigma of the illness together with increased health expenditure" (Lund et al., 2011, p. 124). In turn, the "social causation hypothesis" suggests that "exposure to poverty, debt, unemployment, poor educational opportunities, substandard housing, frequent adverse life events, child neglect, and dangerous and impoverished environments contribute to the etiology of depression" (Ibid., p.124). Hence, access to medical care has been put forward as a possible explanation of social class differentials in health, and current evidence base appears more robust for interventions looking to address the social drift pathway (Ibid., p.125, 129). For governments and international development partners this evidence provides added significant justification for an intervention to reduce inequalities in access to healthcare or health coverage (WHO, 2013a).

Accordingly, it has been found that improving the economic status of the individual goes hand in hand with improvements in clinical symptoms, which has been called the "virtuous cycle of increasing returns" (Lund et al., 2011, p. 1508). Scientific findings from a systematic review of all intervention studies assessing the effects of any intervention designed to treat any type of mental disorder in LAMICs showed a clear trend in which treating MNS disorders "can lead to improvements in the economic status of both the individual suffering from mental health problems and their families and carers, thereby preventing a social drift into poverty" (Lund et al., 2011; as cited by Lund et al., 2014, p. 128). These findings support the need of improving access to mental health services as a public health and economic development priority.

Demographic factors such as ethnicity and gender also weigh in determining a person's mental health. "Experiences of racism, exclusion and alienation by ethnic minorities are likely to increase risk for a range of mental disorders" (Ibid., p.122). Gender roles are considered critical determinants of mental health as they are responsible for the unequal control men and women have over socioeconomic determinants of their mental health, their social position status and treatment in

society, affecting their exposure to mental health risks and their ultimate access to care (WHO, 2001a, p. 21).

> "*Depression, anxiety, somatic symptoms and high rates of comorbidity are significantly related to risk factors that can be related to gender, such as violence, socioeconomic disadvantage, income inequality, low or subordinate social status and rank, and unremitting responsibility for the care of others*" (WHO, 2001a, p. 21).

Differences by sex are also seen in the prevalence of common mental disorders, with women being at increased risk with a typical female to male ratio of 1.5 to 2.0. (M. Prince et al., 2014, p. 107). A study by Araya et al. (2003) showed a that women, and especially those with little education in low social classes, had high rates of common mental disorders (as cited by Saxena et al., 2007, p. 883). Depressive disorders are twice as common in women as in men, across most societies and social contexts; whereas the lifetime prevalence rate for alcohol dependence is more than twice as high for men as for women (WHO, 2001a, p. 20). Depression, anxiety and somatic complaints are most prevalent in women and represent the most common diagnoses within primary care settings. Mental disorders in women are also important because of how they affect reproductive, maternal and child health. "Abuse, anxiety, depression, substance and alcohol use are all robustly associated with dysmenorrhea, dyspareunia, and pelvic pain (Latthe et al., 2006; as cited by M. Prince et al., 2014, p. 106). Maternal clinical depression has also been found to be responsible for reductions in adherence to child-health promotion and disease prevention interventions such as child immunization (Rahman et al., 2004; as cited by M. Prince et al., 2014).

Finally, environmental factors also contribute significantly to the mental health of populations. There is evidence that suggests that living in poor neighborhoods may contribute to ill mental health because of fear of crime, witnessing of violence, poor neighborhood quality and lack of access to social resources (Fone et al.,2007; as cited byLund et al., 2014, p. 122). Also, "(a) range of negative life events which occur as a result of natural disasters war and conflict have been identified as strong determinants of mental illness (Lund et al., 2014, p. 122).

Understanding how social determinants influence mental health is important to plan effective and efficient population-level interventions that aim to reduce social and health inequities (Ibid., p.116). "Community development programmes that aim to reduce poverty, achieve economic independence and empowerment for women, reduce malnutrition, increase literacy and education, and empower the underprivileged contribute to the prevention of mental and substance use disorders and promote mental health" (WHO, 2008, p. 6). Recognizing that for undertaking such a complex issue it is necessary to go beyond the health sector; and that actions need to be planned in

coordination with the social, education, and justice sectors (Skeen et al., 2010; as cited byLund et al., 2014, p. 116) is key to developing successful solutions.

3. Treatment Gap of Mental Disorders

As we have seen, MNS disorders are prevalent in all regions of the world and represent "almost three quarters of the global burden of neuropsychiatric disorders in countries with low and lower middle incomes" (mhGAP, 2008, p6). However there is a rather disproportionate relationship between disease burden and mental health expenditure. Partly as a result of the disregard to mental health as a public health matter, the world is suffering from an increasing burden of mental disorders and a widening treatment gap (WHO, 2001a). "The mental health treatment gap is defined as the absolute difference between the true prevalence of a disorder and the proportion of affected individuals who are treated for the disorder" (Lora et al., 2012; as cited by Eaton et al., 2014, p. 297).

Even high-income countries, where comprehensive mental health services are available, have a large treatment gap (Eaton et al., 2014, p. 298). For example, "(a) large multi-country survey supported by WHO showed that 35–50% of serious cases in developed countries and 76–85% in less-developed countries had received no treatment in the previous 12 months" (mhGAP, 2008, p7). In low-income countries, most patients suffering from severe mental and neurological problems such as schizophrenia and epilepsy do not get treatment even when it is available at low cost (anticonvulsant therapy for epilepsy can cost US$ 5 per patient per year) (WHO, 2001a, p.17). It has been found that "(i)ssues such as treatment acceptability (particularly biological treatments), stigma and different attributions of causation, all affect the utilization of mental health services, even in contexts where they are affordable and available"(Eaton et al., 2014, p. 299).

Furthermore, different disorders are subject to a different gap magnitude. People with severe disorders such as schizophrenia are more likely to obtain services than those with depressive or anxiety disorders. (Eaton et al., 2014, p. 298) "A review of the world literature found treatment gaps to be 32% for schizophrenia, 56% for depression, and as much as 78% for alcohol use disorders" and "many population based studies have shown that more than 95% of people with epilepsy in many resource-poor regions do not receive adequate treatment" (mhGAP, 2008, p7).

Mental disorders account for about 160 million lost years of healthy life; of this, at least 30% can be easily averted with existing interventions (WHO, 2001a, p. 16). However, "less than 50% of the patients who meet the criteria are identified by doctors and patients are reluctant to seek care due to stigma related to mental disorders" (WHO, 2001a, p. 16). Although large psychiatric hospitals or asylums have been strongly criticized for delivering outdated and inhumane care that disrispects

human rights of people with MNS disorders (WHO, 2001a, p. 18), it continues to be the method of choice for mental healthcare delivery in many low-resource settings.

The stigma directed towards people with MNS disorders along with the neglect to their human rights impact their relationships negatively, causing rejection by friends, family, neighbors and employers,. The person's condition is then aggravated by increasing their vulnerability; accelerating and reinforcing their descent into poverty and delaying access to care and rehabilitation. (WHO, 2001a, p. 16). "Unfortunately, negative attitudes towards the mentally ill and stigmatizing stereotypes may also be shared by medical and hospital personnel; patients frequently complain that they feel most stigmatized by doctors and nurses" (WHO, 2001a, p. 19). Consequently, in the healthcare context, the two major concerns are the lack of access to mental healthcare, and ill treatment and abuse by health workers (Eaton et al., 2011, p. 1664).

Decisions about how best to deliver care to people with MNS disorders are critical to to ensure maximum impact, high quality, and equitable coverage of the interventions (mhGAP, 2008, p.17).

> "In order to reduce the treatment gap, many more people need to have access to evidence-based mental health services, and also need to choose to use them. This can be done by not only providing good services, but ensuring that they are culturally appropriate ("acceptable"), and that social beliefs and attitudes that reduce service use are addressed" (Eaton et al., 2014, p. 299) (Eaton Ch14, p 299)

Since the Alma Ata declaration in 1978, it has been generally recognized that primary health care (PHC) services offer the most accessible care to the majority of the population and that mental health should be accessed at this level (Eaton Ch14, p.305). Therefore, in the effort to bridge the gap between available resources and the burden of mental disorders, a special focus has to be given to the delivery of mental health services at non-specialized health settings, that is the primary care level. This is due to the fact that most countries, and especially LAMICs where the gap is much larger, do not have sufficient mental health specialists to meet the required need. Also, it has been found that most people with MNS disorders tend to seek care from primary care services rather than from any other level of health care service (Gureje, O. & Stein, D., 2013, p. 33). In addition, robust evidence suggests that non-specialized healthcare providers (i.e. general doctors and nurses) can be used instead of expensive specialized mental health workers, to manage many mental and neurological disorders in terms of prevention, diagnosis and treatment. (WHO, 2001a, p. 16).

Since most of the current mental healthcare in LAMICs is institutionally based, the shift to PHC requires the allocation of extra funds that have not been made available in most countries (Saxena et al., 2007, p. 878). The fact that financial resources for mental healthcare are typically scarce requires that mental health scaling up is given a priority position in the public health agenda of

countries. According to the WHO, "(w)hat is needed is political will, concerted action by a range of global health stakeholders, and the resources to implement them" (mhGAP, 2008, p.9). The commitment of governments and international agencies to provide adequate funding, especially to increase the capacity in human resources to implement proven treatment and prevention packages is crucial (Eaton et al., 2011, p. 1598).

4. Scientific and Political Momentum

In public health scientific evidence plays a big role in renewing perspectives and changing the way health and healthcare is understood and approached. In the last 20 years, a series of political events and scientific findings have facilitated a shift in perspective causing mental health to gain force and become a more prominent public health issue. "Advances in neurosciences have shown that, like many physical illnesses, mental and behavioral disorders are the result of a complex interaction between biological, psychological and social factors" (WHO, 2001a, p. xiv). In 2001, at the 54th World Health Assembly, the new urgent topic of the burden of mental disorders was discussed by health ministers from around the world who agreed on the fact that mental disorders play an important role in poverty and that mental health is essential not only for individual well-being, but also for enhancing human development including economic growth and poverty reduction (WHO, 2001a, p. 6).

In 2001, Gro Harlem Brundtland, former Director General of the WHO, in an attempt to raise public and professional awareness of the real burden of mental disorders and their costs in human, social and economic terms, made a key statement in favor of the improvement of mental health and wellbeing of all peoples, by calling governments, policy-makers and health providers to action: "mental health– neglected for far too long – is crucial to the overall well-being of individuals, societies and countries and must be universally regarded in a new light". (WHO, 2001a, p. ix).

The World Health Report 2001, the first on its kind devoted entirely to mental health, served as a very much needed comprehensive state of the art of the burden of mental and behavioral disorders, as well as public health policy, and services approach to mental health (V. Patel et al., 2014, p. 12). While it focuses on renewing principles related to the rights of the mentally ill population and gives recommendations for improving access to mental health services worldwide, which will be described later on this document, its innovation lies on the way that it deals in with service provision and planning. The report provides a guide of far-reaching recommendations that can be adapted by every country according to its needs and resources (WHO, 2001a, p. xi). "These context-dependent scenarios were suggested because of the recognition that many countries did not have the resources to take similar actions to address recommendations" (Cohen, Patel, & Minas, 2014, p. 12). "The

report´s recommendations included a wholesale shift from institutional to community-based care for most patients, and efforts to make services more holistic, including allowing more access to psychological treatments and creating better links to social services" (Eaton et al., 2014, p. 299); and it describes medication, psychotherapy and psychosocial rehabilitation as the three fundamental ingredients to care, stating that a balanced combination is always required to adequately care for people with MNS disorders (WHO, 2001a, p. xvii).

Impetus for the mental health agenda gained more strength in 2006 with the adoption of the Convention on the Rights of Persons with Disabilities by the United Nations General Assembly, the first legally binding international human rights instrument offering comprehensive protection to people with physical or mental impairment (Stuart, 2010; as cited by Cohen et al., 2014, p. 14). The convention obliges signatories to guarantee a wide range of economic, social and cultural rights to all persons with disabilities, who have the right to "a full and effective participation in society on an equal basis with others" (Ibid.) The Convention also introduced "the social determinants of disability" model which leaves behind the idea that people with disability are in need of interventions to function better in society and focuses on the social barriers responsible for transforming a person's impairment into disability (Cohen et al., 2014, p. 14).

From 2001 to 2006, WHO continued pushing the mental health agenda through a series of activities to inform development of mental health policies and services, to maximize the use of available resources (Mental Health Policy and Service Guidance Package); to document mental health resources in member states of WHO (ATLAS project and WHO-AIMS) and to help improve organization in situations of armed conflict or natural disasters (Guidelines on Mental Health and Psychosocial Support in Emergency Settings) (Ibid.)

Along with the political momentum, newly funded research on mental health continued to nourish the discussions and recommendations to governments and stakeholders. The Lancet Series on Global Mental Health in 2007 and later in 2011 marked an important milestone in the development of the mental health field by coining the term "Scaling up" of mental health services and further boosting the mental health agenda. Within the Lancet series, five main barriers to scaling up mental health services, were identified and ample recommendations for overcoming them were given (Ibid.). In consonance with the Lancet series efforts, in 2010, the Grand Challenges in Global Mental Health Initiative enrolled a panel of 422 experts who identified the areas in which more scientific thrust is needed to significantly impact the lives of people living with neuropsychiatric disorders (Collins et al., 2011; as cited by Cohen et al., 2014, p. 24). Since then, many reports have made very

similar recommendations for addressing the challenges in scaling up mental health services in low-resource settings, these will be discussed in the next section.

Lastly, the most recent and influential effort to push the mental health agenda was made by the WHO through the publication of the first Global Mental Health Action Plan, approved by the World Health Assembly in 2013 (Mangham & Hanson, 2010; as cited by Eaton et al., 2014, p. 301). The plan sets new directions for mental health, including the central role that must be given to community based care along with an increased emphasis on human rights (WHO, 2013b). Its "(...) goal is to promote mental well-being, prevent mental disorders, provide care, enhance recovery, promote human rights and reduce the mortality, morbidity and disability for persons with mental disorders" (Ibid., p9).

Based on all of these well-grounded and shocking findings is that mental health has reached a key point, becoming more prominent as a public health issue. "Indeed, much of the current interest in MNS disorders among health policymakers is based on the fact that these disorders have consistently been found in cost-of-illness studies to be among the most burdensome health problems in the population" (Kessler, Alonso, Chatterji, & He, 2014, p. 82). Consequently, the Movement for Global Mental Health has called for the immediate scaling up of services for people with MNS disorders to help reduce the overwhelming treatment gap, on the basis of principles of evidence and human rights" (Patel & Thornicroft, 2009, p. 1). Furthermore, attention must be drawn to the need to address global mental health not only as public health priority, but as a neglected priority in international development economics (Lund et al., 2011, p. 1513).

II. Scaling Up Mental Health Services in Low Resource Settings

1. Barriers & Strategies to Scale Up Mental Health Services

Scaling up is a term that establishes a set of principles to be followed in health care development. It has been adopted in the global mental health field and is understood as: "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 program development on a lasting basis"(Simmons et al., 2007; as cited by Eaton et al., 2014, p. 301) (Cite 14 in Eaton Ch14, 301). In general terms, scaling up health service delivery encompasses a series of practical considerations that can lead to success or failure of such efforts:

- Increasing the number of people receiving services;
- Using the best available scientific evidence to design healthcare interventions and services;

- Using a model that has shown to be effective in similar contexts;

- Integrating mental health services into existing health systems; and,

- Ensuring the sustainability of such services through policy formulation, implementation and financing (cite 15 in Eaton Ch14, 301-303).

Since scaling up is a social, political, and institutional process a range of contributors, interest groups, and organizations must be engaged in such efforts. According to the WHO, "(s)uccessful scaling up is the joint responsibility of governments, health professionals, civil society, communities, and families, with support from the international community" (WHO, 2008, p. 5).

Although the overall volume of services provided to treat people with MNS disorders needs to be substantially increased in every country, it is argued that special attention needs to be put to LAMICs so that the access to care is proportionate to the magnitude of need (Lancet Global Mental Health et al., 2007, p. 1241) Multiple reports have agreed on five major barriers to service development that must be taken into consideration when planning to scale up mental health services.

a) *Mental Health is not prioritized in the public health agenda*

The first barrier is the current position that mental health has in the public health agenda and how it affects funding (Lancet Global Mental Health et al., 2007, p. 1248). As we saw before, the funding gap in mental health is substantial, especially in low-income countries and is cofounded by poor organization of the resources that do exist (Eaton et al., 2014, p. 304). Although mental health had never been so present in the discourse of policy stakeholders, the reality is that the scarce allocation of resources shows the low priority that governments continue to give to mental health. Since scaling up of services rely on allocation of funds, not doing so significantly threats the likelihood of improving access to such service. "Health planning pays great attention to efficiency, so it is essential that evidence of cost-effectiveness be presented if resources are to be allocated" (Ibid., p.303).

The main recommendations to overcoming this barrier include efforts to incorporate mental health on the public health priority agenda by conducting advocacy alongside with key stakeholders, including users of services; by educating decision makers within governments and donor agencies about the importance of MNS disorders to public health; and by relying on the evidence supporting the cost-effectiveness of mental healthcare (Lancet Global Mental Health et al., 2007, p. 1249). Evidence also suggests that LAMICs increase their overall health budget along with the specific budget for improving access to mental health services (Jacob et al., 2007, p. 1061)

b) *Over-centralization of mental health care*

The second barrier is the complexity of and resistance to decentralization of mental health services (Eaton et al., 2014, p. 304). Although there have been many criticisms to large psychiatric institutions relative to the inadequate and dehumanizing care provided, the high cost of operation and the weak links with community mental health and general health services (Eaton et al., 2014, p. 304; Lancet Global Mental Health et al., 2007, p. 1249), the shift towards a mixed range of services has not occurred in most lower-income countries where psychiatric hospitals continue to receive the majority of the funds allocated to mental health (WHO, 2011; as cited by Eaton et al., 2014, p. 304).

According to Chisholm et al. (2007) in order to improve the organization of mental health services, national policies, plans and legislation must be developed to enable decentralization of resources and development of services based in the communities. Also, resistance to change from health professionals used to working in the cities and in specialized hospitals needs to be addressed. Funds for developing community based services that do not rely on mental hospital funding need to be made available, since it has been found that such reallocation of funds is not made effective in practical terms. "Only large-scale redistribution of domestic resources and/or new investment from external sources is capable of overcoming the shortfall" (Eaton et al., 2014, p. 304). Experts argue that new funds should be used more efficiently (for example in primary care rather than specialist care) and in an equitable manner (Saxena et al., 2007, p. 878). Finally, international technical collaboration has been found helpful to reorganizing services via sharing successful experiences (Lancet Global Mental Health et al., 2007, p. 1249).

c) *Challenges to integrate mental healthcare in primary care*

The third major barrier are a series of challenges that complicate the integration of mental healthcare into general care (Eaton et al., 2014, p. 305) Within the Lancet series, Saraceno et al. (2007) identified three key barriers to integration of mental health in primary care:

1) Primary Health Care systems in LAMICS tend to be overburdened with multiple tasks and patient loads, leaving insufficient time to properly care for people with MNS disorders;

2) Primary Health Care workers are not mental health specialists and do not receive sufficient supervision and support by specialized services; and,

3) In many LAMICs the essential psychotropic medicines are not continuously available at primary care level (p. 1169).

To tackle these barriers, the development of innovative models of mental health care delivery in primary care settings with low-cost human resources for screening and provision of interventions, and strengthened links to specialist services is recommended (Saraceno et al., 2007, p. 1172). Also,

as stated before, specific mental health budgets for mental healthcare in primary care need to be determined to assure sufficient human resources, essential drugs, psychosocial treatments and specialist supervision. Finally, a team of mental health professionals responsible for training and supervising primary care staff should be appointed (GMH6, 2007, p.1249) "Mental health professionals will need to be retrained on their role as trainers and supervisors in this process, as will primary care staff in the recognition and management of mental disorders"(Lancet Global Mental Health et al., 2007, p. 1250).

d) Scarcity of human resources for mental healthcare

The fourth barrier to scaling up is the very inadequate human-resource base for mental health care (Lancet Global Mental Health et al., 2007, p. 1250). According to the Mental Health Atlas (2011) there is a generalized low number and few types of workers trained in mental healthcare worldwide. "The situation is particularly bleak in low-income countries where on average there only one psychiatrist for every two million inhabitants (compared to one to every 12.000 in high income countries)" (WHO, 2013a, p. 15).

In order to change this reality, and to equip PHC services with appropriate human resources, the quality of mental health training for the general care workforce should be improved, making sure that it is practical and occurs in community or primary care settings. Besides, the mental health workforce needs to be increased and diversified, taking into consideration the non-specialized workforce, such as ex-service users and caregivers, when possible, assuring that financial means are available for providing them with ongoing supervision and support (Lancet Global Mental Health et al., 2007, p. 1250).

e) Lack of public health leadership for mental health

The fifth and final major barrier is the lack of public health perspectives among the mental health leaders in most countries (Ibid). This owes to the fact that most mental health professionals who are called upon governments for technical advice and who assume positions of power within ministries and departments of health, do not have the sufficient training in public health to address policy and service development issues with a population-level perspective (Eaton et al., 2014, p. 307; Lancet Global Mental Health et al., 2007, p. 1250).

To overcome this barrier the recommendation is to strengthen the mental health leadership by providing training opportunities for leaders in mental health and public health. Also, the appointment of public health leaders in mental health positions can be a solution, although they might lack important technical knowledge in mental health (Lancet Global Mental Health et al., 2007, p. 1250). Lastly, it is strongly recommended "(...) that universities and training institutes in all

countries integrate mental health into public-health training and establish public mental health courses that cover policy, legislation, organization of services, prevention and the epidemiology of mental disorders and their risk factors" (Ibid.).

To those five barriers, many more can be added, including the fact that most LAMICS lack reliable local epidemiological data to construct a baseline for prevalence of mental disorders, which complicates the task of defining priorities in terms of policy planning and implementation. However, when developing public policy or planning for scaling up mental health services, at least these barriers should be strategically and systematically considered and addressed. In this process, involving all stakeholders such as decision makers and service users is key to obtain their support and to facilitate sustainability of services (Eaton et al., 2011, p. 1592). Furthermore, "(...) the development or upgrading of mental health services in low-income and middle-income countries need not be derailed on the grounds that it will make unreasonable or excessive demands on future budgetary allocations"(Lancet Global Mental Health et al., 2007, p. 1248). The fact that mental healthcare budget allocation is scarce in most countries regardless of their income and even more so in LAMICS must always be kept in mind when planning to scale up mental health services at low-resource settings.

2. The Cost of Scaling Up Mental Health Services

Very often, even if governments are determined to improve mental healthcare, decision makers do not have up-to-date knowledge about the cost-effectiveness of mental healthcare and end up directing very valuable funding towards less cost-effective care (WHO, 2006b, p. 5). As it has been previously described, resources allocated for mental health services tend to be insufficient at a global level, which is why "the way in which financial resources are used is crucial for provision of effective care to as many people as possible" (Saxena et al., 2007, p. 881). Having access to information regarding cost-effectiveness, affordability and feasibility of interventions is key for planners and decision makers to make the most out of their mental health budget. "Accordingly, there is a need to increase the mental health budget to reduce the current clinical and economic burden attributed to mental disorders" (WHO, 2006b, p. 10).

According to WHO's report *Investing in Mental Health,* cost-effectiveness is a measure that summarizes the efficiency with which an intervention produces desired health outcomes; "a <<very cost effective>> intervention can be defined as one that generates an extra year of healthy life for a cost that falls below the average annual income per person" (WHO, 2013a, p. 18). Yet, most studies on the effectiveness or cost-effectiveness of mental health interventions have been carried out in North America, western Europe or Australia, with very few available in LAMICs (V. Patel et al., 2007).

Cost-effectiveness of care varies according to the interventions that are selected for different MNS disorders. "For example, antiretroviral treatment, which is firmly on the international public-health agenda, is as cost-effective as treatment for depression delivered in primary care" (Saraceno et al., 2007, p. 1167). The combination of pharmacological treatment with psychosocial treatment for severe MNS disorders, such as schizophrenia and bipolar affective disorder, is more cost-effective than pharmacotherapy alone; and psychotherapy is expected to be as cost-effective as generic versions of newer antidepressant drugs used to treat depressive and anxiety disorders. However, the issue with psychosocial interventions is that their delivery is more time-consuming than pharmacotherapy and many low-resource settings lack sufficient human resources to provide them (WHO, 2006b, p. 8).

According to the WHO (Ibid.) a defined package of cost-effective mental health care interventions consisting of community based drug and psychosocial treatment for schizophrenia and bipolar affective disorder, and primary care based pharmacological treatment of depressive and anxiety disorders is estimated to cost US$ 3-4 per capita in low-income settings and up to US$ 7-9 in more middle-income regions (such as Latin America)(Ibid.). "For every US$ 1 million invested in such a mental health care package, it is estimated that 350 to 700 healthy years of life would be gained over and above what would occur without intervention" (Ibid.).

Affordability, which is defined in terms of the actual cost of implementing interventions, must also be taken into consideration when selecting packages of care or specific interventions to be implemented in low-resource settings (WHO, 2013a, p. 18). According to the WHO, an expenditure of US$ 0.50 per capita is the threshold for considering an intervention to be "very affordable/low-cost", and US$ 1 for "quite affordable/low-cost (Ibid., p.18).

Chisholm et al. (2007) defined an essential package of mental healthcare comprising pharmacological and/or psychosocial treatment for schizophrenia, bipolar disorder, clinical depression and hazardous alcohol use, and carried out a very thorough calculation of the resource needs and costs associated with its implementation during a 10 year period. The selection of interventions included in the package was based on cost-effectiveness analyses in 12 LAMICs, including Chile (Upper-middle income) and Paraguay (Lower-middle income) in the Latin American region; the rest of the countries included in the study were Ethiopia, Nepal, Nigeria (low-income), Albania, China, the Islamic Republic of Iran, Morocco, Thailand, Ukraine and Vietnam (lower-middle income). The cost of providing the package of care (excluding training, capital, and other program costs) was estimated to be $0.10-0.20 per capita total population for the low-income countries and from $0.50 (in the Hunan province in China), Morocco and Paraguay up to $1.20-1.25 in Albania,

Thailand and the Islamic Republic of Iran. In Chile, the only upper-middle income country included in the study, the expenditure raised to $3.19. According to the study, the additional cost of extending care over a 10-year period is of "around $0.20 per capita per year for low-income countries and $0.30 for lower-income countries, leading to a total financial outlay of up to $2 per person in low-income countries and $3-4 in lower-middle-income countries by 2015" (Chisholm, Lund, & Saxena, 2007, pp. 532-534; Lancet Global Mental Health et al., 2007).

Current data on affordability provides enough economic justification for investing in cost-effective mental healthcare as there is for other chronic conditions such as anti-retroviral therapy for AIDS and glycemic control for diabetes or cholesterol control with statins (WHO, 2006b). However, in addition to cost-effectiveness and affordability, the feasibility of implementation in a given health system must also be considered.

> "Feasibility is defined by: (1) reach (capacity of the health system to deliver an intervention to the target population); (ii) technical complexity (technologies needed for an intervention); (iii) capital intensity (amount of capital required); and (iv) acceptability (including fairness and human rights)" (WHO, 2013a, p. 18).

According to evidence, economic analysis have indicated that treating depressive disorders in primary care settings with generically produced anti-depressant drugs and brief psychotherapy is feasible, relatively affordable (less than US$ 1) and very cost-effective (WHO, 2013a, p. 19). In the case of epilepsy, its diagnosis and treatment with first-line antiepileptic drugs is one of the most cost-effective interventions for non-communicable diseases, it is very affordable and feasible at the primary level (Ibid., p.18). Furthermore, it has been found that a combined approach of older antipsychotic drugs and psychosocial support to treat psychosis is a quite cost-effective intervention and feasible at the primary level, although some referral to more specialized services must be needed, making it less affordable (Ibid., p19).

In the case of psychosocial care, although there is increasing evidence on its cost-effectiveness, either combined with pharmacotherapy or by itself, the extra cost of training human resources within the primary and secondary level becomes a barrier for its implementation in resource-constrained settings (Lancet Global Mental Health et al., 2007). Shifting away from currently used inefficient structures and practices, such as providing most care at specialized hospitals, to a more cost-effective allocation of resources implies "a potentially major reorganization of the mental health system, not only in terms of strategic policy but also in terms of other dimensions including human resource development and deployment, buildings (primary care and district hospitals), and drug procurement / distribution"(WHO, 2006b).

The absolute amount of financial resources needed to scale up services is not large when compared with estimates of the funding required to tackle other major contributors to disease burden, however, it would be a dramatic shift from current budgetary allocations for mental healthcare in low-resource settings. Consequently, "the development or upgrading of mental health services in low-income and middle-income countries need not be derailed on the grounds that it will make unreasonable or excessive demands on future budgetary allocations" (Lancet Global Mental Health et al., 2007, p. 1248)

3. The Mental Health Gap Action Program

The lack of human, financial and technical resources has important consequences for every aspect of mental health (Cohen et al., 2014, p. 16). Concerted efforts by key political and scientific stakeholders have resulted in accumulated evidence on how to overcome these barriers and move forward in the process to scale up mental health services and to reduce the treatment gap. Part of these efforts has been the development of packages of care and intervention guidelines to care for people with MNS disorders in LAMICs and other low-resource settings.

The WHO recognizes the urgent need for action to reduce the burden of MNS disorders worldwide, especially in resource poor settings, and developed a program grounded on the best available scientific and epidemiological evidence about MNS disorders with the objective of assisting countries in the process of scaling up mental health services. The Mental Health Gap Action Program (WHO, 2008) aims to maximize impact by reinforcing the commitment of governments and other stakeholders to increase the allocation of financial and human resources for mental healthcare and to increase coverage via key interventions in countries with low and lower middle incomes which carry most of the burden of MNS disorders (WHO, 2008, p. 4).

The mhGAP recommends the integration of mental health care into primary care which enables the largest number of people to get easier and faster access to services (WHO, 2008, p. 17). However, to ensure success, the Program must be adapted to local contexts, taking into consideration the health system capacity as well as local needs, aspirations and resources. It is then important to highlight that the Program and Intervention Guide focus in providing a protocol of care and does not guide countries in service development processes. Therefore, program planners interested in scaling up the mhGAP Program in resource-poor settings are in need of support in the process of planning for and implementing the program.

Although "(t)here is a widely shared but mistaken idea that improvements in mental health require sophisticated and expensive technologies and highly specialized staff" (Chan, 2010, p. iii), growing

evidence suggests that non-specialized health personnel (i.e lay people and health workers) can be trained to deliver basic health interventions in non-specialized settings.(Eaton et al., 2011, p. 1597; WHO, 2008). Following the publication of the mhGAP Action Program, in 2010, the WHO released the "Mental Health Gap Action Program Intervention Guide" (mhGAP-IG), a technical tool to facilitate the program's implementation in non-specialized health settings (WHO, 2010a). The mhGAP-IG takes into consideration the existing barriers for scaling up and is based on the premise that "primary care providers can be trained to deliver both psychological and pharmacological interventions for some of the most common mental disorders with the provision of supervision and support by more highly trained health providers, including specialists"(Gureje & Stein, 2014, p. 33).

The mhGAP-IG consists of an integrated package of interventions for prevention and management of nine priority conditions: depressive disorders, schizophrenia and other psychotic disorders, suicide, epilepsy, dementia, alcohol use disorders, substance use, and mental disorders in children. "Priority conditions were identified on the basis that they represented a high burden (in terms of mortality, morbidity, and disability); caused large economic costs; or were associated with violations of human rights" (WHO, 2008, p. 4).   It is designed to guide non-specialists, trained in its use, in the process of assessing people with MNS disorders and providing them with a set of pharmacological, non-pharmacological and psychosocial interventions at non-specialized settings (WHO, 2010a, p. 3). Since the mhGAP-IG is a model guide to increase the capacity of the primary care system to deliver mental healthcare, "decisions about how best to deliver the chosen interventions at health facility, community, and household levels are critical to ensure maximum impact, high quality, and equitable coverage of the interventions" (WHO, 2008, p. 17).

The mhGAP-IG is very user friendly; it includes a section called "General Principles of Care" which provides users with good clinical practices for interacting with people seeking mental health care and a "Master Chart" that guides the clinician through the modules by providing basic information of each of the nine priority disorders. Each priority disorder has a module identified with a specific color, with two sections: the first one is the "Assessment and Management Section, and the second one is the "Intervention Details" (WHO, 2010a, pp. 3-4). This organization helps the clinician use the module very easily when in the process of assessing a patient or deciding the treatment plan.

The intervention details divide in pharmacological interventions and non-pharmacological and/or psychosocial interventions. Each of the modules helps the clinician decide what intervention to use according to the patients needs, either only prescribing medication or combining it with other non-pharmacological interventions such as psychoeducation or structured physical activity. In some cases, there can be a recommendation to use "Advanced Psychosocial Interventions", which are

more time consuming for the care provider to learn and then provide. This can be an issue in settings where trained human resources are very scarce and have very little time per patient (WHO, 2010a, p. 4).
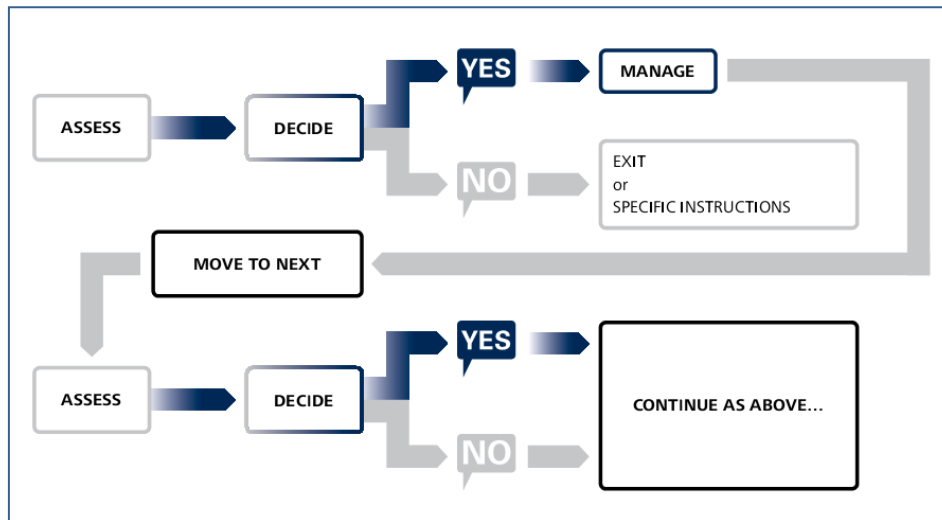
Along with efforts made by the WHO, PLoS Medicine synthesized evidence on management of six MNS disorders in a series of Packages of Care including management of alcohol use disorders, schizophrenia, epilepsy, depressive disorders, dementia and attention-deficit hyperactivity disorder (Benegal, Chand, & Obot, 2009; Flisher, Sorsdahl, Hatherhill, & Chehil, 2009; Mari, Razzouk, Thara, Eaton, & Thornicroft, 2009; Mbuba & Newton, 2009; Patel & Thornicroft, 2009; V. Patel, Simon, Chowdhary, Kaaya, & Araya, 2009; M. J. Prince, Acosta, Castro-Costa, Jackson, & Shaji, 2009). This series of packages of care is designed to be entirely complementary to the mhGAP initiative and intends to answer questions about how to improve treatment and care delivery in low-resource settings to achieve optimal long-term clinical and social outcomes. (Patel & Thornicroft, 2009, p. 1)

4. Innovative Mental Health Care Delivery Strategies

Tools and packages of care, such as the ones presented in the previous section must be scaled up within a well-organized health system in order to be implemented effectively. However, very often, low-resource settings fail to follow current basic recommendations on how to scale up mental healthcare. Evidence shows that there are ways of maximizing resources by using innovative and cheaper alternatives that may already be available in communities, but have not been traditionally used in mental healthcare (Kakuma et al., 2011, p. 1165) In this section, four strategies with a strong evidence-based are suggested: Re-organization of mental health services, integration of mental healthcare into primary care, the development of a diverse mental health workforce, and the use of technological tools. In addition, an online repository of over 60 mental health innovations has been

set up by the Mental Health Working Group and made available at "www.mhinnovation.net/innovation" (V. Patel & Saxena, 2014, p. 3), planners and key stakeholders are strongly advised to consult them, since they have been identified by high-profile experts as likely to make a difference in scaling up mental health services.

a) Re-organization of mental health services

The organizational structure of mental health services affects treatment coverage for different MNS disorders (WHO, 2006b). Low-resource settings, including but not limited to LAMICs, face difficult obstacles to effectively deliver packages of mental healthcare such as the mhGAP-IG. The high divergence between each country's economic and political context, including the organization of its health system, calls for the development of care delivery strategies that follow broad principles and are sensible to local application (World Health Organization & WONCA, 2008, p. 11). It has been found that "innovative strategies involving healthcare systems, mental health professionals, and consumers are needed to close the mental healthcare treatment gap and make the best use of available resources" (Rebello et al., 2014, p. 308).

Health system's organization and healthcare agencies' structures differ between countries, but in general terms three different levels of care can be distinguished in formal health care, in reference to the type of care provided. Primary care facilities provide the most basic care, usually ambulatory; general care facilities offer more services, including in-patient care; and tertiary care refers to specialized facilities such as psychiatric hospitals. Depending on each country's resources and health structure mental health services are provided either in primary care clinics, community-based clinics, outreach clinics, general hospitals or long-stay specialized facilities. Access to specialized health workers also varies at each level of care. Availability of mental health specialists at primary or secondary care, such as psychiatrists, psychologists or mental health nurses, vary not only across countries but also between urban and rural regions of the same country (World Health Organization & WONCA, 2008).

Despite the fact that psychiatric hospitals are still the primary mental healthcare provider in many countries, evidence suggests that most services should be delivered in decentralized locations such as community care or primary care, with an integration between non-specialized and specialized services via collaboration, task-sharing and appropriate referral between levels of care (Eaton et al., 2011; World Health Organization & WONCA, 2008). The collaborative care or shared care model proposes the joint consultation and interventions between primary care providers and mental health specialists. This approach increases the skills of primary care workers and builds mental health

networks, and has been effectively used to provide ongoing support to primary care workers in Australia, Brazil and South Africa (V. Patel et al., 2013).

Based on the principle that "no single service setting can meet all population mental health needs" (World Health Organization & WONCA, 2008, p. 15), the WHO developed *the WHO Service Organization Pyramid for an Optimal Mix of Services for Mental Health*. The model, in which integrated primary mental healthcare is a main component, describes the optimal mix of mental health services based on "support, supervision, collaboration, information-sharing and education across the different levels of care" (Ibid.).

Figure 2. WHO service organization pyramid for an optimal mix of services for mental health, original source diagram.

(World Health Organization & WONCA, 2008, p. 16)
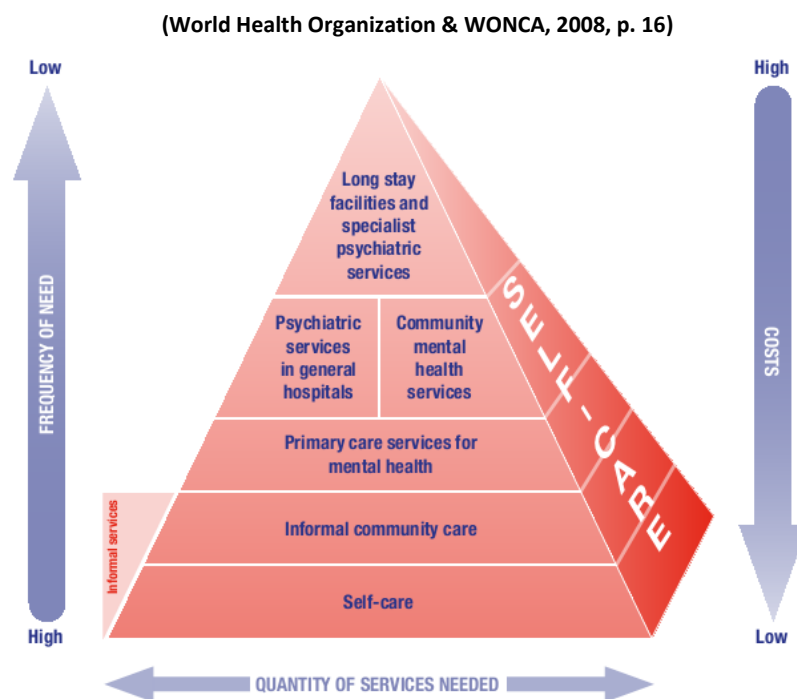
The pyramid goes through the different levels of care available in health systems, ranging from formal care in long-stay facilities or specialized hospitals, psychiatric care in general hospitals, community mental health services and primary care services for mental health, to informal services such as community care and self-care. It showcases the relationship between cost, quantity of services needed and frequency of need; with long-stay facilities and specialized psychiatric hospitals appearing at the very top of the pyramid as the most costly and least necessary in quantity and frequency of use (Ibid., p.16), and primary care services as the most necessary and least costly setting to provide formal mental healthcare. According to the model, in order to ensure adequate mental healthcare a "clear referral, back-referral and linkage system should be implemented in consultation with health managers and health workers at all service levels" (Ibid., p.19).

a) Integrating mental healthcare into primary care

There is a widespread recognition in the global health community that providing care at the primary level is the best way to improve access to care to most populations. In remote settings for example, it is more likely to find pre-established primary care infrastructure than at any other level of care provision (Rebello et al., 2014, p. 308). Several other reasons why mental health should be provided at first-line services have been identified by the WHO (2008) and summarized by Eaton et al. (2014); these include (1) mental and physical needs are linked, offering care at general care settings improves access to holistic care; (2) the prevalence of MNS disorders is to high, resources available at specialized and general hospitals do not suffice to cover the population's needs; (3) the majority of care needed is best delivered at general care settings; (4) providing care at non-specialized levels reduces the stigma and human rights violations, people no longer have to receive care separately; (5) healthcare services at this level are cost effective for service providers, service users, and their caregivers (p.306).

Consequently, there is now accepted consensus on the need to integrate mental health services into non-specialized health settings in order to reduce the treatment gap in LAMICs (V. Patel et al., 2013; WHO, 2013b; World Health Organization & WONCA, 2008). In this line, and to help planners in this decentralization process, the WHO along with the World Organization of Family Doctors (Wonca) issued a comprehensive report on the rationale and strategies for the integration of mental health services into primary care, providing key stakeholders with the following 10 common principles drawn from a detailed analysis of how a range of health systems have successfully achieved integration:

1. *"Policy and plans need to incorporate primary care for mental health;*
2. *Advocacy is required to shift attitudes and behavior;*
3. *Adequate training of primary care workers is required;*
4. *Primary care tasks must be limited and doable;*
5. *Specialist mental health professionals and facilities must be available to support primary care;*
6. *Patients must have access to essential psychotropic medications in primary care;*
7. *Integration is a process, not an event;*
8. *A mental health service coordinator is crucial;*
9. *Collaboration with other government non-health sectors, nongovernmental organizations, village and community health workers, and volunteers is required;*
10. *Financial and human resources are needed" (World Health Organization & WONCA, 2008, p. 49).*

Furthermore, integration brings a number of benefits to the population such as improving access to care by making services available closer to people's homes, thus reducing the cost of seeking specialist care at a distant location; and keeping families together and maintaining their daily activities. From a health management perspective; care provision (i.e. health workers, equipment

and facilities) at the primary level is less expensive than doing so at secondary or tertiary level for patients, communities and governments alike; integration is affordable and cost-effective, giving a high return on investment. Furthermore, it facilitates community outreach and mental health promotion, as well as long-term monitoring and management of service users (World Health Organization & WONCA, 2008, p. 22). From a clinical point of view, numerous studies in a range of settings including LAMICs, have proven that mental disorders can be effectively assessed and treated in primary care, attaining the best health outcomes as a result (World Health Organization & WONCA, 2008, p. 41).

The integrative model has the potential to enhance quality of care and help-seeking behavior by counteracting the barriers related to costs and to stigma associated with psychiatric hospitals (Rebello et al., 2014, p. 308). However, for the model to work appropriately, primary care facilities must have a reliable supply of psychotropic medications along with the availability of other more specialized resources, such as day hospitals and psychiatric care units with beds, to support non-specialists providing mental health care at non-specialized health settings. (V. Patel et al., 2013; World Health Organization & WONCA, 2008). "There is also the risk of placing additional workload on an already overburdened system if adequate resources, supervision, referral processes, and access to follow-up are not in place" (Rebello et al., 2014, p. 310). Therefore, the provision of mental healthcare at this level must be coordinated with a network of services at the secondary and tertiary level to be fully effective and efficient (Ibid., p310).

Numerous low- and middle-income countries, including some in Latin America and the Caribbean, have successfully made the transition to integrated primary care for mental health. For example, in the province of Neuquén, a rural and urban setting in in Southern Argentina, primary care physicians lead the diagnosis, treatment and rehabilitation of patients with severe mental disorders with support from mental health specialists who review and advise on complex cases (World Health Organization & WONCA, 2008). Also in Argentina, in the Patagonian state of Rio Negro, the psychiatric hospital was closed and psychiatric beds in general hospitals and halfway houses were opened. Mental health teams were created in local general hospitals to provide supervision to care providers and direct care to patients that have been referred from primary care (Collins, 2008; as cited by Razzouk, Gregorio, Antunes, & Mari, 2012, p. 191). In Belize, a nationwide approach lead to the training of psychiatric nurse practitioners as a specialized workforce responsible of providing care at a community level and training primary care providers in management of MNS disorders (World Health Organization & WONCA, 2008). "The nurses are supervised by the two psychiatrists

available in the country and they participate in the admission and discharge of patients, review side effects of medication, and perform psychotherapy (Razzouk et al., 2012, p. 192).

In Brazil, four different successful efforts can be highlighted. In Sobral, a city of 175.000 inhabitants in the state of Ceara, a collaborative care approach was taken; primary care practitioners conduct physical and mental health assessments for all patients, treating them if they feel capable or requesting support from a specialist mental health team who visits family care centers regularly (World Health Organization & WONCA, 2008). In Campinas, a city in the state of Sao Paulo of about 1 million inhabitants, the mental health system is now based in 24 hours specialized mental health community centers which provide care to people with moderate to severe MNS disorders and uses mental health teams to provide support and technical supervision to primary care providers (Figuereido & Campos, 2009; as cited by Razzouk et al., 2012, p. 192). Also in Sao Paulo, in the city of Santos, the mental health reform started with the shutdown of the city's mental health hospital and the implementation of community mental health services. Today, there are 5 community mental health centers, 6 outpatient mental health services, 25 psychiatric beds available in both the community center and in the general hospitals and 13 mental health teams working in primary health centers. Even with such offer of services, some patients end up being hospitalized at facilities far away from the city (Razzouk et al., 2012, p. 192). Finally, in Belo Horizonte, a city with a population of about 2,5 million inhabitants, community mental health centers were adapted to deal with severe cases of MNS disorders that used to be referred to the psychiatric hospital (Siveira & Alves, 2003; Oliveira et al., 2008; as cited by Razzouk et al., 2012, p. 192)

In Chile, the impact of a trial showing that depressive disorders can be treated in a low cost way led the government to scale up treatment for this disorders nationwide. The mental health system is now based in primary care and general hospitals with support from psychiatric specialized teams and psychiatric hospitals (Araya, Flynn, Rojas, Fritsch, & Simon, 2006; Razzouk et al., 2012, p. 193). More specifically, in the district of Macul in Santiago of Chile, general physicians in a family health center diagnose MNS disorders and prescribe medications where required, psychologists provide psychotherapy, families have supportive functions and specialists at a mental health community center provide on-going support and supervision to non-specialist care providers (World Health Organization & WONCA, 2008).

In Cuba, although the mental health system operates at three levels of care, community centers coordinate, organize and train human resources in mental health all over the country, which dramatically increased coverage (1 center for 30.000 people) (Hernandez et al., 2002; as cited by Razzouk et al., 2012, p. 193). Finally in Jamaica, Mental Health Officers, "who are specialized trained

nurse practitioners, exposed to knowledge in community psychiatry, psychology, social work, psychopharmacology, and patient management", see patients in primary care and outpatient clinics, where they provide crisis management, home treatment and assertive outreach care; complex cases are referred to more specialized services (Collins & Green, 1976; McKenzie, 2008; as cited by Razzouk et al., 2012, p. 193).

In these and other integration efforts of developing a collaborative and multi-disciplinary team-based approach, clear treatment pathways, defining lines of responsibility for each kind of care provider and referral of complex cases to more specialized care, are some of the lessons learned. In addition, Chile's case showcases the power of well conducted trials to influence policy and successfully scale up mental health services to a national level.

b) *Build a diverse mental health workforce*

Despite the existing evidence on the efficacy of psychosocial interventions for treating MNS disorders in various settings, including LAMICs, the human resources to implement such interventions are scarce (Clarke, King, & Prost, 2013; V. Patel et al., 2009; Rebello et al., 2014; van Ginneken et al., 2013). Furthermore, the difficulty of giving increased responsibilities to already overburdened primary-care staff is often cited (Eaton et al., 2011; World Health Organization & WONCA, 2008). An innovative approach with growing evidence on overcoming barriers related to human resource shortage is to diversify and further develop the mental health workforce of a specific setting via Task-shifting or Task-sharing. "Task-shifting is a method of strengthening and expanding the healthcare workforce by redistributing the tasks of delivering services to a broad range of individuals with less training and fewer qualifications than traditional health care workers (i.e. doctors, nurses)" (Kazdin & Rabbitt, 2013, p. 173) ; task-sharing is a related term often distinguished from task-shifting to refer to lesser trained individuals working with specialized care providers (Ibid., p.185). Although this strategy was initially used to treat infectious and non-communicable disease, and improving life conditions and education of populations, it was then extended to mental health because of its ability to be scaled up successfully in multiple countries (developed or developing), cultures and local conditions, including across different types of healthcare needs (Ibid, p. 174).

The task-shifting or task-sharing approach allows a very efficient use of non-specialists, who are available in greater numbers than mental health specialists and are often already embedded in the health system at the primary and secondary levels. Different types of general care workers, such as physicians, nurses, community health workers, health technicians, paramedics and even non-healthcare community agents such as caregivers and peer support workers can be trained to provide

basic mental healthcare (Rebello et al., 2014). "Certain skills and competencies are required to effectively assess, diagnose, treat, support and refer people with mental disorders; it is essential that primary care workers are adequately prepared and supported in their mental health work" (World Health Organization & WONCA, 2008, p. 11). Collaborative and shared cared models, cited in the previous section, are an especially promising way of ensuring that non-specialized health workers receive on-going training and support (World Health Organization & WONCA, 2008, p. 51).

Although fairly new, there is now a compelling evidence base for task-shifting in mental healthcare in developing countries (V. Patel, 2009). Multiple studies have shown that non-specialized workers such as lay people and community health workers can be trained to deliver pharmacological, psychological and psychosocial interventions for depressive and anxiety disorders, schizophrenia and dementia, among other MNS disorders, in a diverse range of low-resource settings (V. Patel, 2009; Rahman, Malik, Sikander, Roberts, & Creed, 2008; WHO, 2008). The task-shifting approach surpasses the collaborative and shared care models by extending the roles and tasks of mental health specialists beyond the training phase to also being responsible of providing on-going supervision, ensuring quality of care and supporting the non-specialized workforce that is providing mental healthcare at non-specialized settings (Patel & Kirkwood, 2009; mentioned by V. Patel, 2009).

In addition, task-shifting and training non-specialist carers is a particularly attractive model when compared to the resources and infrastructure needed to train and retain specialists. It could be both more efficient and economical to conduct mass training for non-specialized workers in low-resource settings such as LAMICs (Araya et al., 2006; Buttorff et al., 2012; as cited by Rebello et al., 2014).

c) Use technological tools

Scaling up mental health services to low-resourced remote and rural regions implies facing a series of difficulties regarding, not only the increased insufficiency of trained human resources, but also added costs related to transportation and time of mental health specialists who travel to remote areas to provide care and support and supervision to general care workers. Due to the fact that over the last few years global access to technological innovations and communicative devices has increased, attention has been called by the WHO on the utilization of technological tools as a means of scaling up mental health. (WHO, 2013b)

The use of technology to reach rural and remote communities is gaining momentum as evidence on the success of its implementation for scaling up mental health services becomes available (V. Patel & Saxena, 2014, p. 11). It has been found that technological innovations such as telemedicine, mobile phones and internet based tools can help bridge the treatment gap attributed to MNS disorders. " They enable mental health specialists based in urban areas to supervise non-specialist workers and

provide consultations with service users" (ibid, p.11) In addition, the use of computer assisted self-guided psychological therapies is another innovative approach based on technology that has been successfully used in some settings; it consists on automated care provision available on the internet and accessed via computer, tablet, phone or similar devices. " Such interventions have low marginal costs, are accessible in populations with good access to the internet and have been shown to be very effective in randomized controlled trials" (Ibid, p.54).

However, the implementation of these kinds of interventions at a local, regional or national level require an increased access to technology that might be difficult to make available at low-resource settings. For example, making sure computers or phones are available to users might not be so difficult at a setting that the use of technological devices is high among the population, but having access to reliable internet platforms might be harder to obtain. These considerations must be taken before deciding to use technology to scale up mental health services in a low-resource setting.

Chapter 2: Study Design & Methods

I. Study Design

1. Research question

The high prevalence of MNS disorders worldwide alongside the long-established lack of prioritizing of mental health in the public health agendas of countries has resulted in an imposing treatment gap worldwide (Whiteford & Baxter, 2013, p. 1575; WHO, 2001a). Most people in the world who have a mental illness do not receive effective treatment (Thornicroft & Tansella, 2013, p. 849). This gap is especially burdensome in low- and middle-income countries, but extends to low-resource settings in high-income countries as well. The scarce budget allocation to scale up mental health services is a very difficult barrier to overcome in countries where the overall mental health budget is between 1% and 2% of the national health budget and where most of the budget allocated to mental health is used to provide care at dated and expensive long-stay specialized facilities, such as psychiatric hospitals (WHO, 2001b, p. 3).

The insufficiency of adequately trained human resources available at rural and remote settings for mental healthcare provision must be taken into consideration as one of the major barriers when engaging in efforts to reduce the treatment gap. In most LAMICs, mental health specialists are very limited in number and available mostly in specialized facilities in main cities of countries, making access to care difficult for the majority of the population (Kakuma et al., 2011, p. 1654). The lack of trained workforce is a huge challenge when governments intend to follow expert recommendations regarding scaling up mental healthcare coverage via integration of mental healthcare into general care. In addition, it has been found that decision makers in charge of planning for scaling up mental health programs lack the technical expertise to make decisions with a public health perspective (Lancet Global Mental Health et al., 2007, p. 1250). Understanding how health systems function, in terms of wider patterns of care and organization of interdependent services, is key for program planners and decision makers to make accurate decisions regarding cost-effective and affordable strategies that cater to public health needs and local resources. Accordingly, despite the overwhelming treatment gap and shortage of resources for mental healthcare, there is now sufficient evidence about innovative cost-effective and affordable ways of providing comprehensive and good quality mental healthcare in low-resource settings (WHO, 2008).

Since public health programs can only deliver benefits if they are able to sustain activities over time (Schell et al., 2013, p. 7), strategies must not only to be cost-effective and affordable but also

consider sustainability. In this study, sustainability is understood as "the small set of organizational and contextual factors that build the capacity for maintaining a public health program over time" (Ibid.), that is the ability of a mental health program to maintain its programming and health benefits over time. Aiming for sustainability is critical when planning for scaling up mental health services at low-resource settings, because if a program does not have sustainability capacity, there can be a waste of money and resources, a damage in trust between the program and the community and a limitation in the program's ability to achieve its public health goals (Goodman & Steckler, 1989, mentioned by Schell et al., 2013, p. 8).

To better understand how sustainability can be achieved, Shell et al. (2013) developed a framework for public health program capacity, that specifies nine basic domains for *sustainability capacity*, understood as "the existence of structures and processes that allow a program to leverage resources to effectively implement and maintain evidence-based policies and activities". The domains identify the internal or external locus of control, specifying which kinds of activities are managed primarily within the program itself (Organizational Capacity, Program Adaptation, Program Evaluation, Communications, and Strategic Planning) and which ones are influenced by factors external to the program (Public Health Impacts, Funding Stability, Political Support, and Partnerships). This framework facilitates the task of public health decision makers and program managers of organizing a coherent approach to program sustainability strategic planning, and may be beneficial if used to plan for scaling up mental health services in low-resource settings.

On the other hand, in the last decade, a series of international programs, guidelines and packages of care have been developed to help clinicians provide good quality mental healthcare in resource-constrained settings. The mhGAP Program is the WHO's effort to assist low- and middle-income countries in the scaling up of mental healthcare via an easy-to-use tool for the integrated management of MNS disorders in non-specialized health settings, and is considered to be the most comprehensive and well-grounded package of care for the treatment of MNS disorders available to date. The guide provides a full range of recommendations to facilitate high-quality care at non-specialized health facilities. however, despite being very specific in terms of what to do, however, it does not specify how to accomplish it (WHO, 2010a). To date, "there are few evidence-based resources and no validated tools available to help public health program practitioners ensure their programs will be sustainable over time" (Schell et al., 2013, p. 7). Therefore, although sufficient data on good quality, cost-effective and affordable treatment is available, efficient and strategic implementation approaches that consider current resource availability at these settings are not

abundant. Research is very much needed to identify the most effective ways to deliver sustainable mental health services (Eaton et al., 2011).

So, how can improving access to mental healthcare in low-resource settings be done in a sustainable way?

When referring to treatment for MNS disorders, more attention has been placed on the pharmacological aspect of care, making sure medications are developed by the pharmaceutical industry and made available at health settings, either private or public. Nonetheless, according to the WHO Mental Health Report, pharmacological treatment is just one aspect of mental healthcare and should always be provided in combination with psychotherapy and psychosocial rehabilitation (WHO, 2001a, p. xvii). The mhGAP Program, takes into consideration these three aspects of care mentioned before and systematizes them in an easy-to-use Intervention Guide (mhGAP-IG) developed to be used by general healthcare providers (general physicians, family physicians, nurses, and clinical officers) working at first- and second-level facilities (i.e. primary care clinics or district hospitals) to guide them in the process of assessing patients, making decisions regarding their treatment plan and providing care. Delivering interventions as packages has been found to be the most cost-effective option in terms of training, implementation, and supervision; since many of them go naturally together and can be delivered by the same person at the same time (WHO, 2008, p. 10).

Pharmacological, non-pharmacological and psychosocial interventions for prevention and management of MNS disorders, along with a set of Advanced Psychosocial Interventions consisting of different forms of psychotherapy, have been included in the mhGAP-IG for nine priority conditions. The Advanced Psychosocial Interventions section has the special consideration that their delivery requires extra human resources because of their complexity and time-consuming nature (WHO, 2010a). The mhGAP Program identified depressive disorders, psychosis, epilepsy and seizures, developmental disorders, behavioral disorders, dementia, alcohol use disorders, drug use disorders and self harm or suicide to be priority MNS conditions on the basis that they represent a high burden (in terms of mortality, morbidity, and disability); cause large economic costs; or are associated with human rights violations. Each intervention was selected based on evidence about its efficacy and effectiveness, cost-effectiveness, equity, ethical considerations including human rights, feasibility or deliverability, and acceptability (WHO, 2008, 2010a). In addition, aiming to assist clinicians provide good quality yet affordable care, the mhGAP-IG proposes a very complete model guide with protocols of care based on a the best available evidence on treatment of MNS disorders (WHO, 2010a).

However, this tool it is intended for clinicians not for program planners; and the actual implementation of the mhGAP Program, at any specific setting requires an adaptation process for which guidelines are not provided. Program planners have to find ways of adapting the mhGAP program to their setting and improving how health services are organized, even with limited resources, so that those who need them can make full use of them (WHO, 2001a, p. xiii). Most often, due to scarcity of resources for mental health in low-resource settings, the process of adapting the mhGAP to the country's health system must be accomplished with inadequate resources. Although ample recommendations have been made on effective ways to tackle most common barriers effectively, such as the integration of mental health into primary care and the diversification of human resources to overcome resource shortage and improve access to care (Eaton et al., 2011), the lack of public health management expertise among planners makes the task of carrying them out effectively even more complex for local stakeholders.

Figure 3. The Wheel of Global Mental Health

(as developed by Samuel, Schuetz-Mueller & Katz, in press)
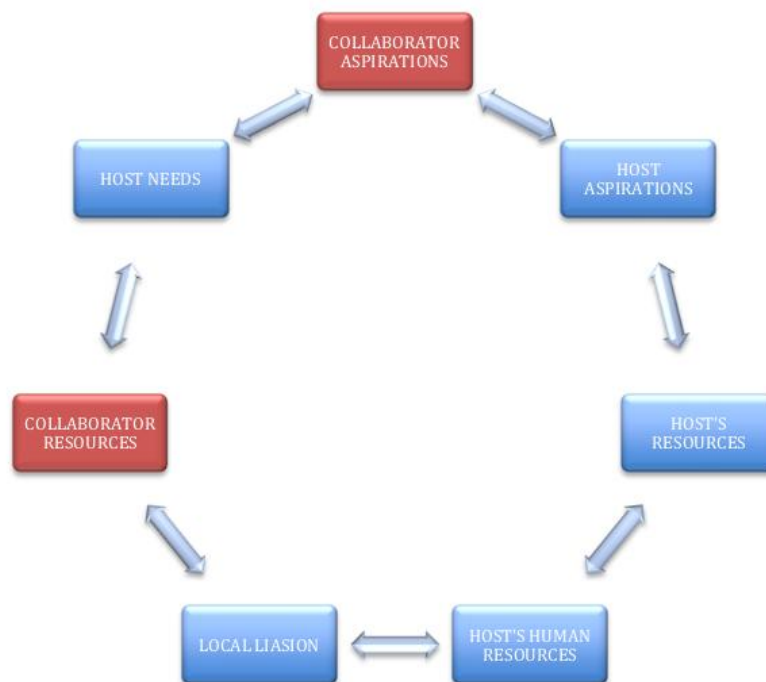
To better understand the relationship between key elements necessary when embarking on practicing mental health in low-resource settings, the Wheel of Global Mental Health (Samuel, Schuetz-Mueller, Katz, in press) identifies 7 mutually interdependent components: Host's Needs, Host's Aspirations, Host's Human Resources, Host's Other Resources, Local Liaison, Collaborator's Aspirations and Collaborator's Resources. They are arranged as a wheel because a change in one of the components dynamically affects the status of the other (Figure 3). According to this model,

when engaging in efforts to scale up mental health services, there are usually two parties involved, one which represents the local setting or organization that wants to implement a specific mental health service and another, or several, that serve as a collaborators to what the Host wants to accomplish (Samuel et al., in press). Using the Wheel of Global Mental Health as framework allows for a better understanding of each stakeholder's needs, aspirations, roles and resources when planning to establish a mental health program within a health system in a low-resource setting.

In order to achieve sustainability, obtaining and maintaining resources throughout the planning and implementation stages of a program is key. Due to the fact that in most low-resource settings mental health specialists are insufficient or even non-existent, and that general care providers are overburdened, ensuring a sustainable and adequately trained mental healthcare workforce is a complex but necessary task in order to implement the mhGAP Program at a national or regional level.

If considering that all necessary drugs were available at the primary or secondary care facility where the mhGAP is to be implemented, delivering the pharmacologic component of the Program less problematic in terms of human resource needs; since assessing, diagnosing and prescribing medication for MNS disorders does not vary much from pharmacotherapy for other illnesses currently being managed at non-specialized health facilities. In addition, pharmacotherapy is not a considered to be a very time-consuming task and can be easily taught and delivered by general care physicians (Kakuma et al., 2011). However, the issue of human resource scarcity becomes more pressing when the interventions to be delivered are more complex and time-consuming, as are basic and advanced psychosocial interventions for MNS disorders included in the mhGAP-IG.

In order to truly improve access to care for people with MNS disorders, and to follow international recommendations regarding the three basic components for treating MNS disorders, scaling up mental health care must always include the psychosocial care. Integration of the psychosocial care component of the mhGAP Program is not as easy to carry out in settings were care providers have very little time per patient and almost no training and experience providing these type of interventions. Planners and local stakeholders face the task of identifying what human resources are available, affordable and capable to provide these interventions within their health system. Due to the fact that most often planners and other stakeholders in low-resource settings work with very small budgets for mental health services, when planning to scale up mental healthcare, taking a low-cost approach that ensures quality of care is essential. Strategies to maximize local existing resources by using evidence-based, innovative and affordable methods that have not been traditionally used in mental healthcare are available (Kakuma et al., 2011). However local planners

and key stakeholders in low-resource settings are not necessarily aware of them, and continue to chose dated, less effective and less affordable strategies. The development of pragmatic models that clearly guide implementation of mental health programs is necessary (Thornicroft & Tansella, 2013) and findings must be made available to those in need of support.

Therefore, due to the added complexity of scaling up psychosocial care in low-resources settings, the development of a practical and low-cost model for psychosocial care delivery that complements the implementation of the mhGAP Program would assist key stakeholders in the decision-making process for program implementation. Such Model should be developed following the recommendations of current global mental health evidence on how to scale up mental health services in low resource settings. Subsequently, program planners and other key stakeholders would have easier access to evidence-based information and strategies on how to improve access to care for MNS disorders at low-resource settings, hence, reducing the treatment gap.

2. Statement of purpose:

This study intends to respond to the need of reducing the treatment gap of mental, neurological, and substance use disorders by assisting in the efforts of increasing access to mental healthcare in low-resource settings. It proposes the development of a practical and affordable model for care delivery that complements mhGAP Program, specifically in terms of psychosocial care. It has been developed with a program planner's perspective with the aim to assist local program planners and other decision makers working at low-resource settings when facing decisions regarding the adaptation and implementation of the mhGAP program or similar evidence-based packages of care for MNS disorders at their local setting.

3. Main objectives

a) Develop a low-cost model for psychosocial care delivery that supports the implementation of the mhGAP Program in order to improve access to care at low resource settings;

b) Exemplify the use of the Model at real setting.

4. Specific Objectives

a) Identify a set of basic and affordable psychosocial care services that would improve access to care for people with mental, neurological and substance abuse disorders in low-resource settings

b) Identify the minimum basic resources necessary to effectively deliver psychosocial care in low-resource settings.

c) Determine an affordable and flexible organizational structure to deliver psychosocial care in non-specialized health settings.

d) Determine lines of action for the implementation of the model for psychosocial care delivery in Costa Rica.

5. Key assumptions

This study was carried out as part of a five-month internship in public health research at the Program in Global Mental Health at the Icahn School of Medicine at Mount Sinai in New York City, USA. The internship is an academic requirement to obtain the degree of Master in Administration of Public Health Policies and programs at the École des Hautes Etudes en Santé Publique (EHESP) located in Rennes, France. Therefore, some of the methodological choices, such as experts selected for interviewing, were made according to the resources already available within the Program in Global Mental Health.

The study also assumes that the mhGAP Program and Intervention Guide (WHO, 2008, 2010a) is the most comprehensive and well-grounded approach available to date for improving access to mental health care in non-specialized health facilities and low-resource settings.

The model for psychosocial care delivery was designed to be implemented at settings and health facilities where the basic WHO list of medication, or its equivalent, is already available along with the appropriate manpower to prescribe it.

Furthermore, although Costa Rica is an upper-middle income country and does not figure among the most resource-poor settings, it was chosen to exemplify the use of the psychosocial care delivery model because the researcher (KC) is native from Costa Rica, and is familiar with its context and mental health system. KC was trained as a psychologist at the University of Costa Rica and later practiced as a clinical psychologist in Costa Rican urban and rural settings. In addition to that, since 2012 the Ministry of health of Costa Rica, with collaboration from PAHO, has been working on the implementation of the mhGAP Program nationwide by training primary care physicians in its use. Thus, the Costa Rican health system provides this study with an excellent setting to exemplify the Model for Psychosocial Care Delivery, while assisting Costa Rican mental health stakeholders by providing them with evidence-based recommended lines of action to improve access to psychosocial care.

This study was supervised by Craig L. Katz (CLK), MD, associate clinical Professor of psychiatry and medical education, and coordinator of the Program in Global Mental Health at Icahn School of Medicine at Mount Sinai Hospital; and Amy Aloysi (AA), MD, assistant professor of psychiatry and

neurology and collaborator at the Program in Global Mental Health. Both CLK and AA were actively involved throughout the whole research process and served as a second and third researcher when data triangulation was necessary.

6. Scope

Although most of the consulted literature in the field of Global Mental Health refers to low- and middle-income countries, this study intends to develop a flexible model of psychosocial care delivery of that can be adapted for its use at different low-resource settings without regards to the overall level of income. This decision was based on the fact that even high-income countries have low-resource settings where the model could be useful. Despite this general approach, a focus in Latin America, and more specifically in Costa Rica, was made to better contextualize the needs and resources of this region and country.

Rather than intending to carry out an economic analysis of mental healthcare interventions or care delivery models, this study takes a qualitative approach to better understand key strategies for delivering psychosocial care at a low cost by building it on the basis of published literature recommendations and enriching it with acquired knowledge and experience of mental health experts working on the field in different low-resources settings around the world. Evidence on cost-effectiveness, affordability, feasibility and sustainability of different approaches have been carried out in previous studies and have been taken into account in the literature review.

Furthermore, due to the high variability of health systems and resources available in low-resource contexts, this study does not intend to give fixed rules of how to implement the psychosocial care component of the mhGAP program, instead, it aims to provide menus of options regarding basic implementation requirements, so that program planners can use it to make informed decisions according to local needs, aspirations, resources and context.

Due to the methodological approach of this study and with the intent of capturing an international perspective, data gathered in English, Spanish and French languages was included and when necessary translated to English verbatim. Data in other languages was not included due to resource limitations.

II. Methods

Since evidence on how to successfully implement mental health programs and psychosocial care in low-resource settings is not abundant, and the development of pragmatic models to guide implementation have been recommended (Thornicroft & Tansella, 2013), this exploratory

developmental study used qualitative methods to develop a practical and affordable model for psychosocial care delivery to assist and guide the implementation of the psychosocial component of the mhGAP Program in low-resource settings.

To develop this model, information from two sources was integrated: (a) literature review of relevant peer reviewed papers and other relevant published material and (b) a series of interviews done to mental health experts with background and experience working in low-resource settings in LAMICs. The rationale for this hybrid approach was to develop a model based on the experiential knowledge of mental health experts working on the field that also followed valuable recommendations found in published literature.

The study was developed in two phases. Phase one was to develop the Model of Psychosocial Care Delivery which required the collection of data regarding psychosocial care interventions and affordable care delivery approaches. Phase two was the definition of the Lines of Action for the Model's implementation in Costa Rica which called for data to understand Costa Rica's health system organization and viable implementation paths. Both phases supposed separate data collection and analysis stages that will be explained in detailed in the next section.

1. Phase One: Developing the Model of Psychosocial Care Delivery

a) Data collection

Literature Review:

To identify evidence on scaling up of mental health services, and more specifically psychosocial care, in non-specialized low-resource settings, The Lancet Series on Global Mental Health (2007 and 2011) was retrieved and studied. Also, a review of the published literature on scaling up of mental health services in non-specialized health settings was conducted to identify evidence available after 2011. Broad search terms (scaling up mental health care, mental healthcare delivery, psychosocial care, LAMICs, low-resource settings) were combined and used to address the fact that "Scaling up" is not a widely used term. The search covered the period from November 2011 to March 2014, inclusive, and was done via WHOLIS, PubMed, PsychInfo, Cochrane Database, Ebsco Health Policy Reference Center, PubMed and Web of Science databases. Titles and abstracts of all retrieved publications were screened for relevance to scaling up mental health services, models for mental healthcare delivery and psychosocial care programs in non-specialized settings and the most relevant for this study's purposes were selected. The evidence found on this literature review was used to build the background and conceptual framework of this study and to enrich the model by comparing and contrasting it with data from interviews.

Limitations of the review are its selective, rather than systematic, nature and its focus on mental healthcare services, rather than on prevention or promotion. Evidence from LAMICs and Latin America and the Caribbean was prioritized to better contextualize the region in which Costa Rica is located.

Expert in-depth Interviews:

Qualitative interviews were used to understand from the perspective of mental health experts the requirements and processes underpinning the planning, implementation and sustainability of scaling up mental health services in low resource settings. A qualitative semi-structured interview guide was developed, with a version for the interviewer and a version for the interviewee (see Appendix 1 & 2), based on data gathered during the literature review to inquire about low cost strategies to scale up psychosocial care services in different low-resource settings. The Wheel of Global Mental Health as developed by the Samuel et al. (in press) was used to develop the interview guide, which included questions for each of the Wheel's components.

Experts were contacted via e-mail, and were given a copy of the interview guide (interviewee version) when requested. If the participant was available in New York City, a personal appointment was set and the interview was done in person, if not, the interview was conducted via telephone or teleconference (Skype).

Selection of Interview Participants

For this study's purposes an expert is understood as a person with relevant field or academic experience in mental health, health program planning or implementation or healthcare administration. The expert group participants were chosen according to the resources already available to the researcher. Sampling was not meant to be an exhaustive or randomized selection, but rather a way to obtain additional unpublished information from people working on the field.

Sixteen experts currently working in different countries (USA, Costa Rica, Panama, Belize, Saint-Vincent and the Grenadines, Japan, Liberia-Monrovia, and India) and who collaborate or have collaborated with the Program in Global Mental Health at Icahn School of Medicine at Mount Sinai Hospital or work with Costa Rica's health system were contacted and invited to participate in the study. A total of 14 participants accepted to be interviewed and because of schedule availability and time difference reasons only 10 participants were interviewed: three of them in person, three of them by video conference call (Skype), and three of them by phone; one of the participants who agreed to participate decided to respond in writing due to schedule complications. Interviews ranged from 25 minutes to one hour, depending on their time availability and verbal consent was

given by experts to audio record interviews for later transcribing. Eight interviews were transcribed verbatim and one recording file was corrupted and couldn't be transcribed, so researcher notes were used to systematize data from this interview.

b) Coding & Data Analysis

Literature Review

Because of the amount of information obtained in the literature review, and according to time and personal resources of the researcher , a thematic coding including all selected articles in full-text was not feasible. Instead, published work obtained through the literature review was synthesized with a focus on: strategies to deliver mental healthcare in low-resource settings. affordable psychosocial interventions, and low-cost strategies to scale up mental health services. The Wheel of Global Mental Health (Samuel et al., in press) was used to help systematize the information. Finally, evidence from the literature review was used to enrich findings from the interviews to mental health experts in order to develop an informed Model for Psychosocial Care Delivery at Low-Resource Settings.

In-depth Interviews

Data obtained from interviews with 10 participants was used for the analysis, including data from the participant who responded in writing. For data anonymity reasons during the analysis, each expert was assigned a letter (A-J). All data was coded in categories and subcategories. The coding process was done in two stages: on the first stage data was coded in 8 categories, 7 o f them followed the structure of the Wheel of Global Mental Health (Host's Needs, Host's Aspirations, Host's Human Resources, Host's Other Resources, Collaborator's Aspirations, Collaborator's Resources and Local Advocate) (Samuel, Schuetz-Mueller, Katz, in press) and an eighth and ninth category for "Background" and "Scaling-up strategies" were included. On the second coding stage, subcategories were determined according to gathered data. For both stages a color-coded template was used to facilitate the systematizing of data. Coding was performed by KC and approved by the supervising team (CK & AA) to ensure quality of data.

For the analysis, published evidence obtained from the literature review and data obtained from the interviews was analyzed qualitatively using the wheel of mental health as framework. Since each of the interviewed participants worked in mental health projects that varied greatly from one another, starting with the country and context and including the project's objective, the objective was not to obtain consensus from experts, rather to acquire valuable information based on experience to compare it and contrast it with evidence-based recommendations found in the literature review. After this comparative exercise, decisions to determine what would be included in the Model were

drawn via consensus between the researcher and the supervising team. The result is a practical Model for Psychosocial Care Delivery, designed to assist program planners and key stakeholders in the process of improving access to psychosocial care at low-resource settings via the mhGAP Program or other evidence based package of psychosocial care for MNS disorders.

2. Phase Two: Designing an Action plan for Costa Rica

a) Data collection

Site visit to Costa Rica

Since "a good understanding of the current level of mental health system in a country is essential for planning and strengthening the system" (Jacob et al., 2007, p. 1062), a three week site visit to Costa Rica was done by KC to gather specific information on how to adapt the proposed Psychosocial Care Delivery Model to the Costa Rican context and mental health system. During the second week, AA joined KC in Costa Rica to support her in part of the data collection process.

To understand how the health system is organized and how mental healthcare services are currently being provided in Costa Rica, KC contacted Dr. Francisco Gólcher the Institutional Comptroller and mental health point person at Costa Rica's Ministry of Health, who then coordinated with Dr. Virginia Rosabal, the Mental Health Program Coordinator and mental health point person at the Caja Costarricense del Seguro Social (CCSS), Costa Rica's Health Administration Institution, who arranged different meetings and observational visits with key stake holders working within Costa Rica's mental healthcare system according to this study´s needs in terms of data collection.

Meetings and visits were held with the following stakeholders working at different institutions: the Mental Health Secretary, head of the mental health Secretariat at the Ministry of Health; the head of the Network for Psychosocial Care at the National Psychiatric Hospital; members of the Mental Health Institutional Commission at the Ministry of Health; the Mental Health Program coordinator at the Caja Costarricense del Seguro Social (CCSS); the Social Work and Psychology head of service at Monseñor Sanabria Hospital, a regional hospital in the province of Puntarenas; the psychiatrist at the Carlos Duran Clinic, a district clinic in the capital of Costa Rica, and former mental health coordinator at CCSS; and personnel from IAFA the Institute for Alcohol and Substance Abuse and the Centro Nacional de Atencion Integral en Drogas para Personas Menores de Edad (National Drug Comprehensive Care Center for Minors).

Due to the fact that the researcher had little control over the itinerary that local stakeholders established for each of the meetings and visits, and that some of them involved observation at

health facilities and interaction with patients, audio recording for later transcription was not a possibility. Instead, field notes were taken by KC for each of the meetings. Since all notes were taken in Spanish, a meeting report was written in English for each meeting and visit and a debriefing session was held after each meeting between KC and AA to discuss about data collected .

b) Data analysis

To define the lines of action, data was systematized using the Wheel of Global Mental Health (Samuel et al., in press) and the systemic and strategic approach developed by the Global Mental Health Movement for scaling up mental health services in low and middle income countries (Eaton et al., 2011) as a verifying method to make sure that all relevant information is included. Recommended Lines of action for each of the Model's components were defined. .

Chapter 3: Results & Discussion

I.   Model for Psychosocial Care Delivery

The Model for Psychosocial Care Delivery was developed by combining findings from published evidence and interviews to mental health experts. It is organized according to the eight components of Wheel of Global Mental Health (Samuel et al., in press), including contextual considerations, which is used to organize data related with needs, aspirations, and resources available to execute mental health projects at low-resource settings. It takes into consideration both the Host's perspective and that of possible Collaborators or partners that would be able to support the Host in the process of scaling up a mental health program. In an effort to maintain a pragmatic approach, the model provides decision makers with menus of options for each of its components to facilitate decisions-making for local program planners or other key stakeholders.

Each interview participant was inquired about their background and expertise in mental health in low-resource settings and about their knowledge about the WHO tool, the mhGAP-IG. To maintain anonymity regarding the information provided, interview participants were assigned a letter (Expert A trough J) for data analysis. Among the group of experts were psychiatrists, nurses specialized in mental health and clinical psychologists; their joint expertise covers: mental health research, high-level education, mental health program implementation in low-resource settings, and direct mental healthcare provision. Experts had background and experience in mental healthcare in different low-resourced settings in the following countries: Argentina, Belize, Brazil, Colombia, Costa Rica, China, Ethiopia, India, Japan, Kazakhstan, Liberia, México, Mozambique, Nigeria, Panama, Rwanda, Saint-Vincent and the Grenadines, South Africa, Tanzania, and USA. Only two of the participants were not at all acquainted with the mhGAP Program (Experts A and D), most of them had good knowledge of it (Experts B, C, E, F, G, H, I, & J, personal communication, May 2014), and some of them had experience with its use in low-resource settings (Experts B, C, G & I, personal communication, May 2014).

On this chapter's first section, findings regarding general contextual considerations for mental healthcare when working in low-resource settings will be presented. The following seven sections will be organized according to each the Wheel of Global Mental Health's components, which are the Model for Psychosocial Care Delivery's components as well. At each of these sections, a brief explanation of the component will be made followed by a description of findings from the interviews and the literature review.

The Model for Psychosocial Care delivery consists of a series of decision points guided by menus of recommendations and considerations for each of the Model's components. The Model's components and its decision points are interrelated and not intended to be hierarchical or in a specific order among components, it is important to understand the Model as a whole before making any decisions, since one is going to affect the other. Results will be discussed as they are presented in order to better explain the Model's scope.

1. Contextual considerations at low-resource settings

Mental healthcare availability in low-resource settings varies greatly from one location to another, even when provided in the same country. Therefore, gathering general contextual information at a setting is recommended to increase chances for success when scaling up mental health services at low-resource settings (Samuel et al., in press; Eaton et al., 2011, p. 1600).

First of all, according to experts it is vital to acknowledge that mental health and psychosocial care are not public health priorities in neither high-income nor low- or middle-income countries (Experts C, G, H & J, personal communication, May 2014), this finding is strongly backed up by scientific evidence and has been one of the reasons why the WHO and the Global Mental Health Movement have called for immediate action to scale up mental health services worldwide (Lancet Global Mental Health et al., 2007; WHO, 2013b). Budget allocation for mental health is insufficient and trained human resources are scarce in these settings (Experts A, B, C, E & J, personal communication, May, 2014; Lancet Global Mental Health et al., 2007). In addition, policy makers and decision makers do not have sufficient understanding of mental health issues to legislate and plan according to the population's needs (Ibid., p. 1250; Expert E, personal communication, May 2014). Although basic recommendations by the WHO and other well respected sources stress the need of strengthening mental healthcare provision at the primary level using treatments that include a combination of pharmacological, psychological and psychosocial care (WHO, 2001b), most mental health services at low-resource settings revolve around psychiatric hospitals (Expert J, personal communication, May 2014) and most usually pharmacological interventions are prioritized (Expert G, personal communication, May 2014).

Different settings and cultures have different approaches to illness, mental illness and care. So, understanding local values related to mental health and general culture is fundamental to providing feasible solutions at low-resource settings (Expert E, personal communication, May 2014). In addition, despite the amount of evidence available on effective and affordable psychosocial treatments for people with MNS disorders, including the mhGAP Program and Intervention Guide, mental health practitioners are not always aware of current evidence-based treatments and tools

available for care provision which obliges them to use dated and many times inadequate treatments. (Expert D, personal communication, May 2014) In Tanzania, for example, proposed interventions to care for a suicidal child could include separating the child from the family, which would be considered to be very traumatizing and counterproductive in other settings (Expert E, personal communication, May 2014).

The educational level of the target population is also key when choosing screening and care delivery methods. According this study's findings, most patients in low-resource settings often prefer pharmacological treatment instead of psychosocial care, yet the more educated population value and prefer other types of treatment such as psychological or psychosocial interventions (Experts A & H, personal communication, May 2014).   Also, it has been found that empowered consumers demand that they are cared for at the primary care clinic (Expert I, personal communication, May 2014). All of this contextual aspects have to be considered by planners in order to use feasible yet culturally acceptable strategies to scale up psychosocial care at these settings.

Furthermore, stigma continues to be an important barrier to care that affects health seeking behavior of people with MNS disorders (WHO, 2001a, p. 16). Because of the risk of being stigmatized by the community, people with signs or symptoms of MNS disorders do not want to go see a mental health specialist and seem to prefer being treated in the community by a general care professional (Expert I, personal communication, May 2014). The problem is that stigma is a major issue, even among the designated mental health workforce who are often untrained, afraid and reluctant to treat people with MNS disorders. As mentioned previously, evidence suggests that ill treatment and abuse by health workers is a major issue in mental healthcare and service users often complain about feeling most stigmatized by doctors and nurses (Eaton et al., 2011, p. 1598; WHO, 2001a, p. 19). This study's findings suggest that users, families and care providers must be educated on what MNS disorders really are along with effective treatments available to be able move beyond the barrier caused by stigma in low-resource settings (Expert E, personal communication, May 2014).

When intending to implement a mental health program that includes psychosocial care as one of its main components, such as the mhGAP, the Model for psychosocial care delivery urges program planners to carry out an analysis of the context in the program is to be scaled up. In this sense, understanding how the health system works, along with the setting's political, social and economic background is helpful to identify possible pathways for implementation.   Starting by a contextual overview; identifying how MNS disorders are understood and currently treated in the local setting and, when necessary, educating the population and care providers on culturally respectful yet more adequate and effective ways of delivering care to people with MNS disorders are all suggested

actions to take. Each setting where the mhGAP program will be used and adapted for, has different health system organizations, specific needs and aspirations regarding those needs, and very diverse access to resources to develop and carry out the Program. Gaining knowledge about each of these aspects at their local setting and understanding how they are interconnected is key for planners to make informed decisions that maximize local resources and chances for sustained success.

2. Host's Needs

According to the Wheel of Global Mental Health, the *Host's Needs* component refers to the need for psychiatric care in terms of prevalence of disorder versus access to care in a specific location (Samuel et al., in press), that is, the total need, met and unmet. Whether florid or hidden, MNS disorders are under-diagnosed and under-treated in all healthcare settings (Ibid.). This fact calls for urgent decision making in terms of prioritizing, or not, the most burdensome conditions at the setting where access to mental healthcare is to be improved.

Since settings vary greatly in terms of epidemiological needs, it is not possible to accurately define which disorder is more burdensome at a specific location without carrying out epidemiological studies that evaluate morbidity, mortality and disability due to MNS disorders, and that consider the economic burden that they represent to the country. Doing so would inform program planners and allow them to make decisions that would maximize the use of the budget allocated to mental health and increase benefits to the population that needs it the most. However, those kinds of studies are very costly in financial and technical terms and take time to be carried out. The fact is that most low-resource settings lack these kinds of studies and, therefore end up making decisions that affect budget allocation without really knowing which conditions are more burdensome, both in financial and health terms.

For this reason, and to assist low-resource settings in the process of improving access to mental healthcare, the WHO carried out an extensive review of evidence to identify the most burdensome MNS disorders in LAMICs along with the identification of affordable yet high-quality interventions the mhGAP Program and Intervention Guide were born from these efforts (WHO, 2008, p. 4). Investing in improving access to care for the disorders that contribute the most to the burden of disease maximizes chances of reducing the treatment gap, which is why it is so important to identify local needs and cater to them. Although the WHO has already identified depressive disorders, schizophrenia and other psychotic disorders, suicide, epilepsy, dementia, alcohol use disorders, substance use, and mental disorders in children to be the priority conditions in low-resource settings, a specific low-resource setting might have a different need because of population factors (i.e. a population composed mostly of people over 65 years old) or contextual factors (i.e. a recent

natural disaster). Due to shortage of financial, infrastructural or human resources, program planners at these settings very often have to choose one or two priority conditions, instead of nine. In such situations, evidence regarding what investments yield high returns in the mental health field are key. For example, "it has been found that "investments in children and adolescents yields high returns in terms of developmental potential realized, adult disorder prevented or less severe, and economic advantage for healthy individuals" (Kieling et al., 2011, p. 1521).

Therefore, in order to obtain information regarding which disorders, either from the list proposed by the mhGAP-IG or elsewhere, should be prioritized; mental health experts who collaborated with this study were queried about the most burdensome MNS disorders in the low-resource settings where they had experience working. Although there was no consensus among experts, most of them agreed on the high burden caused by depressive disorders, due to its high prevalence and the disability it causes (Experts A B, E, G & I, personal communication, 2014). Four disorders or groups of disorders were considered important by three experts: Alcohol use disorders (Experts A, D & I, personal communication, 2014); psychotic disorders including post-partum psychoses and schizophrenia (Experts I, B & D, personal communication, 2014); developmental disorders (Experts A, D & G, personal communication, 2014); and behavioral disorders in children (Expert G, I & J, personal communication, 2014). Dementia was mentioned by two experts (Experts D & G, personal communication, 2014) as well as violence related disorders, including sexual abuse (Experts E & J, personal communication, 2014) and domestic violence (Expert E, personal communication, 2014), drug abuse (Expert I, personal communication, 2014) and mania (Expert D, personal communication, 2014) were brought up only by one participant throughout the interviews.

Finally, one of the participants was hesitant to choose a specific disorder (Expert H, personal communication, 2014), another referred to the great variation according to settings (Expert C), and a last one stressed the need of epidemiological data to make decisions regarding prioritizing care (Expert F, personal communication, 2014). Therefore, prioritizing care could be used as a strategy to adapt to local resources (Expert C, personal communication, 2014). When settings have very little resources, but are interested in scaling up psychosocial care, choosing one or two priority disorders and allocating the resources to them increases local feasibility and stimulates the implementation process. Once care for the first priority disorder has been improved then another disorder can be set as priority, according to resource availability.

Decision point: Identifying the target population

Consequently, with or without epidemiological information, program planners and local stakeholders have to decide which is going to be their target population, and whether they will

prioritize investment for a specific disorder or set of disorders (i.e. as recommended by the mhGAP-IG), for a specific population (i.e. more vulnerable populations according to age), or if mental health services will be provided without diagnostic distinction. The Model for Psychosocial Care Delivery provides planners with four different options organized in a menu to help them visualize this decision (Figure 4).

Figure 4. Decision point: Defining the target population

MENU Define target population			
A	**B**	**C**	**D**
No prioritizing. Provide mental healthcare to all people seeking care at non-specialized health settings without diagnostic distinction.	Prioritize a population or populations with a specific mental disorder according to identified local needs Consider that the mhGAP-IG has prioritized 9 MNS disorders for treatment at non-specialized health settings: depressive disorders, schizophrenia and other psychotic disorders, suicide, epilepsy, dementia, alcohol use disorders, substance use, and mental disorders in children.	Prioritize vulnerable populations according to: health condition, socio-economic status, geography, gender, age, ethnicity, disability status, risk status related to sex and gender, or other populations identified to be at-risk for health disparities.	Start by Prioritizing Depressive Disorders And add other conditions as resources become available

Although this decision point provides four choices (A, B, C or D) and differentiates in terms of who is going to be the target population, it does not prompt its users to chose one over the other. This decision point is intended to provide different ways in which psychosocial care can be provided. Still, ethical aspects of prioritizing care at non-specialized health settings should be addressed by making sure that all the population has access to mental health services at one level or another (Expert C, personal communication, 2014). Since care provision at primary care facilities is less expensive than at tertiary care facilities, health services could be reorganized to maximize resources. Consequently, the majority of the population could access care at non-specialized health facilities, whereas people with severe mental disorders might need more specialized health services (Expert C, personal communication, 2014).

This Model supports the WHO's recommendation to prioritize the nine MNS disorders included in the mhGAP Program, for which an evidence based treatment protocol has been developed and systematized in the mhGAP-IG. However, when resources available at a specific setting do not allow

for full implementation of the mhGAP Program, and when reliable epidemiological data on the local burden of disease is not available; this Model recommends to adapt to local resources and to focus efforts on improving access to care for people with depressive disorders (option D), which is estimated to be the leading cause of disability globally (WHO, 2001a) and to be accountable for the highest proportion of disease burden attributable to mental and substance use disorders across all regions considered in GBD 2010 (IHME, 2013b, p. 6; WHO, 2001a), accounting for 40·5% (31·7–49·2) of DALYs caused by mental and substance use disorders (Whiteford & Baxter, 2013, p. 1582).

3. Host's Aspirations

The *Host's Aspirations* component of the Wheel of Global Mental Health refers to the specific aim that members of a community have in terms of improving access to mental healthcare. This is especially important to identify if we consider that "one third of all countries have no mental health policies, and in Africa, half the countries have none" (Samuel et al., in press). Choices that appear to be evident in current literature, as is the urgent need to close the treatment gap for MNS disorders, aren´t always so evident for local stakeholders who work in settings were stigma is very large and resources are limited (Ibid.). Thus, when scaling up a mental health program, such as the mhGAP, program planners have to consider not only the Host's most urgent Needs regarding mental health, but also what are their actual intentions, their Aspirations, in terms of improving access to mental healthcare.

Understanding this is key to success, because many times and for varied reasons, the Host's Aspirations do not cater to their most urgent Needs. For example, the Host might want to scale up a program for dementia, while the most urgent need is to improve access for people with depressive disorder, yet for political or contextual reasons (i.e. a local decision maker might have a family member with dementia) there is more support for scaling up a program for dementia (Expert C, personal communication, May 2014). In such case, a suggestion would be to start by fulfilling that Aspiration, which most often is also a Need, and then extend the services in a way that most urgent Needs are covered at least partially (Experts C & E, personal communication, May 2014). Understanding so, allows planners to consider an approach that caters to both (Needs and Aspirations) to ensure political support, thus, funding.

The Model for Psychosocial Care Delivery has identified two axes as constituents of the Host's Aspirations component: Axis I is about improving mental health awareness and Axis II is about improving access to care. Both axes are interrelated since local stakeholders and care providers need to be aware of the burden of MNS disorders in their locality in order to understand and be willing to improve access to care.

a) *Axis I : Improving Mental Health Awareness*

One of the main barriers to scaling up mental healthcare in low-resource settings is the lack of political support (Eaton et al., 2011, p. 1594). According to international recommendations and interviewed experts, creating awareness about the societal and economic burden of mental disorders and the need to prioritize them is key to successfully scale up mental health services (Experts C, H & J, personal communication, May 2014; Lancet Global Mental Health et al., 2007). Nowadays, there is compelling epidemiological data on the burden of MNS disorders that could be used to advocate for improving mental healthcare at a local level (Expert F, personal communication, May 2014; Kessler et al., 2014).

Decision point 1: Identifying key stakeholders

Evidence suggests that advocacy is required to shift attitudes and behaviors regarding mental health and MNS disorders. (World Health Organization & WONCA, 2008, p. 49). Contributing to create a larger consensus among all stakeholders on what to do to improve mental healthcare is suggested (Caldas de Almeida, 2013, p. 193). For example, teaching decision makers at the government and local level about the time-loss in primary care medical practice due to health practitioners lack of knowledge in mental health could be used as a way to back-up the need for more adequate funding (Expert E, personal communication, May 2014). In addition, raising awareness among stakeholders on how mental healthcare should be approached will improve chances that comprehensive programs such as the mhGAP will be implemented in primary care, despite the scarcity of resources (Expert C, personal communication, May 2014).

Gaining buy-in from local stakeholders and having them be in charge of the implementation efforts of mental health programs is key for funding allocation and long-term sustainability (Experts E & J, personal communication, June 2014). But who are the key people to persuade? The Model for Psychosocial Care Delivery presents its users with a menu regarding who could be a key stakeholder in the process of scaling up psychosocial care at a low-resource settings (Figure 5).

Figure 5. Key stakeholders menu

MENU
Key stakeholders for implementation
• Regional and local government decision makers (i.e. Ministry of Health, Public Health administration, municipalities)
• Mental health specialists providing care at private or public specialized settings
• General care providers working at non-specialized health settings
• Community associations, grassroots organizations, worker unions, health or social foundations linked to the health sector.
• Service users and their families.

Implementing psychosocial care at the primary care level will most definitely change the roles and responsibilities of healthcare related agencies and healthcare workers providing care at this level. Since organizations tend to resist change at an individual and system level, mental health awareness efforts should consider including stakeholders who will ultimately be responsible for implementing the mhGAP-IG and its psychosocial care component, so that they understand the implications of the burden of MNS disorders and how learning how to manage these conditions appropriately is going to help reduce the treatment gap, as well as help them gain time in their practice.

Decision point 2: Defining methods to foster awareness

Conducting advocacy alongside key stakeholders, including users of services, is one of the main strategies recommended by literature to overcome the lack of prioritization given to mental health services (Lancet Global Mental Health et al., 2007, p. 1249). According to the context and resources available to do so, mental health awareness can be delivered via complex and expensive programs, or via inexpensive and more informal efforts. Findings suggest that enlisting stakeholders who are personally affected by mental illness, whether directly or indirectly, could be used to advocate about the need to prioritize mental health (Expert C, personal communication, May 2014). In addition, the creation of a local mental health association for training and awareness efforts is suggested (Expert D, personal communication, May 2014).

In an effort to be practical, the Model for psychosocial Care Delivery presents its users with a menu of key messages that should be used to convince decision-makers, funders and other stakeholders about the need for scaling up psychosocial care at the primary care setting (Figure 6).

Figure 6. Key messages to foster awareness

Key messages to convey to stakeholders
• There is no health without mental health
• Stigma and discrimination lead to pervasive human rights violations against people with MNS disorders
• The global burden of disease of mental disorders is great and low-resource settings are especially vulnerable.
• The cost of time-lost in general care medical practice due to the lack of knowledge of non-specialized health providers about mental healthcare is high.
• The delivery of evidence-based brief and simple psychosocial interventions by general care providers improves access to care in a cost-effective way.

Findings regarding possible methods of delivering those messages are also presented (Figure 7). Evidence suggests not to invest in information brochures at waiting rooms, since they have not been found to be an effective way of informing patients at some low-resource settings (Expert I, personal communication, May 2014). Instead, posters, short films, websites and similar resources with information conveyed in a way to which a patient can relate in cultural terms and which is attractive to read or see, are better ways of educating the population about MNS disorders and creating

awareness (Expert B, I & J, personal communication, May 2014). In addition, using the best local epidemiological data and evidence supporting the cost-effectiveness of mental healthcare is key to advocate for scaling up mental health services (Lancet Global Mental Health et al., 2007). It is important that not only decision makers are aware of the benefits of mental healthcare; care providers and the population itself need to understand how improving access to psychosocial care and mental healthcare in general is going to positively affect them, so that they are more open to change.

<div align="center">Figure 7. Methods to increase awareness</div>

MENU
Possible methods to increase awareness in low resource settings
• Use of media: Billboards, television or radio spots • Use existing websites as platforms for information and training • Plan workshops for different target populations (users and professionals) • Use existing health professionals societies as platforms to reach stakeholders • Create a mental health association for training and awareness efforts • Use posters, short films and websites to create community awareness • Develop mental health community awareness campaigns or festivals.

In general terms, the Model recommends using key messages to persuade all parties involved about the benefits of improving access to psychosocial care and mental health services in general. To convey such messages, a series of low-cost alternatives to educate people are presented. However, other strategies could be incorporated if the Host manages to obtain resources, whether financial or other, to scale up a mental health awareness campaign, for example. In either case, it is fundamental to choose information delivery and education methods that are culturally relevant and feasible to implement in terms of resource availability and local acceptability.

b) Axis II : Improving Access to psychosocial care

Improving access to care starts by the coined premise: "there is no health without mental health" (WHO, 2013b). In that sense, a series of decisions need to be made to ensure access to mental healthcare in low-resource settings. This Model has identified 5 decision points to assist program planners in key issues regarding improving access to psychosocial care.

Decision point 1: Reorganizing care delivery structures

Ample and repeated recommendations have been made regarding the need to integrate mental healthcare into non-specialized health settings, such as primary care clinics, general hospitals and community care facilities (World Health Organization & WONCA, 2008). Yet, "(m)ost of the funds that are made available by governments are specially directed to the operational costs of specialized but increasingly outdated mental hospitals (that are commonly associated with isolation, human rights violations, and poor outcomes)" (WHO, 2013a, p. 15).

Reorganizing the way a health system provides mental healthcare is no easy task, let alone with scarce resources. Evidence suggests that the best way to improve access to mental healthcare in low-resource settings is via integration of mental healthcare into non-specialized care, i.e. primary care (V. Patel et al., 2013; Rebello et al., 2014; World Health Organization & WONCA, 2008). However, this is a very complex task and to achieve it successfully, primary care services and care providers must be supported by other more specialized resources at other levels of care, such as day hospitals, psychiatric units with beds in general hospitals, ambulatory community care facilities and specialized hospitals. Task-shifting has been recommended as a strategy to diversify the workforce and render mental healthcare provision feasible at the primary level. In this shared care approach the responsibility to provide psychosocial care, including screening, management, referrals and follow-ups is shared between mental health specialists and general care providers. "Specialized secondary care should be available for referral cases and mental health care should be integrated into primary health care, maternal and reproductive healthcare, internal medicine and paediatrics, and emergency medicine, so that the majority of the persons with mental health needs can enjoy local access to treatment and care" (WHO, 2013a, p. 20). Also, a reliable supply of medications must be ensured in non-specialized health settings. (V. Patel et al., 2013; World Health Organization & WONCA, 2008).

It is important to acknowledge that the integration of mental healthcare into general care is a process, not an event, and requires adequate allocation of financial and human resources (World Health Organization & WONCA, 2008, p. 49). However it is implemented, task-shifting requires coordination among government agencies, nongovernment organizations, professional organizations, and local governments (Kazdin & Rabbitt, 2013, p. 174). Also, besides looking for other mental health services being provided within the health system, either private or public, planners must go beyond the health sector, and coordinate actions with agencies from the social, education, and justice sectors (Skeen et al., 2010; as cited by Lund et al., 2014, p. 116). Finding support in other stakeholders, health agencies, donors, and other collaborators helps the Host improve access to mental healthcare while sharing the task of care provision, hence, sharing costs as well. Furthermore, local stakeholders with no experience scaling up psychosocial services and interventions at the primary level, need support on-site in order to carry out efforts effectively (Expert J, personal communication, May 2014).

Three major barriers for integration of mental healthcare in low-resource settings have been identified and must be taken into consideration when trying to scale up the psychosocial component of the mhGAP-IG or other evidence-based package of care. First, primary care providers are

overburdened with multiple tasks and patient loads, which leaves insufficient time to properly care for people with MNS disorders. In some health settings, primary care providers usually have as little as 12 minutes per patient, in others, such as intermittent outreach clinics even less (Experts A & F, personal communication, May 2014). Second, primary care providers are not mental health specialists, lack proper training and very often do not receive sufficient support and supervision by more specialized providers (Saraceno et al., 2007, p. 878). Furthermore, psychotherapy services are generally not available at non-specialized health settings (Expert E, personal communication, May 2014) only at secondary or tertiary level (Expert E & I, personal communication, May 2014). And third, very often the essential psychotropic medicines are not available which jeopardizes treatment continuity (Experts E & J, personal communication, May 2014; Saraceno et al., 2007, p. 878).

Additionally, "the vested interests of mental health professionals and hospital workers might be one of the most pervasive barriers to decentralization" (Saraceno et al., 2007, p. 1168). Findings show that specialized health workers are often very resistant to integration efforts, fearing changes in their status quo (Expert D, communication, May 2014), losing their jobs (expert C, personal communication, May 2014), or a drop in quality of care (Expert E, communication, May 2014). In order to tackle these barriers health program planners must focus in obtaining low-cost human resources for mental healthcare provision, while strengthening links between non-specialized and highly specialized services and professionals (Saraceno et al., 2007, p. 1172). In addition, there are tools such as the WHO QualityRights Project, that aim to improve quality and human rights conditions in all inpatient and outpatient mental health facilities and social care homes. The QualityRights tool kit could help low-resource settings face risks related to guaranteeing quality of care by providing them with basic standards that must be respected in facilities, including: living conditions, the treatment available for physical and mental healthcare, and how care givers should treat services users (Eaton et al., 2011, p. 1665; WHO, 2012).

With the intent to remain practical, this Model has summarized its findings regarding the reorganization of health settings for mental healthcare. A menu of suggestions is provided to help planners decide which approach suits their setting best, or how they can be modified and adapted locally (Figure 8).

Although there are several programs and packages of care for mental healthcare available, they are sometimes very complicated to follow at low-resource settings due to their current access mental health infrastructure and access to human resources (Expert E, personal communication, May 2014). These suggestions are meant to inform planners in the decision-making process by providing them with general suggestions regarding reorganization of services. In some settings, for example,

education might be necessary to improve awareness on MNS disorders and mental health before deciding how to reorganize mental health system (Expert G, personal communication, May 2014). Also, in order to get buy-in from governments and communities, the Model strongly suggests to follow the Host's Aspirations and to make sure that communities see value in the mental health program.

Figure 8. Recommendations for reorganization of the Mental health system

MENU
Recommendations for reorganization of the Mental healthcare system
- Consider that systems have a hard time changing at an individual and systems level   - Make sure care provision reorganization is initiated by a need or aspiration from the local setting   - Getting buy-in from countries and local settings and having them be in charge of efforts improves chances for program sustainability   - Having a very motivated and committed person in charge of running the efforts is key   - Identify other entities and programs providing psychosocial services to the population before creating new ones   - Use existing health programs as platforms and modify them to meet the program's needs   - If possible do not add new programs and staff   - Find existing successful programs and replicate them at new settings   - Plan in advance strategies to overcome known barriers and be prepared for unexpected obstacles when scaling up mental healthcare   - Pre-set manageable goals with measurable outcomes for each specific setting   - Strengthen relationships between primary, secondary and tertiary levels of care.   - Ensure sufficient human resources at each health facility to cover all aspects of care   - Rely on support and supervision by mental health experts available at other levels of care or via collaboration   - Consider all possible organizational structures for a mental health program to find want that meets both needs and resource availability (i.e. individual care or group care)   - Increase out-patient services to decentralize services   - Provide care via house visits in case no physical space is available at the primary care facility   - Use phone technology to provide care (i.e. Apps and sms for CBT, support messages, or reminders for following an exercise routine)

Although there are several well-known barriers to scaling up mental healthcare, there is a big possibility of encountering unexpected obstacles all throughout the planning and implementation process of a program such as the mhGAP-IG (Expert F Expert G, personal communication, May 2014). The person who will be in charge of reorganization efforts must be knowledgeable of the setting's health system and be able to adapt to local needs and aspirations. In order to maintain new costs to the minimum, the use of existing health programs that have proven to be sustainable over time, as platforms for psychosocial care is highly encouraged (Expert C & I, personal communication, May 2014). Also, if settings have had positive experiences with local programs for mental health provision, exploring replication options is also suggested by the Model.

In Latin America & the Caribbean, some progress in integrating mental health has been observed in countries like Argentina, Brazil, Belize, Chile, Cuba, El Salvador, Guatemala, Jamaica, Mexico, Guatemala and Panama (Caldas de Almeida & Cohen, 2008; as cited by Razzouk et al., 2012, p. 191;

World Health Organization & WONCA, 2008). Looking at successful experiences from other countries with which the Host Country shares characteristics is a good practice to inform local stakeholders, gain insight on possible strategies to overcome obstacles and identify recommendations for success.

The exact nature of collective actions to improve access to mental health services in any setting will vary according to prevailing notions of social choice and the existing health system structures and constraints (WHO, 2013a, p. 12). This said, the objective is not that governments provide all of the services related to mental health and psychosocial care themselves; private partners and donors could be great partners to ensure part of the services. However, "governments have an obligation to ensure that appropriate institutional, legal, financing and service arrangements are put in place to protect human rights and to address the mental health needs of the population" (Ibid.) Finally, it is key for program planners and local stakeholders to keep in mind that changing the way a health system works and how care is provided is a complex task; change takes time to establish in organizations and people, and health systems, care providers and service users need time accommodate to a new way of mental healthcare delivery.

Decision point No. 2: Defining the health setting

When intending to improve access to psychosocial care at non-specialized health settings, planners have to start by defining the health setting for care provision. To make this decision, affordable strategies that improve chances for the population to access care must be considered. As it has been discussed, international recommendations, as well as interviewed experts, suggest the integration of mental healthcare, including psychosocial care, into primary care (Experts C, H, I & F, personal communication, May 2014; World Health Organization & WONCA, 2008). Evidence suggests that "(m)ental health services configured around a community-based model achieve similar mental health outcomes to hospital-based services, but are less costly to maintain" (WHO, 2006a, p. 9). In agreement with this, experts stress the fact that providing care in asylum-like health facilities and psychiatric hospitals (Expert I & J, personal communication, May 2014) should be avoided, since it is more expensive for the health system and more difficult for the population to access. Furthermore, providing psychosocial care at the primary level can help low-resource settings cope with difficulties accessing medication at this level (Expert B, personal communication, May 2014).

Findings suggest that to improve access to care and reduce costs, care should be provided at convenient locations, in communities (Experts H, F, I & J, personal communication, May 2014), remote areas (Expert D, personal communication, May 2014) and marginal zones (Expert F, personal communication, May 2014) which reduces the patient's out-of-pocket transportation expenses and patient transferring fees paid by hospitals. Facilitating home-visits by mental-health workers (Expert
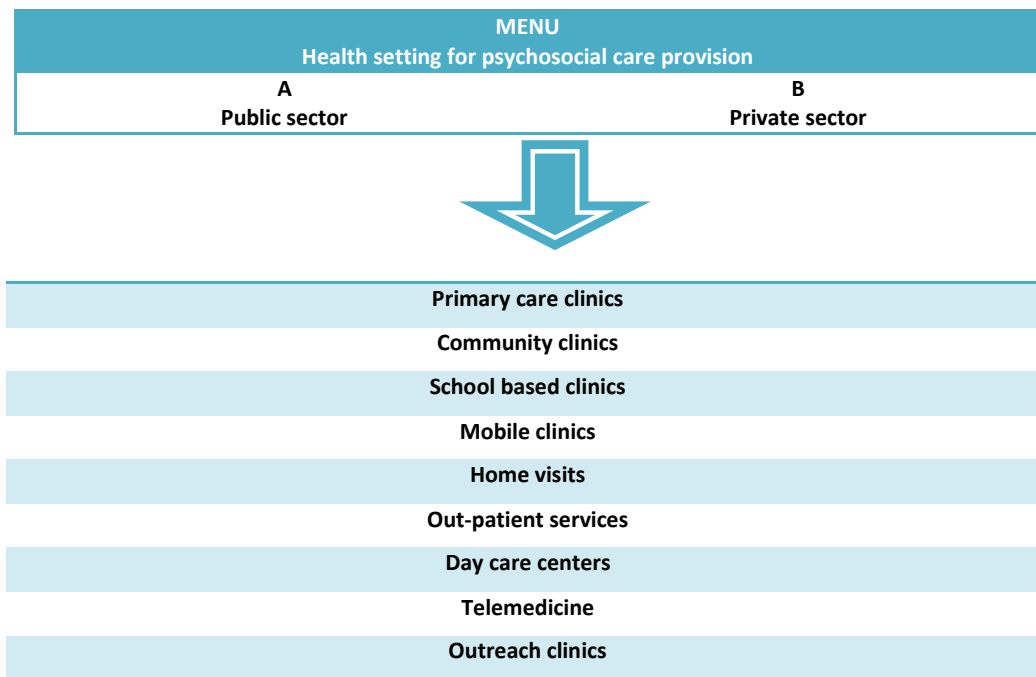
I, personal communication, May 2014) as well as providing care in other types of non-specialized health facilities such as schools (Expert C, personal communication, May 2014) are some possible strategies to improve access to care at a low cost.

Since health facilities for general care in low-resource settings vary greatly in terms of infrastructure, human resources available and type of care provided, an assessment of what health facilities are available in the Host country and their characteristics must be performed before deciding where to implement the psychosocial component of the mhGAP program. In some countries, the majority of primary care clinics that provide care close to the community are run privately (Expert A, personal communication, May 2014). This could mean that in order to reach the target population, local planners would have to work along private practitioners and prompt them to include mental health services within their practice. On the other hand, there are also settings, where there is a well-established public health system that runs different kinds of general care clinics, at primary and secondary level (Expert J & F, personal communication, May 2014). Choosing the best platform for care provision is a key decision to ensure that access is actually improved for the population. If the wrong choice is made, for example, implementing the mhGAP Program at general hospitals distant from the target population to help ensure human resource availability, help-seeking behavior might be hindered, since to receive care patients have to pay expensive transportation fees; on the contrary, if the most remote primary care clinics are chosen, obtaining trained human resources for mental healthcare provision might become a difficult task.

The Model for Psychosocial Care Delivery provides its users with a menu of options regarding different health settings that could be used as platforms for psychosocial care delivery (Figure 9). Each decision-maker must identify what settings are available locally and which one would be the most accessible for the population and the most adequate for psychosocial care provision.

Choosing to provide care at non-specialized health facilities that exist already and have proven to be sustainable within the Host's health system is a lower cost strategy that would increase chances for program sustainability (Expert C, personal communication, May 2014). Accordingly, this Model recommends program planners to select the most abundant and geographically widespread type of non-specialized health setting available at community level that has proven to be sustainable over time. In addition, access to mental healthcare for different types of populations (i.e according to age group or socio professional situation) could be improved by providing care through health programs directed to a specific population (i.e. health programs for pregnant women).

Figure 9. Defining the non-specialized health setting

MENU
Health setting for psychosocial care provision

A	B
Public sector	**Private sector**

Primary care clinics
Community clinics
School based clinics
Mobile clinics
Home visits
Out-patient services
Day care centers
Telemedicine
Outreach clinics

According to needs and aspirations, decision makers can choose among the resources they already have available, in order to adapt them for psychosocial care provision. It is not necessary to chose only one type of health setting, nor to choose them all. The menu is a way of visualizing types of general healthcare facilities usually available at low- and middle-income countries as a way to help inform the decision-making process.

Decision point No. 3: Choosing psychosocial services

According to the WHO's recommendations, "a defined set of mental health conditions and interventions should be explicitly recognized and included in the essential list of package of health benefits offered to all citizens by governments (...)" (WHO, 2013a, p. 21). As it has been described, the mhGAP-IG is a systematized a treatment protocol that follows international recommendations by including pharmacological, non-pharmacological, psychosocial and advanced psychosocial interventions for nine priority MNS disorders. In terms of psychosocial care, the mhGAP-IG differentiates between basic and advanced psychosocial interventions: basic interventions are brief and simple to learn and deliver and advanced interventions take more than a few hours of a health-care provider's time to learn and typically more than a few hours to provide (WHO, 2010a). Findings suggest that incorporating psychosocial care into a patient's treatment plan helps improve their quality of life in a sustainable way (Expert C, personal communication, May 2014). In addition, international evidence has identified a clear trend in which increasing access to mental health interventions is associated with improved economic and clinical outcomes in low-income and middle-income countries (Lund et al., 2011, p. 1508).

However, because resources are insufficient, many times program planners in low-resource settings have to decide to scale up just a part of a program, and due to the fact that pharmacotherapy is easier to teach to general care providers and less time-consuming to provide, it ends up being prioritized over psychosocial care. Although access to medication at low-resource settings needs to improve greatly (Expert B, personal communication, 2014), as it has been stated before, the Model for Psychosocial Care Delivery parts from the premise that pharmacological care, whether via the mhGAP or a different program, is already available at the setting where psychosocial care will be provided.

This Model also recognizes that psychosocial care is very broad in scope and can mean different things to different people (Expert E, personal communication, 2014), which is why, before implementation at any low-resource setting it is necessary to define what psychosocial care means locally along with the services that the Host aspires to provide. Therefore, to assist program planners in low-resource settings in identifying a set of basic and affordable psychosocial care services that can be delivered at their setting a low cost, interviewed experts provided a series of characteristics that according to their experience, must be present in psychosocial interventions to be feasible and affordable at low-resource settings.

Figure 10. Psychosocial Interventions' suggested characteristics

MENU
Psychosocial interventions' suggested characteristics
• Should be brief
• Should be specific
• Should be contextually appropriate
• Should be culturally relevant
• Should be delivered in the local language
• Should address the community's interests
• Should be easy to deliver for general care providers
• Should address stigma related to MNS disorders
• Should address both psychological and social components of care
• Should be provided even when medication is not available
• Should ensure the respect of human rights
• Should address the patient's general needs, other than medical treatment
• Should inform users about common questions, problems and coping strategies for illness related situations

Each of the characteristics presented in Figure 10 should be taken into consideration by planners when choosing which psychosocial interventions best fit the needs and aspirations of their Host in terms of psychosocial care provision, whether they are intending to scale up the entire mhGAP Program, a part of it or a different package of care for MNS disorders.

It is not within the scope of the Model to describe each of the proposed psychosocial interventions in depth. Extensive literature regarding treatment protocols is and effectiveness of psychosocial care

is already available for the mhGAP interventions and other evidence-based packages of care (WHO, 2008, 2010a). The Model for Psychosocial Care Delivery presents planners with a menu of options that includes the psychosocial interventions that are recommended by the mhGAP-IG along with other interventions that are not included in the Program, yet were suggested by experts because they considered them to be helpful when implemented in low-resource settings (Figure 11). Although the mhGAP-IG was developed as a package, meaning that all of the interventions recommended for a specific disorder must be made available, the reality is that low-resource settings most often do not have the resources to scale up all of the interventions. Therefore, this Model aims to help planners make an informed decision, in case they have to chose between one intervention or another.

Figure 11. Psychosocial interventions

MENU **Basic psychosocial interventions** **included in the mhGAP Intervention Guideline**	
Psychological components: • Psychoeducation to patient and family • Addressing psychosocial stressors, (i.e. Emotional support) • Regular follow-up • Conveying the results of the assessment • Interventions for cognitive symptoms and functioning • Managing behavioral and psychological symptoms • Brief intervention techniques • Self-help groups	**Social components:** • Reactivation of social networks • Rehabilitation in the community • Advice to teachers • Promotion and protection of human rights of the child and the family • Support for families and carers • Promotion of independence, functioning and mobility • Address housing and employment needs (i.e supported employment) • Harm reduction strategies
Advanced psychosocial interventions included in the mhGAP-IG:	
• Behavioral activation • Cognitive Behavioral Therapy • Contingency management therapy	• Family Counseling or therapy • Interpersonal Psychotherapy • Motivational enhancement therapy
Other interventions not specified in the mhGAP-IG:	
• Do promotion and prevention of MNS disorders at different levels of the health system • Ensuring safety first	• Occupational therapy and skills building • Jail diversion interventions

Although there was no consensus, many of the interviewed experts suggested to follow WHO's recommendations for psychosocial interventions presented in the mhGAP-IG, since they were chosen based on their effectiveness and feasibility at low-resource settings. In general terms, two experts strongly suggested the need of addressing stigma related with MNS disorders in order for psychosocial care to be delivered effectively (Experts I & J, personal communication, 2014).

When referring to the psychological aspects of psychosocial care, two experts suggested prioritizing the provision of psychoeducation to the patient and the family (Experts A & E, personal communication, 2014) while one made emphasis on prioritizing psychoeducation at a community level (Expert J, personal communication, 2014). Another expert stressed the need to provide interventions that included multidisciplinary stakeholders, including patients, relatives of patients, churches, traditional healers and other community-level organizations (Expert C, personal communication, 2014). The provision of care through self-help groups was another one of the interventions that could be prioritized in low-resource settings (Expert A, personal communication, 2014), since the mental health provider's time is maximized by facilitating an intervention for several people at a time.

Finally, in terms of social interventions, the inclusion of social services within the primary care facility was suggested (Experts A, E & H, personal communication, May 2014). More specifically, these services could be used as platforms to provide information to users about common questions, common problems, and what to do in specific illness related situations (Expert A, personal communication, May 2014). The provision of culturally relevant skills training that takes into consideration gender based roles, along with occupational therapy and supported employment opportunities was recommended as a key component of psychosocial care at the primary level (Expert H & J, personal communication, May 2014).

One of the experts mentioned the need to address violence reduction separately from psychosocial care, including: ensuring food and shelter and ensuring safety (addressing domestic violence and childhood abuse, reducing suicide risk, reducing adverse childhood events as prevention for mental illness); to this expert, low-resource settings still have a great deal of violence related mental health issues that do not need medical treatment, rather a more social approach that does not need to be provided in a health setting (Expert E, personal communication, May 2014). Nevertheless, the fact that addressing social circumstances alone cannot eliminate mental illness was also brought up as an important consideration that must not be forgotten (Expert C, personal communication, May 2014).

Providing psychosocial care at the primary level does not only support the patient, who is in need of mental health screening and treatment, but also the overburdened general practitioner (Expert A, personal communication, May 2014), who can focus on diagnosis and pharmacological treatment if added care providers ensure the psychosocial aspects of treatment.

Decision point No. 4: Screening

Because MNS disorders have substantial comorbidity with other diseases that are also increasing in burden, screening and interventions for MNS disorders should be included in all aspects of the

health-care system (Ngo et al., 2013). Interviewed experts proposed the design of a systematic screening protocol to identify MNS disorders at primary care facilities (Experts A, D & J, personal communication, May 2014) that is sustainable (Expert A, personal communication, May 2014) and sensitive (Expert D, personal communication, May 2014). The mhGAP-IG presents a screening protocol for nine priority disorders that can be used by non-specialized health practitioners that are trained in its use. However, each Host can select its own screening protocol based local on needs and resources (Expert E, personal communication, May 2014).

Although the Model for Psychosocial Care Delivery does not intend to define a new screening protocol different than that proposed in the mhGAP-IG, general suggestions for planners will be made regarding three interrelated aspects of screening: the delivery method, the screening tool and the human resource used for screening. In order to effectively design a screening protocol for a low-resource setting, or adapt the one presented in the mhGAP-IG, choices must be made according the Host's Needs, Aspirations and Resources. In this sense, low-cost screening alternatives entail the use non-proprietary, freely accessible screening tools that are not time consuming and for which highly specialized human resources are not required. Screening results should then be used by care providers to determine if patients are in need of basic psychosocial care that can be provided at the non-specialized health setting, or if they have to be referred to a more specialized service.

Regarding delivery methods, the Model proposes choosing if screening will be done for every patient at a clinic without regards to their motive for seeking care or if it will be optional, available just for patients that ask for it or to those for which the general practitioner considers a screening for MNS disorders should be carried out. Another important element is the decision to rely solely on clinical interviewing or if a screening tool, such as self-report questionnaire, scale or inventory, will be used to assist the practitioner in the screening process

Figure 12. Considerations to select the screening tool

MENU
Screening tool considerations
• Should be brief and easy to use
• Should be inexpensive to obtain and use on a regular basis
• Should be contextually appropriate
• should be validated for the local health setting
• Should be sensitive to identify signs and symptoms of target mental disorders
• Should address violence screening (sexual and physical)
• Should consider different levels of education, including illiteracy

If planners decide to use a screening tool, such as a quality of life, functional level screening scales (Expert H, personal communication, May 2014) or general health questionnaires (Expert G, personal communication, May 2014), it must be chosen taking into consideration its adequacy to evaluate the

MNS disorder or disorders that were prioritized by the Host. Also, the cost to obtain it and use it regularly, along with the difficulty to implement it at a non-specialized health setting, should be considered. Findings regarding key characteristics of screening tools for are presented in Figure 12. Embedding the tool into the health information system was suggested to facilitate and systematize its use in low-resource settings (Expert I, personal communication, May 2014).

Finally, the availability and type of mental health care providers vary greatly from one low-resource setting to another, ranging from general care doctors to community health workers. Consequently, the mhGAP-IG was developed to be used by non-specialized care providers at primary care settings. furthermore, not adding extra personnel was strongly suggested as one of the most affordable and feasible ways to scale up mental healthcare in low-resource settings (Expert C, personal communication, May 2014). Therefore, in order to keep added costs to the minimum when choosing adequate human resources for screening purposes, the Model for Psychosocial Care Delivery recommends using current care providers and other human resources available at the health setting instead of recruiting personnel for screening purposes. In this line, the level of difficulty in doing screening must be considered to make sure there is sufficient adequately trained workforce to perform it.   Further considerations regarding human resources choices for psychosocial care delivery will be presented in the Human Resources component of the Model.

Decision point No. 5: Defining clear referral pathways

Since psychosocial care is not usually provided exclusively in health facilities, program planners intending to implement the mhGAP-IG should identify local agencies that are providing high quality psychosocial services, public or private, where patients could be referred to. Creating partnerships and clear links between agencies would help the Host in the process of improving access to mental healthcare. In addition, it would help relieve the burden of general care providers and maintain added costs for mental healthcare at a bare minimum, since some services would be assured by another provider.

The importance of setting a single entry to point to facilitate access to the health system is key to improve access to mental health care (Expert I, personal communication, May 2014). Findings suggest the need of establishing clear referral pathways so that patients con access services easily and not get lost in the process, which can happen when with chronic patients who receive care by multiple care providers (Expert E, personal communication, May 2014). Also, the use of a case severity scale that allows practitioners to identify which cases they can treat and which ones must be referred to a more highly specialized practitioner was strongly suggested (Expert E & C, personal communication, May 2014). The mhGAP-IG helps general care providers make this decision for

referral, mostly when diagnosing a patient, however, establishing clear roles and responsibilities would help ensure quality of care at non-specialized health settings.

This study's findings regarding key strategies to optimize referral pathways for psychosocial care provision are presented in Figure 13. Local planners and key stakeholders can choose among these strategies or modify them and adapt them to best serve their needs.

Figure 13. Optimizing referral pathways

MENU
Strategies to optimize referral pathways:
• Establish a single entry point to the healthcare system • Establish a case severity scale for targeted mental disorders and use it for referral purposes • Establish clear referral pathways between general care providers and mental health specialists according to case severity • General care providers should refer patients to a more specialized level only if the patient needs more specialized care that he or she is not trained to provide • Before referring, the general care practitioner should consult with the specialist if the referral is necessary (via phone or e-mail), until the general care provider is confident to make the decision on his or her own. • Define the roles and responsibilities of general care providers and mental health specialists according to case severity • Develop strategies to build good relationships between care providers at all levels of care. • The same patient should see the same care provider on a regular basis to ensure treatment continuity and to build a therapeutic alliance • Identify other entities and programs providing services that can serve as support to the population with mental disorders and create clear communication pathways for easy referral

As it has been previously described, the mhGAP-IG is intended to be used at primary care facilities, which could be established as the entry point to the healthcare system for people with MNS disorders. Focusing efforts in optimizing referral pathways allows for better care for service users since they can receive regular care close to the community and be referred to a more specialized service only when absolutely necessary, saving time and money both for the user and to the health system. Also, consulting referrals with the specialist when in doubt is a strategy that helps reduce costs since a general care practitioner trained in basic mental healthcare might think that a particular patient needs more specialized care, yet with the specialist's remote or on-site support he or she could realize that a case is less complex than it looks and can be managed at the primary setting.

The Model for Psychosocial Care Delivery relies on the identification of clear referral pathways within the health system and partner agencies. These should be defined according to case severity in order to optimize resources and reduce care delivery cost, since non-complicated cases can be treated by general care providers trained in mental healthcare provision, and only complex cases would need to be referred to a more costly specialized facility.
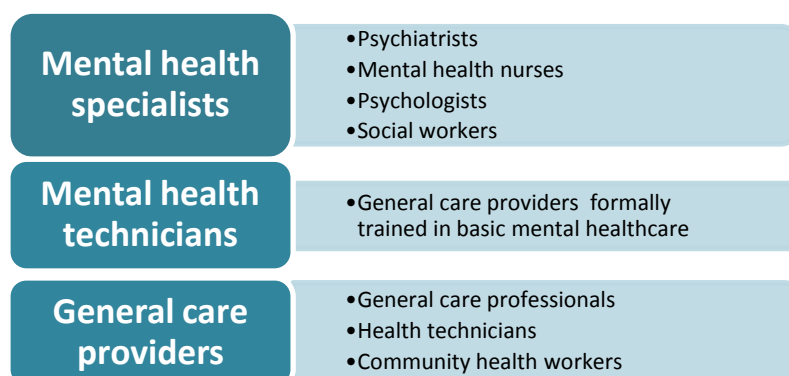
4. Host's Human Resources

The scarcity of *Human Resources* is one of the biggest barriers to scaling up mental healthcare in low-resource settings. The very limited access to adequately trained mental health workers in low- and middle-income countries with a median of 0.05 psychiatrists and 0.16 psychiatric nurses per 100.000 population (Saxena et al., 2007, p. 881) and the equally insufficient amount of child psychiatrists, psychiatric nurses, social workers and other mental health workers available (Samuel et al., in press; experts A, B, C, D, H, I & J, personal communication, May 2014) complicates the task of improving access to mental health services to populations that need them the most. There are settings in which psychiatric hospitals are run without psychiatrists because they are simply not available in the country. Therefore, other mental health specialists, such as psychologists, have had to take over and try to provide care in a setting where most personnel has no training in mental healthcare (Expert I, personal communication, May 2014).

Since very often low-resource settings lack adequate platforms to train the mental health workforce, the Wheel of Global Mental Health recommends the use of affordable and cost-effective alternatives such as training community health workers to become mental health workers (Samuel et al., in press). In that sense, the Model for Psychosocial Care Delivery follows international literature and mental health experts' recommendations by setting the diversification of the mental health workforce at its core. Consequently, a series of decisions are proposed in order for planners to define a low-cost strategy to obtain human resources that is congruent with their Needs and Aspirations.

Human Resources for mental health care provision range from highly specialized professionals such as child psychiatrists to non-specialized care providers such as community health workers. Since mental health specialists at most low-resource settings are very scarce and general care providers are overburdened and not trained to provide mental healthcare, evidence suggests that building a platform for human resources development and support based on task-shifting and capacity building is the best strategy to overcome human resource scarcity at a low-cost (Kazdin & Rabbitt, 2013, p. 174). The Model for Psychosocial Care Delivery has organized the variety of human resources that could be used to provide psychosocial care at low-resource settings so that planners can easily identify which ones are available at their setting and which ones are lacking (Figure 14). It is not necessary to have them all at one setting, nor are all of the possible mental healthcare providers present in the diagram. The idea is to give a general overview of different care providers that can be used to implement the mhGAP program, including its psychosocial component.

Figure 14. Human Resources for mental healthcare

Mental health specialists	• Psychiatrists • Mental health nurses • Psychologists • Social workers
Mental health technicians	• General care providers formally trained in basic mental healthcare
General care providers	• General care professionals • Health technicians • Community health workers

The Model for Psychosocial Care Delivery differentiates between three categories regarding human resources for mental healthcare. The first category refers to highly specialized mental health professionals. Mental health specialists are professionals who have followed formal and exhaustive training (that usually takes several years to complete) and who are trained in all aspects related with diagnosis and management of MNS disorders. This group usually includes psychiatrists, psychologists, mental health nurses and social workers, but other health professionals who have followed a specialization degree in mental health could be included. The second category refers to all general care providers whether they have professional training in general care or they have followed training in a specific area of basic healthcare. General care physicians and nurses would be in the general care professional sub-category; and people who have followed formal training in a specific field of health or care delivery would be in the health technician subcategory promotion (i.e. auxiliary nurses, radiology technicians or dental technicians). Community health workers have been included in the general care provider category due to the fact that they represent the main workforce for care provision in many low-resource settings. Community care providers have usually only followed short trainings on the delivery of specific interventions for a specific condition. They can be volunteers, health service users, family members of health service users, students, or traditional healers. Finally the third category refers to health technicians; this includes those workers from the general care provider category who have followed a formal training on diagnosis and management of MNS disorders.

Using training, support and supervision to develop a mental healthcare workforce and modify traditional roles of general care providers is a low-cost strategy for overcoming scarcity of specialized human resources at low-resources settings. The Model for Psychosocial Care Delivery provides its users with an organizational structure to help its users understand how Human Resources roles and responsibilities should be redefined with the objective of optimizing costs and coverage. A series of decision points have been included in order to guides decisions related with

redefining roles and tasks and building a strong platform for task-shifting that includes training, support and supervision of general care providers.

Decision point 1: Redefining Human Resources roles and responsibilities

It has become evident that the workload of general care providers at low-resource settings is great. Findings suggest that physicians and nurses at primary care clinics are overburdened with patients and responsibilities (Expert E, C, G & I, personal communication, May 2014) and have very little time per patient (Expert E & F, personal communication, May 2014). Thus, for the most part it is not feasible for them to follow time-consuming guidelines to assess and manage patients (Expert E, personal communication, May 2014). In addition to that, most primary care doctors in low-resource settings are not formally trained in treating mental disorders (Expert E, D & I, personal communication, May 2014) nor in psychosocial care interventions (Expert I, personal communication, May 2014). In some settings, general care doctors working at primary clinics are over 60 years old and have followed little professional development training (Expert D & E, personal communication, May 2014). Consequently, primary care staff working at low-resource settings are generally overwhelmed at the prospect of handling patients without appropriate instruction (Expert J, personal communication, May 2014).

Human resources can be organized in varied ways according to availability and aspirations of the health setting or system, yet according to evidence, in order to overcome the scarcity of human resources for mental healthcare in low-resources settings, the roles and responsibilities of care providers need to shift in a specific direction. "Clinical tasks should be shared with non-specialists so that the provision of essential care and support is not thwarted by the absence of specialist mental health providers" (WHO, 2013a, p. 21). The task-shifting model, which has been recommended by numerous studies as a way to overcome the human resource barrier, proposes that the responsibility for mental health screening, diagnoses, treatment and follow-ups is shared between specialist and non-specialist care providers (Rebello et al., 2014, p. 310).

In practical terms, task-shifting is about modifying the tasks that mental health specialists and general care providers usually perform for mental healthcare provision. In this sense decisions must be made regarding who will do what in a specific health setting or for a specific health program. Evidence from a study carried out in KwaZulu-Natal, South Africa, suggests that the task-sharing approach can substantially reduce the number of specialized healthcare providers who would otherwise be needed to provide mental healthcare in a low-resource setting; furthermore, the added cost of hiring non-specialized health workers to provide basic mental healthcare can be offset

but a reduction in the number of other specialist and non-specialist health personnel (Petersen et al., 2011; as cited by WHO, 2013a, p. 22).

In the case of scaling up psychosocial care through the mhGAP-IG, a series of roles and responsibilities need to be assigned to one or several care providers, to ensure that the pharmacological, non-pharmacological and psychosocial interventions included in the protocol can be adequately provided (Figure 15).

Figure 15. Redefining tasks for mental healthcare

Tasks for mental healthcare	Care provider?
• Identification of signs and symptoms of mental disorders • Diagnosis of mental disorders • Pharmacological interventions • Basic psychosocial interventions • Advanced psychosocial interventions • Referral to more specialized care • Follow-up	• Psychiatrist • Psychologist • Social worker • General doctor • General nurse • Health technician • Community Health worker • Other health providers

Task-shifting encompasses the use of mental health specialists not only as trainers of non-specialized care providers, but also as on-going supporters and supervisors of their work (Rebello et al., 2014). Since general care providers are not used to managing patients with MNS disorders, they need special support in order to adequately learn to assess and diagnose a patient and to provide psychosocial or pharmacological interventions. In this sense, having a specialist oversee their work closely and be available for questions regarding complex cases can help them gain familiarity and confidence with the new task. General care providers' roles do not vary greatly, with the difference instead being that they would now be trained and capable of providing basic mental healthcare to the population at the non-specialized health facility (World Health Organization & WONCA, 2008, p. 11).

Considering that networks between mental health specialists and primary care doctors in remote areas are not usually well developed (Expert D, personal communication, May 2014), the Model for Psychosocial Care Delivery presents planners with a diagram to help them visualize the recommended relationship network that should be developed among mental health specialists, mental health technicians and general care providers to overcome scarcity of human resources at a low-cost (Figure 16).

Figure 16. Relationship between human resources

Mental health specialist	Mental health technician & liaison	General care providers
• Trains general care providers on mental healthcare • Provides support on-site and remotely • Provides on-going supervision to ensure quality of care • Provides direct care to complex cases	• Provides direct basic mental healthcare • Refers complex cases • Serves as link between mental health specialist and general care provider	• Provide basic care to patient • Refer patients to the mental health technician

According to the Model, there should be an ongoing mutual relationship among mental health specialists, general care providers and the mental health technician or liaison. Due to the scarcity of mental health specialists in low-resource settings, the Model recommends that their role is shifted from direct care provision to being responsible of training, support and supervision of mental health technicians and general care providers. Mental health technicians & liaisons, who as it has been described would be any of the general care providers who have followed some kind of formal training in mental healthcare (i.e. mhGAP-IG), would be in charge of providing direct care to patients, referring complex cases to specialists and serving as a link between specialists and general care providers not trained in mental health. General care providers, not trained in mental health, would provide basic care to the population as usual, but would refer cases that require mental health management to the mental health technician. Who will assume the role of mental health technician & liaison is something that needs to be decided on-site, taking into consideration that general care providers are often overburdened and having the general physician assume this role could be unfeasible in terms of work burden.

In addition, evidence suggests that these new tasks must be limited and doable, in order for the shift to be feasible for non-specialized care providers (World Health Organization & WONCA, 2008, p. 49). Since tasks can be shared among professionals, there is no need to train only one of the care providers at the health facility. The Model for Psychosocial Care delivery also recognizes that there are tasks for which certain care providers would be a better resource than others; for example in general terms, nurses are more open to provide psychosocial care than general doctors who prefer to use medication (Expert I, personal communication, May 2014). So, the Model includes a menu of Human Resources suggested tasks that includes specific responsibilities that can be given to mental health specialists, general care professionals (such as general doctors or nurses) and community health workers with no previous formal training in health. All of these care related tasks would be

assigned to different workers only after following a training program to educate them on their adequate delivery (Figure 17).

Figure 17. Human Resources tasks menu

MENU
Mental health specialists suggested tasks

• Shift the role of mental health specialists at non-specialized settings from providing care to patients to being responsible for:
    o Program development and coordination
    o Training, support and supervision of general care providers working at non-specialized health settings.
    o Assessment and management of complex cases
• Social workers can be responsible of ensuring basic safety of patients

General care professionals and health technicians possible tasks
• General care professionals can be responsible of diagnosis and pharmacological treatment of MNS disorders depending on local regulations • General doctors can focus on diagnosis and prescribing psychiatric medication • Nursing staff (different specialization levels) are a great resource for patient and family psychoeducation • Nursing staff and health technicians can be used to provide basic psychosocial care

Community health workers possible tasks
• Identify people with mental disorders signs and symptoms within the community and refer them to the primary care clinic for mental health assessment and management • Screen patients at non-specialized health facilities • Provide basic mental healthcare in the community or at non-specialized health facilities • Refer patients to other mental health services available • Support general care professionals with basic tasks to optimize their time • Improve access to care in remote areas • Work as administrative staff (answer phones, register patients, clean, open the center) • Peers can educate people with mental disorders about their illness

Redefining roles and responsibilities often comes hand in hand with resistance from care providers, specialized and non-specialized, to modify the way the work. Some mental health specialists fear their jobs could be at risk if less specialized personnel provides mental healthcare (Expert C, personal communication, May 2014) and others oppose the simplification of mental healthcare believing it risks not being adequate (Expert E, personal communication, May 2014). In many low-resource and even high-resources settings, doctors hold a respected position in society and are not always willing to share responsibilities or even training with community health workers (Expert D, personal communication, May 2014). In addition, general care providers do not always understand that learning how to manage MNS disorders is going to help them relieve their burden. They usually focus on the fact that they are already overburdened and do not have time to add yet another service to their already overbooked practice (Expert E & F, personal communication, May 2014). Due to the commonly found resistance from care providers, it is important to make this decision on how to implement task-shifting at a local level, taking into consideration the need to educate the mental health workforce on the benefits of task-shifting for care providers and for the population.

Decision point 2: Defining the strategy to obtain human resources

One of the main reasons why task-shifting is so important is because it allows low-resource settings to improve access to mental healthcare with less specialized human resources, which are easier to find and cheaper to obtain than mental health specialists. Having more mental health specialists providing care at non-specialized health settings is good but should not be a priority (Expert I, personal communication, May 2014). As it has been discussed, through task-shifting, mental healthcare can be provided by general care providers trained in basic mental healthcare. However, general care providers at primary care settings are usually overburdened and not very acceptant of new responsibilities, which is why planners have to define a strategy to obtain human resources for psychosocial care that is feasible locally.

Figuring out if it is feasible to reorganize current health services and shift tasks of current human resources to avoid having to add new personnel for which there is virtually no funding, or if a new program has to be established to ensure sufficient human and financial resources is one of the most important decisions that the Model Psychosocial Care Delivery prompts its users to make. To assist them in making informed decisions to obtain Human Resources at a low cost, the Model summarizes findings in a menu regarding strategies to obtain human resources al low resource settings. The menu describes the implications of either trying to obtain human resources through organizational change or through the establishment of a new program and proposes a series of low-cost strategies that experts recommended to obtain human resources (Figure 18).

The Model for Psychosocial Care Delivery presents two basic considerations, regarding whether Human Resources will be obtained via reorganization of current human resources or via recruitment of new human resources. To aid planners in a practical way, the Model is clear in differentiating that establishing organizational change requires temporary funding allocation until change is established, while the establishment of a new program usually needs new fixed funding that is difficult to obtain at low-resource settings. A series of considerations regarding both processes are presented. Then, general low-cost strategies to obtain human resources based on findings are included to exemplify concrete ways to put the mode into practice. For example, developing collaborations is a good way of obtaining human resources at a very low cost since there are many international and even national agencies looking forward to donate their time, money and expertise to help improve the access to healthcare worldwide; it's just a matter of finding the right collaborators and working together to develop a project.

Strategies to obtain Human Resources	
__Establish organizational change__ Funds need to be allocated temporarily, until change in the organization is established.	__Establish a new program__ New funding is necessary on a long-term basis to assure sustainability.
Organizational change is least costly than establishing a new program *Do not add new staff unless sufficient funding for training, support and supervision is available*	

MENU

A	B
Reorganization of current human resources If mental health specialists and general care providers are available within the health system, then their roles and responsibilities need to be redefined to optimize the resource. This Reorganization entails mobilizing extra human and financial resources temporarily, until change is established. 1. Budgeting mental health specialist's time to provide training to general care providers to become mental health technicians 2. Shifting the amount of time mental health specialists allocate to providing direct care to patients, and focus their efforts on providing training, support and supervision to general care providers at non-specialized health settings. 3. Budget time and financial resources for training of general care providers on basic mental healthcare. 4. Specific time must be budgeted for the mental health technician to provide psychosocial care at non-specialized settings and to meet regularly with peers and supervisors for support.	**Recruitment of new human resources** If there are no mental health specialists, mental health technicians or general care providers available, because they are inexistent at the setting or overburdened, then new human resources need to be recruited. Recruiting new personnel entails obtaining mid- to long-term funding that covers training, support and supervision of new human resources, to ensure the program's sustainability. 1. Recruiting already trained mental health providers (either specialists or technicians) 2. Recruiting un-trained general care providers (professionals, technicians or community health workers) and train them to become mental health technicians.

Diversification of the workforce, recruitment of general care providers, using nontraditional human resources (such as service users, caregivers and community agents) and using existing health programs as platforms for psychosocial care provision are some of the key recommendations to obtain affordable and sustainable human resources. The Model's low-cost strategies to obtain human resources are presented in Figure 19. In addition as it has been described, the task-shifting approach always necessitates substantial training; however, where there is high staff turnover, this investment might be wasted. To avoid this so-called brain-drain some reports call for task sharing with families, carers, and volunteers, empowering them to play a more informed part in caring for people with MNS disorders in the community (Eaton et al., 2011). Experts suggested that people with basic school education could be trained to provide mental healthcare (Expert A & E, personal

communication, May 2014). However, a mental health specialist should work on-site at the first stage program implementation to advocate, teach others, and build things (Expert A & F, personal communication, May 2014).

Figure 19. Low-cost strategies to obtain sustainable Human Resources

MENU **Low-cost strategies to obtain sustainable human resources**

• Diversify of the workforce
• Recruit general care providers already providing general care at non-specialized health settings and train them to provide mental health care
• Take advantage of human resources trained in psychosocial care for specific health programs (i.e. HIV-AIDS)
• Identify the roles that peers, family, community agents, and general care providers can have in providing mental healthcare and use them as human resources instead of relying solely on more expensive mental health specialists
• Have general care providers work in teams to share the workload
• Shift the tasks of specialists working at the tertiary and secondary level to provide train support and supervise care providers at the primary level.
• When recruiting new staff for mental healthcare select people who have time availability and who can commit mid- to long-term to avoid brain drain
• Using volunteers to provide mental healthcare is not a sustainable strategy because of high turnover and brain drain effects. Some kind of compensation, even if small, needs to be given for the workforce to be sustained. (i.e. stipend, academic credit, traveling expenses)
• Reduce specialists' transportation and accommodation costs by using technology for remote support and supervision.
• If available select community health workers and general care professionals who:
    ○ Show an inclination to work in the mental health field
    ○ Are empathetic
    ○ Have good communication and networking skills
    ○ Have at least basic academic knowledge (i.e. reading and writing skills)
    ○ Have cultural competence
• Train high school graduates to become mental health providers
• Partner with existing NGO's, hospitals or other collaborators who already have mental health specialists and who would be willing to donate their human resources time
• If new staff is added specifically for mental healthcare at a health facility, original general care staff should be included in their training so that they understand the health technician role and mental health awareness improves

The Model for Psychosocial Care Delivery provides planners with a menu of options to help them make the best decisions on how to obtain human resources for their setting without needing a budget that is impossible to obtain. However, it does not intend to limit planners to these options. They are presented as suggestions to guide the decision making process, and could be used as examples so that better more locally appropriate strategies can identified.

Decision point 3: Training, support and supervision

Although primary care personnel in low-resource settings are usually motivated to do training in mental health (Expert F, personal communication, May 2014), mental healthcare training platforms are usually not very well developed in these settings, and if available, training is not provided in an on-going and systematical way. In some settings, for example, in-service mental health training is provided intermittently by external collaborators (Expert B, personal communication, May 2014). In

others, specific trainings (i.e. psychological first aid) are made available for some of the a part of the general care workforce but it is not carried out in a systematic way, meaning that some care providers get trained and others don't because the Host cannot afford training everyone.

There are some exceptions though, and very positive experiences regarding training of non-specialized health workers have been carried out in many low- and middle-income countries. In Belize, for example, a training of psychiatric nurse practitioners to assess patients mental health and to provide pharmacological, non-pharmacological and psychosocial interventions was successful in developing a new mental health workforce (World Health Organization & WONCA, 2008) However, although adequate training of primary care workers is required (Ibid, p.49) most low-resource settings have very little training opportunities in the mental health field. Also, mental healthcare provision varies across settings, psychosocial care could be available in one health setting and non-existent in another, even in the same country or region, and general care practitioners often find themselves providing mental healthcare without any specific training in mental health (Expert D & J, personal communication, May 2014) which causes frustration for care providers and jeopardizes quality of care.

According to findings, although most primary care providers are reluctant to add mental healthcare to their workload, most of them would welcome more human resources to help them provide mental healthcare (Expert G & I, personal communication, May 2014). It is then important to motivate general care providers to get training by showing them the benefits of learning to handle patients with conditions that would otherwise be unfamiliar to them (Experts E, F & I, personal communication, May 2014). In addition, when general practitioners do receive basic training, they are often hesitant to prescribe most psychotropic medications with more vulnerable populations such as children (Expert I, personal communication, May 2014). Good quality training that offers non-specialized care providers a clear understanding of MNS disorders and their treatment is necessary to address their fear, stigma and frustration due to lack of knowledge (Expert E, personal communication, May 2014). Educating primary care providers about mental healthcare allows them to feel able and comfortable and not afraid of providing this kind of care (Expert C & E, personal communication, May 2014). Also, since some disorders are more stigmatized than others, a better understanding of these conditions would help reduce stigma among MNS disorders themselves (Expert C, personal communication, May 2014).

In more practical terms, in order to improve access to psychosocial care at low-resource settings, planners need to figure out how training, support and supervision is going to be carried out, so that it is high quality and not very costly. Evidence suggests that mental health professionals and facilities

must be available to support primary care, and the identification of a mental health service coordinator is crucial (World Health Organization & WONCA, 2008, p. 49)

The Model for Psychosocial Care Delivery systematizes findings to provide planners with a menu of suggestions on important strategies to take into consideration for sustaining a Human Resources development platform for mental healthcare in low-resource settings (Figure 20).

Figure 20. Building a Human Resources platform

MENU **Strategies to build a platform for sustaining** **Human Resources for mental healthcare**
- Train existing personnel in mental healthcare provision to reduce the cost of hiring new staff.   - Use existing training, support and supervision channels available for general healthcare and use them for mental healthcare.   - Make sure that the budget covers the three aspects of the human resource development platform (training, support and supervision) in an on-going way to ensure sustainability   - Distribute tasks among trainers: use psychiatrist to provide training in pharmacotherapy and psychologists and social workers to provide training in psychosocial care   - Provide training for local care providers to become mental healthcare trainers so that the workforce can continue to expand locally   - Use training methods that will provide general care providers with a sense of familiarity and confidence about managing patients with mental disorders, such as: - Combining on-site and remote trainings   - Doing supervised patient-interviewing with patients   - Practicing with role plays   - Using videos to exemplify the population and interventions   - Using case study methodology   - Combine on-site and remote training, support and supervision   - Provide protocols, guidelines and other resources that are requested by primary care providers to facilitate their job   - Create mental health provider's group meetings to share experiences and ensure peer support   - Create a local mental health assembly composed by all mental healthcare providers that meets regularly for training and awareness activities   - Ensure easy access to mental health specialists by the general care providers in charge of basic mental healthcare (i.e. via phone, e-mail, chat, other communication platform)   - Create a structure for support and supervision of mental health programs (i.e. networks or teams of mental health specialists that oversee several mental health programs at primary care clinics)   - Use technology to do remote access training, support and supervision in order to reduce transportation and professional's time (i.e. web based training)   - Reduce wasted time in medical practice by training general care doctors and other providers

According to this study's findings, and specifically in reference to experience of interviewed expert in scaling up mental health services in low-resource settings, these programs tend to fall apart when mentoring is not available. Making training accessible is not enough in these settings, on-going support and supervision is needed to sustain their impact (Expert C, personal communication, May 2014) and existence (Expert G, personal communication, May 2014). In addition, the effort to develop a human resource platform for mental healthcare should not only train local workers on how to provide basic mental healthcare, but also on how to train others, so that the workforce can be expanded locally in an inexpensive way (Expert E, personal communication, May 2014).

The provision of protocols, guidelines and other resources that are requested by primary care providers to facilitate their job is also important (Expert I, personal communication, May 2014). Although many times they won't use them regularly, having them available gives care providers a sense of security to perform the task. Also, in order to provide adequate psychosocial care to people with MNS disorders, care providers must at least have the basic resources that have been identified by this Model (human and otherwise) to carry out the interventions. Planners must make sure that proper support infrastructure, including mental health specialists and materials to assess patients and provide care, are available either on-site or remotely, so that access to care can be sustained.

Psychosocial interventions are time consuming and will often require more than one care provider to deliver them in a low-resource setting. The Model for Psychosocial Care Delivery emphasizes the need to create a structure for support and supervision of mental health programs. In terms of support, findings suggest that general care providers must be supported and accompanied by a person, not just guidelines and materials (Experts A, E, F, G & I, personal communication, May 2014). Although there can be different organization strategies, the Model suggests the creation of local networks or teams that link the mental health specialist with the non-specialized care provider (Expert I, personal communication, May 2014). Teams should have team coordinators at each level of care, and clear communication pathways must be established among its members. Mentorship by a team of mental health specialists would allow general care providers to familiarize with management of MNS disorders and be more open about taking care of this population. Regular team meetings will allow its members to share and discuss among specialists and non-specialists before making concerted decisions about how to adapt to evolving local needs.

In addition, findings suggest the use of remote training, support and supervision to reduce costs (Expert A & D, personal communication, May 2014). However, for remote supervision to be successful, first a personal relationship needs to be created in-person between the specialist and the non-specialized practitioner (Expert D, personal communication, May 2014), only then it becomes possible to successfully shift to e-mailing, teleconferencing or other remote methods. Since some non-specialized health settings in resource-poor locations have a good information technology platforms (i.e. internet access, equipment for conference call), support could be provided remotely by phone or e-mail. Although the mental health specialists would not be on-site with the general care provider, a phone conversation could help answer questions and reassure a hesitant care provider if a good trusting relationship with the specialist has been developed beforehand.

When a particular setting makes the decision to train general care providers in psychosocial interventions for MNS disorders, program planners must also identify what they should be trained

on, in order to be able to provide such interventions. Although every case is different, according to the Host's aspirations and the disorders or population that has been targeted, identifying a basic set of contents that must be taught to all primary care mental health providers would help planners in the planning process. It is important to emphasize that according to findings all general care providers can be trained provide basic psychosocial interventions such as the ones presented in the mhGAP-IG (Lancet Global Mental Health et al., 2007; WHO, 2008). Therefore, low-resource settings must not rely only upon general physicians or nurses, which could be difficult to obtain at some settings. Diversifying the workforce and using lay workers to provide basic mental healthcare is possible if a good Human Resources platform is developed (Rahman et al., 2008, p. 2).

Figure 21. Training content for psychosocial care providers

MENU
Basic training content

- Prevalence of mental disorders in non-specialized health settings
- Understanding mental disorders as a psychological, social and biological disorder
- Public Health capacity for mental healthcare providers and program coordinators
- Disability caused by mental disorders
- How to differentiate between mental illness and physical illness when a patient is agitated
- Patient assessment and diagnosis with basic screening tools and clinical interviewing
- Structuring a treatment plan for people with mental disorders
- Effective use of the mhGAP-IG
- Responsibilities and limitations as non-specialized mental healthcare providers
- Well-timed referral to more specialized services
- How can non-specialized mental healthcare providers effectively support general care doctors
- Delivery of basic psychosocial intervention techniques:
  - Shared principles of psychosocial care for treating mental disorders (i.e. mhGAPs general principles for care)
  - Active listening techniques
  - Counseling techniques
  - Creating a therapeutic alliance
  - Managing counter transference
  - Psychological first aid
  - Managing frustration with non-compliant patients
- According to needs and resources more advanced interventions such as Cognitive Behavioral Therapy, Interpersonal Therapy, Psychodynamic Psychotherapy or interventions for specific vulnerable populations (i.e. child mental health) can be taught to general care providers.

The Model for Psychosocial Care Delivery provides planners with a list of basic contents for training based on this study's findings (Figure 21). The contents suggested in the menu are broad in terms of mental healthcare and could be specified further according to local needs. The idea is to give care providers a general understanding of MNS disorders, mental health ant the interventions of choice, according to the Host's Needs, Aspirations and Resources. Once again, this menu is intended to guide planners, by providing them access to possible recommendations for training content based on scientific and experiential evidence on what is needed when providing psychosocial care at low-resource settings. However, choosing training contents should not be carried out by planners alone,

but along with a team of different mental health specialists who understand technical needs to fulfill the Host's Aspirations in terms of psychosocial care provision.

Finally, although trying to adopt low-cost strategies is key, this suggestion should not be in detriment of quality of care or capacity for sustainability. The Model for Psychosocial Care Delivery highlights the need for a budget that covers the platform's three components: training, support and supervision. Failing to do so would jeopardize quality of care (Experts A, C, E, D & G, personal communication, May 2014), program sustainability (Experts E, C, D & G, personal communication, May 2014), and could result in a waste of valuable resources.

5. Host's Other Resources

In order for human resources to be able to effectively scale up the psychosocial component of the mhGAP-IG, or other evidence based packages of care for MNS disorders, *Other Resources* must also be present at the health setting. According to the Wheel of Global Mental Health, "some of these include finances, mental health policies, access to healthcare, access to medication and health insurance" (Samuel et al., in press). This component of the Model for Psychosocial Care Delivery refers to those basic resources such as infrastructure, supplies, and technical resources that must be made available in order to effectively provide psychosocial care at low-resource settings.

Decision point 1: Identifying other resources needed

As it has been described, ensuring sufficient allocation of resources for mental healthcare is a difficult task when the mental health budget is not prioritized in most low-resource settings. Local stakeholders looking to scale up mental healthcare have to work with very inadequate resources in terms of infrastructure availability, and access to technical, technological and material resources. Although the human resource is often available, physical space where care could be provided or access to laboratory equipment to run necessary tests for patients are lacking (Expert C, personal communication, May 2014). Although very often, due to the inadequate budget allocation, Host's focus on the need to increase financial resources, there are other types of resources that are also necessary when intending to scale up psychosocial care at non-specialized health settings.

Since availability of Other Resources varies greatly from one country to another, and even one health setting to another, once program planners have identified the Host's Needs, Aspirations and Human Resources for psychosocial care provision, Other Resources must be identified. The Model for Psychosocial Care Delivery presents a list of basic Other Resources that according to findings are required for scaling up psychosocial care at the primary care level (Figure 22).

Basic Other Resources for Psychosocial care menu
Financial
• Sufficient funding to finance human and other necessary resources • Care provider's time to care for the patient
Infrastructure

• Social Services agencies and services
• Space:
   o Private room or space for counseling
   o Conference room for family and staff meetings
   o Administrative infrastructure (i.e. for registration of patients)

Technical
• Library access • Access to good quality and sensitive screening tools • Educational pamphlets & posters for mental health education • Basic books, guidelines, compilations and materials for basic mental healthcare and psychosocial care • Equipment for laboratory tests
Material Supplies
• Access to medication for mental disorders • Materials to provide care to children and adults • Screening tool copies • Paper
Information technology
• Computers • Internet platform • Telephone lines • Fax • Copy machine • Teleconferencing platform

This study's findings suggest that financial resources continue to figure at the top of priorities of Other Resources, due to the fact that they can be used to obtain other resources needed to effectively care for people, such as paying for human resources, and obtaining access to good quality screening tools and care provision materials (Experts A,B,D,F,H & I, personal communication, May 2014). In addition to difficulty obtaining the necessary funds for program implementation, many settings are lacking in care provision infrastructure, such as social service agencies, to oversee basic needs and wellbeing the population (Expert E, personal communication, May 2014). This makes it more difficult to scale up psychosocial care, since program planners have not only to think in delivering psychosocial interventions, but also in finding ways to improve access to other basic services.
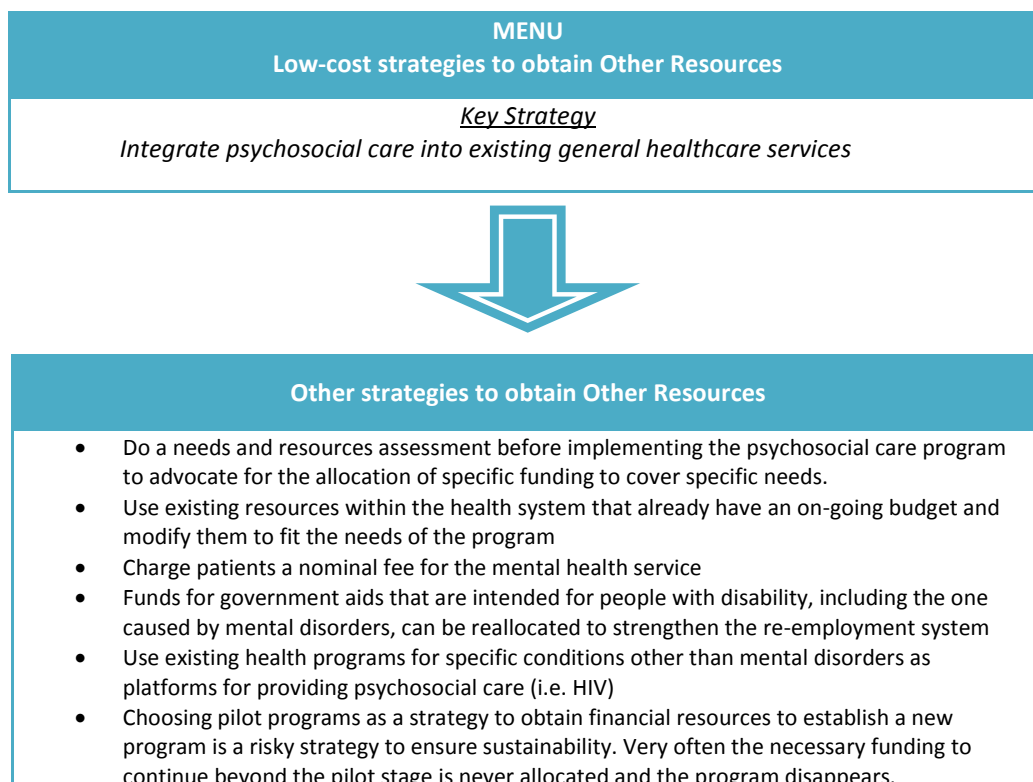
In terms of infrastructure, stress was put on the need of private space, although findings show that this space can be made available in different forms, just as long as privacy for care provision is obtained. Material resources needed for psychosocial care delivery are not many. The need for professional actualization platforms (i.e. journal databases) and educational materials was suggested

(Experts A,B & I personal communication, May 2014). Although this Model is intended to be used at settings were medication for MNS disorders is available, the need to strengthen the reliability of medication provision was stressed (Expert A, B, E, I & J, personal communication, May 2014). Finally, the need for technological equipment, other than laboratory equipment, was mentioned (Expert A & C, personal communication, May 2014. Even when in low-resource settings, having access to computers, internet platforms and other similar devices were addressed (Expert A & J, personal communication, May 2014).

Decision point 2: Obtaining other resources

Once planners are aware of which Other Resources are needed for psychosocial care provision, ways to obtain them must be defined. In general terms, it is strongly recommended not to minimize financial needs when requesting funds for psychosocial care or mental healthcare (Expert A, personal communication, May 2014), this is key to ensure the program's success and sustainability from the start. However, if insufficient funding is allotted, low-cost alternatives to fund Other Resources should be explored. The Model for Psychosocial Care Delivery presents a menu of low-cost strategies to obtain Other Resources, based on recommendations from experts and the literature review (Figure 23). Among these recommendations, a key action to obtain resources would be the integration of psychosocial care into existing general healthcare services. Doing so would help ensure sustainability and would keep added costs to a minimum.

Figure 23. Obtaining Other Resources

MENU
Low-cost strategies to obtain Other Resources
Key Strategy
Integrate psychosocial care into existing general healthcare services

Other strategies to obtain Other Resources

- Do a needs and resources assessment before implementing the psychosocial care program to advocate for the allocation of specific funding to cover specific needs.
- Use existing resources within the health system that already have an on-going budget and modify them to fit the needs of the program
- Charge patients a nominal fee for the mental health service
- Funds for government aids that are intended for people with disability, including the one caused by mental disorders, can be reallocated to strengthen the re-employment system
- Use existing health programs for specific conditions other than mental disorders as platforms for providing psychosocial care (i.e. HIV)
- Choosing pilot programs as a strategy to obtain financial resources to establish a new program is a risky strategy to ensure sustainability. Very often the necessary funding to continue beyond the pilot stage is never allocated and the program disappears.

Since it is very unlikely that low-resource settings will invest in building new infrastructure for scaling up psychosocial care (Expert C, personal communication, May 2014), integrating mental health services into existing health facilities reduces the need for high investments in infrastructure (Expert A & C, personal communication, May 2014). Other affordable alternatives currently being used at low-resource settings were identified, such as charging nominal fees to patients who receive the service, however this would become a barrier to care in settings where patients cannot afford to pay for that fee. The Model for Psychosocial Care Delivery recommends the integration of psychosocial care into general health care to reduce added expenses of obtaining new financial, infrastructural, technical, material and technological resources solely for the use of a psychosocial care program. In this sense, identifying which basic Other Resources are not available at the health setting is key to make sure that they are made available through budget allocation or via collaboration with a partner agency or donor. Collaborations, will be explored further in the next section, is one of the low-cost strategies suggested to obtain Other Resources at settings were the budget allocated to scaling up psychosocial care does not cover implementation needs.

6. Collaborator's Aspirations

Low-resource settings around the world face the great task of reducing the treatment gap of MNS by scaling up mental health services. According to the Wheel of Global Mental Health, the Collaborator is the Host's partner in the process of scaling up mental health services (Samuel et al. in press). Many non-governmental agencies and donors from high-resource settings attempt to aid these countries, yet many times they are not fully aware of the Host's real needs, which are most often related to shortage of resources and limited access to care.

While Collaborators might aspire to conduct research on mental health outcomes following an intervention, the Host might be in need of prevalence studies or technical support carrying out an intervention. "There is palpable lack of consideration in service planning about if and how for-profit and not-for-profit services can be mutually complementary within a wider system of care (Younes et al., 2005; Badrakalimuthu et al. 2009; Pollock, 2010; Wahlbeck et al., 2011; mentioned by Thornicroft & Tansella, 2013, p. 856). Since, very often, Collaborators have access to resources that the Host doesn't, collaborations could be of great support to low-resource settings trying to scale up mental healthcare. However, in order to develop a successful partnership planners need to find a way to match the Host's Aspirations with that of Collaborator's, in some way so that both parties benefit from it and are interested in sustaining it (Expert E, personal communication, May 2014).

Decision point 1: Identifying Collaborators

Program planners can draw upon different types of collaborators, either in-country or foreign. Identifying national and international profit and non-profit organizations interested and willing to collaborate with the Host in the process of scaling up psychosocial care at a their setting is a strategy to overcome barriers related to insufficient funding, lack of trained human resources or inadequate access to other resources. In addition, according to the WHO and Wonca (2008) collaboration with other government non-health sectors, nongovernmental organizations, village and community health workers, and volunteers is required (p. 49).

The Model for Psychosocial Care Delivery urges planners to try to develop partnerships with non-profit organizations related with healthcare provision or interested in helping low-resources settings ; with academic institutions, either national or foreign, who hold mental health programs (Expert G, personal communication, May 2014); with professional societies of health professionals, who would be interested in supporting non-specialized care providers (Expert G & H, personal communication, May 2014); with government institutions, either from the health sector or other, who are interested in providing support according to their resources (Expert A & B); with retired or other mental health experts willing to donate time to provide training and supervision to non-specialists (Expert C, personal communication, May 2014); with community or other grassroots organizations (Expert G, personal communication, May 2014) or advocacy or consumer groups (Expert H, personal communication, May 2014) who could be interested in supporting the improvement of access to mental healthcare in their communities.

It is important to mention that planners in low-resource settings tend explore for collaborations with foreign agencies, rather than local (Expert B & G, personal communication, May 2014), but the role of both in-country and foreign multi-country collaborations is essential to scale up psychosocial care and share knowledge on best practices (Expert C, personal communication, May 2014). Taking into account all possible partners is a smart strategy to avoid spending resources on services that can be available at little or no cost by developing clear pathways between Host and Collaborators.

Decision point 2: Defining areas for collaboration

Besides knowing who can collaborate with the Host, it is important to identify what kinds collaborations can be practically pursued. The establishment of private-public collaborations for funding and coordination of mental health programs could be carried out. For example, private companies could donate resources as part of social responsibility programs intended to improve the wellbeing of the community where they operate, and non-profit organizations could be in charge of overseeing the administration of mental health programs at the primary level (Expert F, personal

communication, May 2014). Evidence from Latin America and the Caribbean strongly suggest the promotion of international cooperation, particularly in capacity building, research and policy development (Caldas de Almeida, 2013, p. 17). When improving access to psychosocial care at low-resource settings, there are certain areas in which Collaborator's assistance would be of greater benefit for local stakeholders. These considerations were systematized and included in the Model for Psychosocial Care Delivery to guide on identifying possible areas of Collaboration for scaling up psychosocial care (Figure 24).

Figure 24. Areas of Collaboration

MENU
AREAS OF COLLABORATION
Financial
• Direct financial support via budget allocation or funding of a program component • Establishment of private-public collaborations for funding and coordination of mental health programs • Private companies can donate resources as part as social responsibility programs
Technical
• Direct care provision by external mental health specialists • On-site and remote training, support and supervision • Academic exchange programs (i.e. medical resident exchanges) • Addressing policy issues rather than only focusing on direct care provision • Help local settings acquire, adapt and implement pre-existing and new effective tools and mental health interventions, rather than developing new ones. • Extended on-site help on program development and implementation • Non-profit organizations can oversee the administration of mental health programs at non-specialized level. • Capacity building, research and policy development
Material and program development
• Development of mental health awareness campaigns at a community level • Development of short films locally to inform, educate and raise awareness on mental disorders, using easy language in culturally relevant scenarios. • Facilitate access to library resources

In order to increase sustainability capacity, the Model for Psychosocial Care Delivery recommends planners to aim at developing long-term and on-site collaborations. Three areas of collaboration have been highlighted: financial, technical, and material and program development. In terms of financial collaborations, Collaborators are prompted to directly fund either completely or partially local efforts to scale up psychosocial care. For example, Collaborators could assist a health setting on the purchase of a vehicle or materials for care delivery (expert F, personal communication, May 2014). In terms of technical cooperation, Hosts are especially interested in obtaining access to specialized human resources, via direct care provision or training of care providers. Also, collaborations for capacity building, research and development are strongly suggested. Finally in terms of material and program development, the assistance in development of local mental health awareness campaigns or materials for this purpose was cited.

For collaborations to be successful it is crucial that all parties are involved and work together to develop a plan of action" (Razzouk et al., 2012, p. 193); objectives, rules and methods for collaboration must be planned, programmed and coordinated by both parties prior to program implementation to avoid creating unnecessary difficulties and improve the collaboration's chances for success.

7. Collaborator's Resources

The main reason why the Host is interested in developing a collaboration is because of the Resources that the Collaborator can contribute that are not available at the local setting. In this sense, the *Collaborator's Resources* component of the Wheel of Global Mental Health is key to meaningfully address mental health needs in LAMICs (Samuel et al., in press) and adequately plan for collaborations regarding scaling up psychosocial care at low-resource settings.

Decision point 1: Identifying Collaborator's resources

Currently, most LAMICs could benefit from a collaboration to scale up psychosocial care at non-specialized health settings. According to findings, there are a some resources that Collaborator's usually have available that would be of great help to improve access to psychosocial care at low-resource settings. Consequently, to aid planners in identifying resources that could be obtained via collaboration, the Model for Psychosocial Care Delivery includes a menu of financial, human, technical and material resources that could be obtained via collaboration, either with national or international agencies (Figure 25).

Figure 25. Collaborator's Resources menu

Financial
• Funds: either one time grants or on-going financial resources

Human Resources
• Remote and on-site specialized mental health manpower time and advice for:
o care provision
o training, support and supervision
o program design and implementation
o design and production of materials for care provision

Technical and Material
• Access to journals
• Guidelines, books and other technical resources for health providers
• Provision of films, posters, or other types of displays to inform the population about mental health and MNS disorders
• Supplies for care delivery

Although, stakeholders and program planners at low-resource settings usually identify financial support as the most needed resource for scaling up psychosocial care and mental healthcare in general (Experts A,B,D,F,H & I, personal communication, May 2014), it is important to acknowledge that partnerships are not limited to program funding. There are many ways in which Collaborator's

Resources could help reduce the treatment gap, one of which is the provision of specialized manpower that would otherwise be non-existent at some settings (Expert A, B, C, D, E, G, H, I & J, personal communication, May 2014). Making mental health specialists available to visit remote settings and to provide direct care, but most importantly to teach general care providers how to treat MNS disorders is key in settings where mental health specialists are virtually non-existent. Also, improving access to technical resources and materials could be obtained via collaboration, by developing partnerships with agencies that have the resource available, such as hospitals and universities. The Model for Psychosocial Care Delivery urges planners to identify possible collaborations to cope with shortages in local resources.

8. Local Advocate

According to the Wheel of Global Mental Health, a *Local Liaison* could be a person or organization that has "a good understanding of the local burden of disease, health care system, human and other resources, infrastructure, culture, customs, language, politics, history as well as stigma towards mental illness" (Samuel et al., 2014). Since the Wheel was developed from the Collaborator's point of view, rather than from a program planners perspective, the Model for Psychosocial Care Delivery refers to the Wheel's Local Liaison as the Local Advocate, to stress the fact that its main role is to do advocacy work to improve access to psychosocial care, and not only to link the Host and the Collaborator efforts.

Decision point 1: Identifying the Local Advocate

In practical terms, the Local Advocate must be a person who is in a position of influence, that is able to make decisions, but that is close enough to the field to support the implementation of the program. Evidence from Latin America & the Caribbean suggests that having "(...) a body in the ministry of health with adequate leadership, solid technical capacity, access to the centers of political decision, and capacity to influence all components of the mental health system(...)" is key to be successful in the improvement of mental health services (Caldas de Almeida, 2013).   Having technical knowledge in both mental healthcare and public health are necessary attributes for advocacy and implementation efforts (Lancet Global Mental Health et al., 2007, p. 1250).   In addition, being in a position to influence change in the local setting is an essential quality to look for, along with dedication, empathy and passion about mental health (Samuel et al., 2014).

Since the context and approach to mental healthcare will vary across settings, it is not possible to say exactly who the best Local Advocate for scaling up psychosocial care is in every low-resource setting. For example, enlisting decision makers who are personally affected by mental illness as Local Advocates could be a strategy to facilitate the implementation of a program that would not be

prioritized otherwise (Expert C, personal communication, May 2014). Therefore, aiming to assist planners in the process of scaling up psychosocial care, The Model for Psychosocial Care Delivery presents a menu of options regarding possible agencies that could function as Hosts to the program and where the Local Advocate could be found (Figure 26).

Figure 26. Local Advocates Menu

MENU
Local advocates can be found at:
• Government institutions linked to the health sector: at the national, regional or community level
• Non-governmental organizations
• Professional associations related to the health sector
• Academic institutions with health related programs
• Consumer groups
• Community based organizations
• Advocacy groups of specific populations or interests (i.e. users of mental health services)

Local Advocates vary greatly from one setting to another, but are key in the implementation of mental health programs in low-resource settings (Samuel et al., in press). Many times, especially in low-resource settings, unexpected situations occur during program implementation and plans have to be reconfigured. Local Advocates must have sufficient technical expertise to modify and adapt programs in changing settings, in order to ensure care provision for the population.

The Model for Psychosocial Care Delivery urges planners to choose the Local Advocates carefully, making sure that the person has sufficient decision making influence and is knowledgeable about public health and psychosocial care provision, in order to improve chances for program sustainability.

II. Recommended Lines of Action for Costa Rica

With the objective of exemplifying the use of the Model for Psychosocial Care Delivery in a real setting, lines of action for its implementation in Costa Rica were identified and will be presented in this chapter as recommendations for local stakeholders to consider when planning to carry out actions to improve access to psychosocial care for people with MNS disorders. Although Costa Rica is an upper-middle income country, and does not figure among the poorest countries nor among the list of countries that should be given higher priority according to the mhGAP Program and the WHO, the treatment gap for people with MNS disorders is great and local stakeholders have expressed the need for support to maximize their resources and successfully scale up mental healthcare. Furthermore, since the ratification of Costa Rica´s National Mental Health Policy in October 2012, consistent efforts are being made by the Ministry of Health and its collaborating agencies to scale up the mhGAP Program at a national level.

These recommendations are based on findings obtained via a three-week site visit to Costa Rica where the researcher and one member of the supervising team met with key local stakeholders working at different health agencies Costa Rica's public health system to explore possible pathways to implement the Model for Psychosocial Care Delivery. The purpose of each meeting and visit along with a list of key stakeholders consulted are summarized in Figure 27. Official mental health Policy and other relevant public health documents were also consulted, along with local epidemiological data available for MNS disorders.

Figure 27. Meetings with Costa Rican key stakeholders

Purpose of the meeting	Local stakeholders present at the meeting
Meeting to collect data regarding possible implementation pathways in Costa Rica.	**Dr. Virginia Rosabal, MD** Psychiatrist Mental Health Program Coordinator at the Caja Costarricense del Seguro Social (CCSS)
Meeting to collect data regarding possible implementation pathways in Costa Rica.	**Dr. Allan Rimola, MD** Mental Health Secretary Mental Health Secretariat at the Ministry of Health
Visit to three different community centers where the Network for Psychosocial Care for Children and Teenagers provides its services Meeting to collect data regarding possible implementation pathways in Costa Rica.	**Laura Chacón, PhD, Clinical Psychologist** Head of the Network for Psychosocial Care for Children and Teenagers at the National Psychiatric Hospital. **Dr. Virginia Rosabal, MD, Psychiatrist** Mental Health Program Coordinator at the Caja Costarricense del Seguro Social (CCSS)
Meeting with the Mental Health Institutional Commission at the Ministry of Health to collect data regarding possible implementation pathways in Costa Rica.	**Dr. Allan Rimola, MD** **Dr. Carmen Macanche, MD, psychiatrist** **Patricia Barquero, psychologist, MPH**
Visit to Monseñor Sanabria Hospital's Psychology and Social Work service to explore primary and secondary care services for people with MNS disorders, and to identify how the mhGAP program is currently being implemented at rural and remote settings Meeting to collect data regarding possible implementation pathways in Costa Rica.	**Dr. Mariana Vargas, Clinical Psychologist** Head of the Psychology and Social Work service Monseñor Sanabria Hospital
Meeting to explore services available for people with substance and alcohol use disorders and to collect data regarding possible implementation pathways in Costa Rica. Visit to the teen and adult care facilities	**Vera Barahona** Head of IAFA **Dr. Luis Eduardo Sandí, MD, Psychiatrist** Especialist in addictions and at IAFA and mhGAP Trainer
Visit to Carlos Duran Clinic and to EBAIS to explore current primary care services for people with MNS disorders and how the mhGAP is being implemented at the primary level at an urban primary care clinic. Meeting to collect data regarding possible implementation pathways in Costa Rica.	**Dr. Francisco Montero, MD, psychiatrist** Head of mental health at Carlos Duran Clinic and EBAIS
Meeting to collect data regarding possible implementation pathways in Costa Rica.	**Dr. Allan Rimola, MD** Mental Health Secretary Mental Health Secretariat at the Ministry of Health **Dr. Francisco Gólcher, MD, psychiatrist** Institutional Comptroller, Mental Health Point person at the Ministry of Health

The following sections include this study´s findings regarding Costa Rica´s mental health system, their current needs and aspirations along with resources available for mental healthcare. For the contextualization component, results are described broadly to give a good idea of Costa Rica's health system and context. The results regarding the rest of the Model's components will be presented in a more practical form, as recommended lines of action that local program planners can use for the implementation of the psychosocial component of the mhGAP program at local non-specialized health settings.

1. Contextual Considerations

The Republic of Costa Rica, a Central American country of 51.100 Km2 and a population of 4.713.168 inhabitants (INEC, 2014), has been recognized internationally as a peaceful country since the abolishment of its armed forces in 1948; it has a very stable democracy, with a longstanding tradition of promoting education, health and other social policies (WHO, 2010b, p. 9). Costa Rican's have universal access to education, healthcare, clean water, sanitation, and electricity. More specifically, the healthcare system, which sustains on various regimes of social security managed by the Caja Costarricense de Seguro Social or *CCSS* (Costa Rican Social Security Administration), is one of the few in Latin America that offers almost complete, universal coverage, both in financial and geographical terms. This reflects on Costa Rica's leadership in health indices that attain levels similar to those of developed countries.

Costa Rica's population is ageing, with an average birth rate of 6.25 births/1,000 people and an average death rate of 4.44 deaths/1,000 people; the average life expectancy at birth is of 79 years; 76 for men and 81 for women (CIA, 2014). According to 2011 Census, poverty affected 20,7% of households with a 6,4% considered to be in extreme poverty (INEC, 2014). Poverty tends to be accentuated in rural areas, at a ratio of 1,86 per urban household. (INEC, 2011; as cited by Ministerio de Salud de Costa Rica, 2012, p. 25). Literacy is also high in Costa Rica; 95.2% of people over 10 years-old are considered to be literate, with a better rate for women (96.9%) than for men (94.9%).

The Ministry of Health (MoH) is in charge of regulating all matters and agencies related with health including, but not limited to, the CCSS; which is Costa Rica´s largest autonomous institution. However, in its governing role, the MoH does not administer nor has any jurisdiction upon the Social Security Regimes. This results in inconsistencies and coordination difficulties between the MoH and the CCSS when implementing national health policy (WHO, 2010b, p. 6). The CCSS works along with other public agencies to ensure healthcare, access to health services, and medication. It finances its services through contributions of workers, employers and the state, and has five different types of

beneficiaries (direct contributors, self-insured, pensioner, family insured, and insured by the state) (WHO, 2010b, pp. 6-7). However, there is no separation of service packages depending on the type of insurance; "every insured pays for integrated healthcare as an indivisible right guarded by the constitution and the laws of the State" (WHO, 2010b, p. 8). In addition to public services, there is a tendency towards the use of private health care services, "caused by long waiting periods before obtaining access to examinations, specialized medical evaluations, diagnoses, and surgery, which are quality problems that undermine the fidelity towards the system" (Ibid., p 16).

Costa Rica has an updated National Mental Health Policy and Action Plan, signed in October 2012 and in rigor until 2021, which calls for decentralization of mental healthcare into community care services (Ministerio de Salud de Costa Rica, 2012). In addition, Costa Rica complies with human rights standards for people with MNS disorders which are monitored regularly in mental health facilities around the country (WHO, Ministerio de Salud de Costa Rica, CCSS, & OPS, 2008, p. 7). The CCSS offers a service network of primary, secondary and tertiary care that ensures geographic coverage. The Country is divided into health regions, that differ from the geopolitical provinces, and then into Health Areas of approximately 30.000 to 60.000 residents. However, it is estimated that mental health is allocated 3% of Costa Rica's health budget, of which 67% goes to psychiatric hospitals (WHO et al., 2008, p. 12). Therefore, "(...) mental health resources are insufficient, unevenly distributed, and concentrated in the third level of care: all of which impedes the creation, formation or sustainment of community-based health units" (WHO et al., 2008, p. 7).

Following the National Mental Health Policy Action Plan, the Mental Health Secretariat at the MoH was created in 2013. The secretariat is now responsible for overseeing regulation and policy development of all mental health services. This task is carried out with support from an institutional mental health commission composed by members of different departments of the MoH, and an inter-institutional mental health commission composed by high-level decision-makers of multiple government agencies related to the health sector (personal communication with Dr. Allan Rímola, June 2014).

At the primary level, Health Areas are subdivided into population sectors of 3500 to 4000 people who are provided care by the Equipos Básicos de Atención Integral de Salud or *EBAIS* (Basic Provision Units of Integrated Healthcare) (WHO, 2010b, pp. 6-7). Each EBAIS is a team of primary care providers composed by one general doctor, one nurse-auxiliary, one primary healthcare technician, one pharmacy technician and one medical records technician, who work together to ensure basic care at small non-specialized health facilities within the communities (WHO et al., 2008, p. 10). One health facility can house several EBAIS (units of care) depending on the size of the population that

they tend to. To date, there are 1045 EBAIS all over the country, which conform the first level of care along with some peripheral and deconcentrated clinics (personal communication with Dr. Virginia Rosabal, June 2014).

The primary level has specific population-based programs (Children, teenagers, Women, Adults, Senior Citizens) and financial resources are allocated to each primary healthcare facility based on analysis and projections of the population's demographical and epidemiological needs. However, healthcare services respond to a population of 3.8 million, and not 4.7 million as is the current reality, which forces EBAIS to undertake the assistance of more patients than its recommended according to their response capacity (WHO, 2010b, p. 14).   Furthermore, the lista oficial de medicamentos (official list of medicines) explains in detail the medicines that the CCSS can offer to its beneficiaries. (WHO, 2010b, p. 11). Most psychotropic medications are available in Costa Rica for the entire population, and according to regulations, can only be prescribed by medical personnel (WHO et al., 2008, p. 7). However, it is important to acknowledge that "out of the total amount of out-of-pocket expenses, 80% is related to the purchase of medicines and medical consultations, while 7% corresponds to lab examinations and other procedures" (Muiser, 2010; as cited by WHO, 2010b, p. 11). In addition, there are no established protocols available for most MNS disorders; yet, an adequate referral system does exist at the primary level to ensure access to healthcare services at other levels of care (WHO et al., 2008, p. 7).

Although there are no formal mental health programs currently available at the EBAIS, an effort to train general care doctors nationwide in the mhGAP Program has been carried out since 2013 by the MoH, along with PAHO, in order to improve access to mental health services at the primary level. The training process is underway with the objective to train a total of 450 general practitioners by August 2014, when an evaluation of the Program's implementation process will be carried out. (personal communication with Dr. Francisco Gólcher, June 2014).   An effort to create mental health teams in all health areas has also been carried out by the CCSS, however it has been very difficult to establish them, mostly in rural areas (personal communication with Dr. Virginia Rosabal, June 2014). Mental health teams availability vary at non-specialized health settings. Some mental health teams work in a coordinated and effective way, such as the one at the Carlos Duran Clinic, a primary care clinic where a team consisted of a psychiatrist, a psychologist and a social worker working together to assess and treat patients; however the success of establishing mental health teams varies according to the willingness and interest that different care providers have in working as a multidisciplinary team, since doing so is not mandatory (personal communication with Dr. Francisco Montero, July 2014). There is currently no updated information regarding what mental health teams

are in operation at a national level, nor are there guidelines on how to organize mental health teams according to roles and responsibilities at the different levels of care.

The secondary care level comprises a network of 11 major clinics, 13 peripheral hospitals, and 7 regional hospitals, which provide emergency services, diagnosis support, specialized outpatient consultation and simple surgical interventions (WHO, 2010b, p. 7).   In terms of mental healthcare provision, there are 26 psychiatric units available in several general hospitals. They are run by psychiatrists and other mental health specialists with a rate of 2 beds per 100,000 population (WHO et al., 2008). There are also 38 mental health outpatient facilities available to treat 1 916 users per 100,000 general population. In average users have 4.32 contacts with the service and only 3% of outpatient facilities provide follow-up care in the community.   All mental health outpatient facilities have reliable and on-going access to at least one psychotropic medication of each therapeutic class (antipsychotic, antidepressant, mood stabilizers, anxiolytic and antiepileptic) either at the health facility or a near-by pharmacy (Ibid., p. 13). Besides pharmacological treatment, most outpatient facilities (51% to 80%) also offer some kind of psychosocial interventions (Ibid). For example, regional hospitals, such as the Monseñor Sanabria in Puntarenas, have a Psychology and Social Work Service that provides out-patient and support in-patient services at the hospital. It is run by a team of clinical psychologists and social workers, however, the human resource is insufficient and it is difficult for them to provide timely care to the population, along with support for primary care providers (personal communication with Mariana Vargas, July 2014).   In addition, there are 35 community residential facilities available in the country, with a rate of 3.9 beds per 100,000 population for people who have been discharged from the Psychiatric Hospital but need further support and care.

The tertiary level comprises national concentration hospitals and specialized hospitals, and provides in-patient services and medical-surgical services of high technological complexity (WHO, 2010b, pp. 6-7). Although the National Mental Health Policy urges to shift care provision from specialized facilities to non-specialized health settings in communities, most of the mental healthcare services are still being provided by the two psychiatric hospitals: Hospital Nacional Psiquiátrico and the Hospital Chacon Paut. Both hospitals are located in the metropolitan area, at a rate of 22 beds per 100.000 people, which complicates access for the rural population. Most patients admitted at this level have been diagnosed with schizophrenia and other psychotic disorders (28%; F20-F29) and mood disorders (37%; F30-F39) (WHO et al., 2008, p. 14). In addition, there are two day hospitals for the entire country, both located in the capital city.

Finally, it is important to notice that Costa Rica does not systematically measure mental health budget allocation nor expenses. A study that looked at feasibility of Activity Based Costing to analyze and cost-effectiveness of pharmacotherapy, psychotherapy and a combination of both when treating people with depressive disorders at a primary clinic in the capital of Costa Rica, showed encouraging results (Montero, 2003). However, there are no cost-effectiveness studies regarding current mental health interventions to treat MNS disorders at a national level, and no reliable data regarding their economic impact is available (Ministerio de Salud de Costa Rica, 2012, p. 26). Furthermore, no epidemiological studies to establish a baseline for prevalence of MNS disorders have been carried out at a national level (personal communication with Dr. Francisco Gólcher, June 2014). This lack of information is common in low-resource settings, where mental health has been traditionally left in the back seat of public health policies, programs and plans of actions.

2. Host's Needs

To date there are no baseline studies regarding the epidemiologic, economic or societal burden of MNS disorders in Costa Rica.

Recommended Lines of Action

1. Prioritize psychosocial care for the nine disorders included in the mhGAP Program (depressive disorders, schizophrenia and other psychotic disorders, suicide, epilepsy, dementia, alcohol use disorders, substance use, and mental disorders in children) at non-specialized health settings.

2. If budget allocation does not cover financial needs to scale up the psychosocial care component of the mhGAP program for the nine priority disorders, then prioritize care for major depressive disorder at non-specialized settings

3. When reliable data on the prevalence of MNS disorders and current societal and economic burden becomes available, the priority target population should be reconsidered based on findings.

3. Host's Aspirations Component

Costa Rica aspires to develop their mental health system by combining increased mental health promotion efforts with improved access to prevention and healthcare for mental, neurological and substance use disorders at the community level.

<u>Recommended Lines of Action</u>

<u>Axis A: Improve access to psychosocial care</u>

1. Reorganize care delivery structures by integrating mental healthcare services in primary care facilities:

   a) Use task-shifting to share the burden of psychosocial care delivery between the primary, secondary and tertiary care facilities and avoid overcharging the primary care level.

   b) Establish specific mental health teams conformed by care providers at the primary, secondary and tertiary level to ensure access to training, support and supervision. Each mental healthcare provider at the primary level should have easy and efficient communication pathways with care providers at the secondary and tertiary levels. And timeframes for regular on-site and remote meetings should be established to ensure their sustainability.

   c) Identify and organize all agencies and programs (private and public) currently offering psychosocial care services to the population (i.e. maternity care platforms); and use them as a resource to complement the psychosocial interventions that will be provided at the primary care facility, by developing clear referral pathways between different care provision agencies.

   d) Identify and organize all mental health promotion services available at the local setting (private or public); and use them to improve access to mental health promotion services by developing clear referral pathways via the primary care facility.

   e) Increasing access to psychosocial care at the primary care setting and sharing care provision between multiple agencies and programs lightens the burden of mental health specialists at secondary and tertiary levels and allows them to allocate more time to training, support and supervision tasks and to focus on more complex cases.

   f) Establish a manageable goals with measurable outcomes (i.e. at first only scale up psychoeducation services at the primary care facility) and be prepared to face unexpected obstacles (i.e. staff resistance to change).

   g) According to the patient's needs and resources available at the health facility, psychosocial care can be provided either in group or in individual sessions, house visits could be used to provide family support, and phone technology could be used to provide psychosocial services remotely.

2. Use the EBAIS and other primary care clinics of the Areas of Health as the main platform to deliver psychosocial care to the population

    a) Train current care providers at the EBAIS that could allocate the time needed in the psychosocial component of the mhGAP; if this is not possible, obtain alternate human resources to ensure psychosocial care provision at this level.

    b) Use home-visits currently carried out by EBAIS health technicians to identify and refer possible cases.

3. Provide the recommended psychosocial interventions included in the mhGAP-IG at the primary care level

    a) The EBAIS should be used as platform to educate the population about mental health and MNS disorders, and to provide basic information to users regarding common questions, problems and coping strategies for illness related situations.

    b) EBAIS should be responsible of providing the basic psychosocial interventions included in the mhGAP-IG for the nine priority disorders with support via referral from other agencies and programs (public and private) currently providing psychosocial care

    c) General hospitals should be responsible of providing the advanced psychosocial interventions included in the mhGAP-IG for the nine priority disorders for patients with more complex MNS conditions

    d) Patients should be referred to social service agencies when necessary to address basic needs other than medical and psychosocial treatment (i.e refer children to services at Patronato Nacional de la Infancia; or refer women to the Oficina de la mujer available at municipalities).

    e) A referral pathway for mental health promotion services should be created to link mental healthcare and mental health promotion services delivered by different agencies.

4. A screening protocol for MNS disorders that includes screening at the EBAIS and other primary care settings should be officially established by the CCSS

    a) The mhGAP-IG should be formally established as the basic protocol for MNS disorders assessment at the primary level.

    b) An inexpensive, easy to use, culturally relevant, sensitive and reliable screening tool should be selected and included in the protocol in order to facilitate the screening process for primary care providers working at EBAIS (i.e. Goldberg's General Health Questionnaire).

c) Physical and sexual violence screeners should be included in the screening protocol

d) If possible, include screening tools for illiterate population

5. The EBAIS should be established as the entry-point to the mental healthcare system and clear referral pathways should be established according to the disorder's severity.

a) General care providers at the EBAIS should be able to perform all basic psychosocial care interventions and should refer the patient to more specialized care only when the protocol of care demands it.

b) Advanced psychosocial interventions cannot be performed by primary care providers trained in the basic mhGAP psychosocial interventions. Patients in need of advanced support should be referred to secondary care.

c) When unsure of referral, the general care provider at the EBAIS should consult with the mental health specialist of his team if the referral is necessary (via phone or e-mail) who in turn must be readily available to provide support to the primary care provider.

d) Efforts should be made for the same patient to be treated by the same psychosocial care provider on a regular basis, to ensure treatment continuity and to build a therapeutic alliance.

e) Identify clearly other agencies providing psychosocial care services and establish clear communication and referral pathways to improve access to those services.

Axis B: Improve mental health awareness

1. Key stakeholders, at the Ministry of Health, the CCSS and its collaborating agencies, in charge of making decisions regarding allocation of resources and defining priority programs should be approached and educated about the burden of MNS disorders in, economic, societal, and public health terms.

a) Deliver convincing key messages for mental health awareness via informative bulletins distributed via internal mail, e-mail or in agencies general assemblies.

2. Care providers and directors of health facilities at the three levels of care should be educated about the benefits that task-sharing to provide psychosocial care has for all parties.

a) Deliver convincing key messages via training platforms, informative bulletins, and professional societies (Colegio de medicos y cirujanos, Colegio de psicólogos, colegio de enfermeros, etc).

b) Create a mental health association for training and mental health awareness purposes

3. Service users should be informed about the availability of mental health care and promotion services at the primary level in order to improve health seeking behavior in the population.
   a) Establish a mental health awareness week with different interactive activities carried out in the communities for service users to obtain access to information; promote the mental health awareness week via posters and flyers distributed in each community.

4. Host's Human Resources

In Costa Rica "continuous refresher training, albeit irregular and sporadic, has been provided in some areas (e.g. child mental health, alcohol/drugs, and depressive disorders) to primary healthcare personnel, specialists, and other health workers" (WHO et al., 2008, p. 7). However, overall, general healthcare personnel receive little training in mental health and mental healthcare both during their training as health professionals and as care providers within the Costa Rican health system.

Therefore, following the Model's general recommendation to integrate psychosocial care into primary care, and in compliance with Costa Rica's aspiration to strengthen community mental health services; to overcome the scarcity of human resources available for mental healthcare it is necessary to develop a strong platform for mental healthcare human resources and reorganize them in a more cost-efficient way.

Recommended Lines of Action
1. Use task-shifting to redefine the tasks traditionally given to care providers for mental health care at different levels of care.
   a) Mental health specialists at the secondary and tertiary levels should provide assessment and advanced psychosocial and pharmacological treatment of more complex cases.
   b) Psychiatrists, psychologists, mental health nurses, and social workers at secondary and tertiary levels should provide on-going training, support and supervision to primary care providers who will be in charge or providing psychosocial care at the EBAIS:
      - Psychiatrists should focus on the pharmacologic component of care of the mhGAP-IG
      - Psychologists and social workers should focus basic psychosocial care included in the mhGAP-IG
      - Mental health nurses could focus on psychoeducation regarding treatment compliance.

c) Primary care providers trained in mental healthcare will become mental health technicians and will function as a liaison between mental health specialists and other general care providers.

   - General doctors could be trained on: assessing patients with the mhGAP-IG, conveying the results of the assessment, and prescribing medication
   - General nurses could be trained on: psychoeducation to patient, family and other caregivers, providing regular follow up, managing behavioral and psychological symptoms, giving advice to teachers, promoting independence, functioning and mobility,
   - Health technicians could be trained to: identify signs and symptoms of MNS disorders and refer them to the mental health service at the EBAIS, deliver basic interventions for cognitive symptoms and functioning, brief intervention techniques, addressing psychosocial stressors, reactivation of social networks, rehabilitation in the community, addressing housing and employment needs, and promotion and protection of human rights.
   - Community health workers or health track students could be trained to deliver the same interventions as health technicians.

d) General care providers not trained in mental healthcare and working at the primary or secondary level will refer patients to the mental health technician when an assessment is required.

e) Mental health teams should be composed by at least one care provider of each level of care and should keep close and on-going communication.

2. Most human resources for psychosocial care provision at the EBAIS should be obtained by implementing task-shifting; and specific time should be budgeted for each of the care providers to be able to perform the new tasks.

a) Time and money for mental health specialists, at the secondary and tertiary level, to be able to provide on-going training, support and supervision to primary care providers must be budgeted and allocated.

   - Remote training, support and supervision can help reduce costs
   - Partner with existing NGO's (red cross), hospitals (public, private, non-profit) or other collaborators who already have mental health specialists who'd be willing to donate their human resources time for training, support or supervision.

b) If care providers are already too overburdened at the EBAIS and time allocation for psychosocial care is not feasible, the recruitment of low-cost community health workers or second year health tracks students should be explored.

c) Avoid the brain drain by recruiting people who can commit mid- to long-term or who will later become care providers and will use the training provided.

d) Clinical training spots for medicine, nursing and psychology residents could be opened at the EBAIS to obtain a good quality low-cost resource for psychosocial care provision.

e) Service users, family, care givers and community agents, can be trained to provide basic interventions and could be used as a low-cost human resource instead of relying solely on more expensive mental health specialists.

f) Always include general care providers when training in mental healthcare interventions is provided, even when specific care providers for psychosocial care has been recruited.

3. A strong platform for the development of human resources for mental healthcare that includes training, support and supervision must be created and sustained.

a) Currently existing channels for training, support and supervision available for general healthcare should be used for mental healthcare.

b) Distribute tasks among different kinds of mental health specialists in charge of training.

c) Provide training for general care providers at the EBAIS to become trainers of the psychosocial interventions so that the workforce can continue to expand locally

d) Use training methods that will provide general care providers with a sense of familiarity and confidence about managing patients with mental disorders, such as:
   - Combining on-site and remote trainings
   - Doing supervised patient-interviewing with patients
   - Practicing with role plays
   - Using videos to exemplify the population and interventions
   - Using case study methodology

e) Combine on-site and remote training, support and supervision

f) Provide the mhGAP-IG guidelines, screening tools and other resources that are requested by primary care providers to facilitate their job

g) Establish regular mental health group meetings for general care providers at EBAIS to share experiences and ensure peer support.

h) Create a local mental health assembly composed by all mental healthcare providers that twice a year for training and mental health awareness activities.

i)   Establish mental health teams as a formal and mandatory structure for training, support and supervision

j)   Define an easy communication pathway between mental health specialists at secondary and tertiary level and general care providers at the EBAIS (i.e. via phone, e-mail, chat, other communication platform)

k)   Use technology to do remote access training, support and supervision in order to reduce transportation and professional's time (i.e. web based training)

4. Training for general care providers in charge of delivering psychosocial care at the EBAIS (mental health technicians) should include the following contents:

a)   Prevalence of mental disorders in non-specialized health settings

b)   Understanding mental disorders as a psychological, social and biological disorder

c)   Public Health capacity for mental healthcare providers and program coordinators

d)   Disability caused by mental disorders

e)   How to differentiate between mental illness and physical illness when a patient is agitated

f)   Effective use of the mhGAP-IG

g)   Patient assessment and diagnosis with basic screening tools and clinical interviewing

h)   Structuring a treatment plan for people with mental disorders

i)   Responsibilities and limitations as mental healthcare technicians

j)   Well-timed referral to more specialized services

k)   How to effectively support general care practitioners

l)   Delivery of basic psychosocial intervention techniques:

   ▪ Shared principles of psychosocial care for treating mental disorders (i.e. mhGAP general principles for care)

   ▪ Active listening techniques

   ▪ Counseling techniques

   ▪ How to create a therapeutic alliance

   ▪ Managing counter transference

   ▪ Psychological first aid

   ▪ Managing frustration with non-compliant patients

m) Training on how to use the mhGAP-IG and actualization courses on advanced psychosocial interventions should to be provided to mental health specialists to ensure a cohesive approach to mental healthcare.

5. Host's Other Resources

The most current data shows that 67% of Costa Rica's mental health budget, which is estimated to be of approximately 3% of the national health budget, is allocated to the tertiary care level. In order to provide psychosocial care at the EBAIS and other primary care clinics, a set of basic and resources must be made available at this level at a low-cost in order to overcome budget insufficiency.

Recommended Lines of Action

1. Basic financial, technical, technological, material and infrastructural resources must be made available to ensure the delivery of appropriate psychosocial care services.

    a. Financial resources for mental health should be increased in order to effectively scale up mental healthcare services at a national level.

    b. Mental health specialists currently working at the tertiary levels must allocate part of their time to train, support and supervise general care providers at the primary level, in order to shift the use of resources towards non-specialized health settings in the community, as recommended by Costa Rica's National Mental Health Policy.

    c. Social services agencies should be linked with the EBAIS and other primary care services in order to facilitate support with ensuring the patient´s basic needs, that are not related with treatment, but that can affect its outcome.

    d. A private space for counseling (i.e. office, conference room) must be made available at the EBAIS for individual and group psychosocial support sessions.

    e. A registry service for patients who are receiving psychosocial care should be established and included in the general care file, so that both physical and psychosocial aspects of health are considered jointly by care providers when studying a patient's file.

    f. Sufficient material supplies should be ensured for psychosocial care delivery (i.e. access to copies of screening tools; informative and educational pamphlets & posters for psychoeducation)

    g. Access to the mhGAP-IG tools at each EBAIS along with other tools, reference books and materials for psychosocial care should be ensured.

    h. Access to computers, internet platform, telephone lines and other information technology equipment is necessary to communicate with other agencies and colleagues.

2. To obtain these basic other resources at the lowest cost possible, without jeopardizing their quality, integration of mental healthcare into primary care services and budget is recommended.

a. Use existing resources within the health system that already have an on-going budget and modify them to fit the needs of the program

b. Use existing health programs for specific conditions other than mental disorders as platforms for providing psychosocial care (i.e. maternity, senior citizens)

c. Choosing to carry out a pilot program as a strategy to obtain financial resources to scale up psychosocial care is a risky strategy to ensure sustainability. Very often the necessary funding to continue beyond the pilot stage is never allocated and the program disappears.

d. Consider developing partnerships with agencies interested in improving access to mental healthcare (private, public or non-profit) either local or foreign, to obtain other specific resources needed.

6. Collaborator's Aspirations

As an upper-middle income country Costa Rica does not figure among the countries that receive humanitarian aid nor a lot of international cooperation for development. However, specific collaborations can be developed to scale up psychosocial care since the global treatment gap is alarming and many international agencies and organizations of different collaboration capacity are interested in supporting efforts to reduce it.

Recommended Lines of Action

1. Identify possible organizations or agencies either from the health sector or other sectors (such as education, economic development, justice, human rights, etc.), foreign or local that show interest in improving access to mental healthcare in Costa Rica.

2. Explore possible collaborations between the Ministry of Health, the CCSS, IAFA and:

   a. Academic institutions (i.e. Universities with health track programs; global mental health programs)

   b. Local and foreign professional societies of health professionals

   c. Government agencies (i.e. ministry of education)

   d. Foreign or local retired mental health experts willing to donate their time

   e. Community or grassroots organizations (i.e. Fundamentes)

   f. Advocacy or consumer groups

3. Define areas in which collaboration could be useful to ensure resources for psychosocial care provision at the EBAIS that can't be covered by the allocated budget

   a. Funding to improve infrastructure for psychosocial care provision at existing EBAIS

   b. Collaboration in development, implementation and coordination of psychosocial care services via private-public partnerships (i.e. Fundamentes)

c. Social Responsibility programs with the private sector to support mental healthcare provision

d. On-site and remote training, support and supervision by external collaborators to help overcome human resource scarcity in remote settings.

e. Academic exchange programs for professional actualization of the mental health workforce

f. Strengthening the efforts to implement the National Mental Health Policy

g. On-site support for the implementation of the psychosocial component of the mhGAP Program at a national level.

h. Capacity building, research and policy development

i. Development of mental health awareness campaigns at a community level

j. Material supplies provision and development (i.e. support on local development of short films to inform, educate and raise awareness on mental disorders and mental health)

k. Facilitate access to library and other academic resources

7. Collaborator's Resources

Costa Rica could benefit from collaborations to obtain very specific resources for psychosocial care provision that otherwise would be very difficult to obtain through public mental health budget allocation. After identifying what resources are available at each EBAIS where psychosocial care will be provided, collaborations should be explored based on those resources that are available to collaborators but insufficient locally.

Recommended Lines of Action

1. Identify the resources that collaborators could assist the EBAIS with and focus efforts on establishing those that are most beneficial according to local needs.

    a. Care providers at EBAIS could benefit greatly from on-site or remote training, support and supervision sessions provided by international mental health experts with broad experience implementing mental health programs at low-resource settings.

    b. Improving access to academic journals, care provision guidelines or protocols and actualization courses (on-site or remote) could greatly benefit general care providers at the primary care level.

    c. Funds to improve infrastructure or to purchase equipment (i.e, information technology equipment) could be useful to improve psychosocial care provision at EBAIS with very basic infrastructure.

8. Local Advocate

Costa Rica has recently appointed a mental health secretary at the Ministry of Health Mental health Secretariat, who is in charge of overseeing and coordinating all matters related with regulations and policy regarding mental health services. Therefore a very clear figure has been established as the Mental Health Advocate. However, since this is a fairly new position, efforts must be made to establish the Secretariat's influence and leadership in the mental health sector.

Recommended Lines of Action

1. Identify government agencies linked to the health sector at the national, regional, and community level, and use the secretariat to create awareness about the burden of MNS disorders and to inform them about specific objectives that will be pursued at a national level.

2. Identify non-governmental institutions interested in collaborating to improve psychosocial care and inform them about the lines of action that the Mental Health Secretariat will take to improve access to mental healthcare; explore ways for them to support public healthcare provision.

3. Identify Academic institutions with health track programs and inform them about the lines of action that the Mental Health Secretariat will take to improve access to mental healthcare; explore ways for them to support public healthcare provision.

   Create awareness among the general population about the burden of MNS disorders in Costa Rica and inform them about the lines of action that the Mental Health Secretariat will take to improve access to mental healthcare

Chapter 4: Conclusions, Recommendations & Study Limitations

This study intended to respond to the need of reducing the treatment gap of mental, neurological, and substance use disorders by supporting the efforts of increasing access to mental healthcare in low-resource settings. The Model for Psychosocial Care Delivery focused on defining affordable strategies to scale up psychosocial care at the non-specialized health settings. It was designed to assist program planners in making key decisions for the adaptation and local implementation of the psychosocial component of the mhGAP Program at low-resource settings.

The Model includes eight components: Contextualization, Host's Needs, Host's Aspirations, Host's Human Resources, Host's Other Resources, Collaborator's Aspirations and Collaborator's Resources. These components are interdependent, meaning that a decision made for one component directly affects the others. However it is not hierarchical. Although it is natural to start by assessing the context and identifying needs, some program planners might find themselves having to make decisions regarding human resources before establishing the target population; the model will help them approach this decisions in a more informed way. Each of the components has several decision points to prompt program planners to ask themselves key questions that will help them organize their resources according to local needs and aspirations, with the objective of maximizing them.

Because the Model was designed to support the implementation of the mhGAP Program, most recommendations go hand in hand with the implementation of this Program at a local setting. However, it was designed to be sufficiently broad and flexible so that planners can use it when intending to scale up other evidence-based packages of psychosocial care for low-resource settings.

Each component includes a menu of recommendations for action, based on scientific evidence and empirical findings. A set of basic and affordable psychosocial care services that take into consideration strategies to improve access to psychosocial care along with suggestions for improving mental health awareness have been included. Furthermore, the minimum Human and Other Resources needed to scale up psychosocial care at non-specialized health settings have been identified; and specific recommended strategies to obtain them and sustain them over time have also been included. Recommendations regarding how to organize health services for psychosocial care provision, that focus on strategies to integrate psychosocial care into primary care, in order to maximize local resources and make the task feasible for low-resource settings are a key part of this Model.

Furthermore, in order to exemplify the use of the Model for Psychosocial Care Delivery, the Costa Rican public health system was studied and the Model was used to identify specific lines of action to

scale up the psychosocial care component of the mhGAP Program. These recommended lines of action have been presented in practical wording and organized according to each of the Model's components to showcase how it can help program planners make key decisions regarding the adaptation and implementation process of the mhGAP Program.

While this study recognizes the importance of mental health promotion and prevention for the general population, along with the pharmacological component of treatment for people with MNS disorders; this study's focus on improving access to psychosocial care provision limits the comprehensiveness of the approach. Increasing efforts to improve mental health promotion actions is strongly suggested to positively affect the population's well-being.

Moreover, because this study focused on defining affordable strategies to improve access to psychosocial care at low-resource settings based on a combination of scientific evidence and qualitative empirical data; no quantitative cost analyses regarding the affordability of Model's recommendations for action were carried out. Therefore, it is not possible to assure that their implementation at low-resource settings will be the least costly available. Thus, carrying out research about the cost-effectiveness of improving psychosocial care at non-specialized health settings is highly recommended.

Also, due to the nature of this study and the resources available to the researcher, a more detailed action plan with objectives, specific actions and measurement indicators for implementation of the psychosocial component of the mhGAP in Costa Rica was not carried out. However, it is strongly suggested that based on the recommended lines of action presented by these study further efforts are made to develop a more thorough action plan for its implementation.

Finally, by integrating a broad but fragmented literature with an expert-informed framework to assist the decision making process for mental health program implementation, this study has taken a step to aid planners in low resource-settings in identifying and organizing their capacity for improving access to psychosocial care in an affordable and sustainable way.

Appendix 1

Interview Guide: Interviewer version

Psychosocial Care Delivery Model: A Supplement to the MhGAP Action Program

Karen Carpio
MPH candidate, psychologist

The mental health GAP Action Program developed by the World Health Organization in 2008 proposes an integrated package of interventions to care for people with Mental, Neurological and Substance Use disorders at non-specialized settings.

The mhGAP has identified **depressive disorders, psychosis, epilepsy and seizures, developmental disorders, behavioral disorders, dementia, alcohol use disorders, drug use disorders and self harm or suicide** to be the priority MNS conditions on the basis that they represent a high burden (in terms of mortality, morbidity, and disability); cause large economic costs; or are associated with human rights violations.

The package consists of pharmacological and psychosocial interventions for prevention and management of each of the priority conditions based on evidence about their efficacy and effectiveness, cost effectiveness, equity, ethical considerations including human rights, feasibility or deliverability, and acceptability.

This study focuses on the delivery of psychosocial care and presupposes that the pharmacological treatment for people with MNS disorders proposed by mhGAP, or its equivalent, is already available at the setting where psychosocial interventions will be provided.

The objective of this interview is to identify a low-cost way of ensuring that high-quality and equitable psychosocial care is delivered at primary care level.

1. **To better understand your background and expertise in mental health, could you describe the setting where you currently work and the roles you have played as a mental health expert?**
2. **Are you familiar with the mhGAP Program? In what ways?**

Questions organized according to the wheel of mental health

⇨ **Hosts needs**

Disease burden

3. To what extent would the provision of psychosocial care at primary care settings help relieve the current burden of MNS disorders in your locality?
4. Patients with which MNS disorders would benefit most from receiving psychosocial treatment in primary care?

⇨ **Hosts aspirations**

<u>National policies</u>

5. Where would you say psychosocial care fits among societal priorities in your locality?
6. Where does psychosocial care stand in the public health agenda?
7. Is there any impetus to develop more psychosocial care programs at primary care level?

<u>Range of services to be offered</u>

8. Have mental health services been incorporated into primary care in your locality? Is psychosocial care included?
9. What are the most important psychosocial interventions to offer to people with MNS disorders at primary care level?
10. The following range of psychosocial interventions is included in the mhGAP Action Program. How would you modify it?

For the patient only:

– Providing psychoeducation
– Providing support and advice
– Providing regular follow-up as needed
– Addressing current psychosocial stressors
– Reactivating social networks
– Structuring a physical activity program
– Facilitating community based rehabilitation
– Human rights promotion and protection
– Support conveying the result of the assessment
– Managing behavioral and psychological symptoms
– Psychosocial interventions for cognitive symptoms and functioning
– Promote independence, functioning and mobility

– Taking alcohol use history
– Brief interventions to reduce harmful alcohol consumption
– Referral to Self-help groups
– Addressing housing and employment needs
– Brief intervention techniques
– Harm reductions strategies
– Care for the person with self harm

For families, carers and teachers:

– Providing psychoeducation
– Advice
– Providing support

11. Would there be a need for mental health screening by the psychosocial service providers? If so, how do you think screening should be implemented at primary care level? What screening tool would you recommend?

⇨ **Hosts Human Resources**

<u>Skills</u>

12. Have non-specialized human resources been used successfully for mental health care in your locality? How? (Consider: health professionals, non-specialized personnel, ex-service users, caregivers and family, the community, other sectors, regulations to provision of care)
13. What skill set must a health worker possess to be able to provide adequate psychosocial care at primary care settings?
14. How would you obtain and maintain adequate human resources for the delivery psychosocial care at primary level? (Consider: need for training, support and supervision)
   - Human resource to provide it
   - Type of training necessary
   - How to support staff
   - How to supervise staff

⇨ **Other Host's Resources**

Infrastructure and supplies

15. What infrastructural, material and logistic resources would be necessary for delivering care at non-specialized settings?

Existing health system

16. Can you think of successful examples in which mental health services have been decentralized into primary care settings in your locality? Was psychosocial care incorporated?

17. To what degree would primary care settings be capable of providing the range of psychosocial interventions specified by the mhGAP?

Funding & sustainability

18. How could a psychosocial care program comprising the mhGAP interventions be sustained in primary care settings?

19. How would you reduce the cost of delivering mental healthcare in a non-specialized setting?

Model of care delivery

20. Taking into consideration the range of psychosocial treatments to be provided and the resources needed to do so; how could a new primary care program be organized to deliver adequate psychosocial treatment at a low-cost?

⇨ **Collaborator Aspirations**

21. What roles could foreign collaborators have in the process of scaling up psychosocial care at primary level?

22. What roles could in-country collaborators, external to the health sector, have in the process of scaling up psychosocial care at primary level?

⇨ **Local liaison/Advocate**

23. Who would you consider to be a key partner in setting up a psychosocial care program in primary care settings?

⇨ **Collaborator resources**

24. What are the most needed resources that collaborators could bring to help with the process of scaling up psychosocial care?

Appendix 2

Interview Guide

Psychosocial Care Delivery Model: A Supplement to the MhGAP Action Program

Karen Carpio, Psychologist, MPH candidate
Program in Global Mental Health at the Icahn School of Medicine at Mount Sinai
Ecole des Hautes Etudes en Santé Publique

The mental health GAP Action Program developed by the World Health Organization in 2008 proposes an integrated package of interventions to care for people with Mental, Neurological and Substance Use disorders at non-specialized settings.

The mhGAP has identified **depressive disorders, psychosis, epilepsy and seizures, developmental disorders, behavioral disorders, dementia, alcohol use disorders, drug use disorders and self harm or suicide** to be the priority MNS conditions on the basis that they represent a high burden (in terms of mortality, morbidity, and disability); cause large economic costs; or are associated with human rights violations.

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This study focuses on the delivery of psychosocial care and presupposes that the pharmacological treatment for people with MNS disorders proposed by mhGAP, or its equivalent, is already available at the setting where psychosocial interventions will be provided.

The objective of this interview is to identify a low-cost way of ensuring that high-quality and equitable psychosocial care is delivered at primary care level.

1. To better understand your background and expertise in mental health, could you describe the setting where you currently work and the roles you have played as a mental health expert?

2. Are you familiarized with the mhGAP Action Program? In what ways?

3. To what extent would the provision of psychosocial care at primary care settings help relieve the current burden of MNS disorders in your locality?

4. Patients with which MNS disorders would benefit most from receiving psychosocial treatment in primary care?

5. Where would you say psychosocial care fits among societal priorities in your locality?

6. Where does psychosocial care stand in the public health agenda?

7. Is there any impetus to develop more psychosocial care programs at primary care level?

8. Have mental health services been incorporated into primary care in your locality? Is psychosocial care included?

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- Care for the person with self harm

For families, carers and teachers:

- Providing psychoeducation
- Advice
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11. Would there be a need for mental health screening by the psychosocial service providers? If so, how do you think screening should be implemented at primary care level? What screening tool would you recommend?

12. Have non-specialized human resources been used successfully for mental health care in your locality? How?

13. What skill set must a health worker possess to be able to provide adequate psychosocial care at primary care settings?

14. How would you obtain and maintain adequate human resources for the delivery psychosocial care at primary level? (Consider: need for training, support and supervision)

15. What infrastructural, material and logistic resources would be necessary for delivering care at non-specialized settings?

16. Can you think of successful examples in which mental health services have been decentralized into primary care settings in your locality? Was psychosocial care incorporated?

17. To what degree would primary care settings be capable of providing the range of psychosocial interventions specified by the mhGAP?

18. How could a psychosocial care program comprising the mhGAP interventions be sustained in primary care settings?

19. How would you reduce the cost of delivering mental healthcare in a non-specialized setting?

20. Taking into consideration the range of psychosocial treatments to be provided and the resources needed to do so; how could a new primary care program be organized/structured to deliver adequate psychosocial treatment at a low-cost?

21. What roles could foreign collaborators have in the process of scaling up psychosocial care at primary level?

22. What roles could in-country collaborators, external to the health sector, have in the process of scaling up psychosocial care at primary level?

23. Who would you consider to be a key partner in setting up a psychosocial care program in primary care settings?

24. What are the most needed resources that collaborators could bring to help with the process of scaling up psychosocial care?

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Annex 1: Summary in French

Élaboration d'un Modèle de Prestation de Soins Psychosociaux: un complément pour la mise en place du Programme mhGAP dans des milieux à ressources faibles.

I. Introduction

La santé mentale, ou le bien-être psychosocial, est un principe qui figure dans la constitution de l'Organisation Mondiale de la Santé (OMS) où la santé est définie comme "un état de complet bien-être physique, mental et social, ne consiste pas seulement en une absence de maladie ou d'infirmité" (WHO, 2013b, p. 7). La capacité qu'une personne a pour vivre une vie pleine, pour créer et maintenir des relations avec sa famille, avec ses pairs et avec la société; et pour prendre des décisions sur de différents aspects de la vie quotidienne, tels que l'emploi, l'hébergement ou l'éducation, est essentielle pour maintenir une bonne santé mentale. (WHO, 2010; 2013a, p. 1521). Dans ce sens, les personnes qui souffrent d'un trouble mental, neurologique ou lié à l'utilisation de substances psychoactives (MNS), tels qu'ils sont définis par le Manuel Diagnostique de Troubles Mentaux (DSM-V) et la Classification Internationale de Maladies (ICD-10), ont une capacité amoindrie d'accomplir ces activités basiques ainsi que un fonctionnement diminué à niveau individuel, de ménage et de société. (WHO, 2013a, p. 7).

Les troubles mentaux contribuent de façon notable au fardeau globale de la maladie, étant responsables du 30% du fardeau total de maladie pour les maladies non-communicables (WHO, 2008, p. 6), et de 7,4% (6.2–8.6) du fardeau total de maladies en 2010. Les troubles MNS sont devenus la cinquième catégorie la plus importante parmi les catégories des troubles par rapport aux années de vie corrigées de l'incapacité (AVCI) ou DALYs (en Anglais, Disability Adjusted Life Years) et la première cause globale des années vécues avec un handicap (AVH) ou YLDs (en Anglais, Years Lived with Disability) (Whiteford & Baxter, 2013, p. 1579).

La santé mentale, comme n'importe quel autre aspect de la santé, peut être affectée par une série des facteurs socioéconomiques qui doivent faire l'objet d'approches stratégiques pour la promotion, la prévention, le traitement et la réhabilitation. (WHO, 2013b). La santé mentale n'est pourtant pas à l'ordre des priorités des agendas en santé publique de plusieurs pays. Très souvent, les individus souffrant de troubles MNS sont traités avec indifférence et préjugé par les communautés et sociétés où ils habitent. (WHO, 2013a, p. 7). Les nouvelles connaissances par rapport au fardeau des troubles MNS doivent devenir des actions concrètes pour aider à la réduction du fardeau des maladies à niveau global.

Il existe donc une relation très disproportionnée entre le fardeau de maladie et les dépenses accordés à la santé mentale, ce qui affecte directement les personnes qui ont besoin d'aide. (WHO, 2001). Cet écart est partiellement dû au fait que les pouvoirs publics des pays ne se sont pas saisis de cette problématique. Cette lacune de prestation de soins devient plus importante dans les milieux à ressources faibles, tels que les pays à revenue faible et moyen (LAMICs). L'OMS et le très renommé mouvement globale pour la santé mentale, ont lancé un appel à la communauté internationale, les gouvernements, les organisations donatrices, et d'autres acteurs de la santé mentale, pour l'action immédiate pour l'amélioration d'accès aux services pour la santé mentale dans tous les pays, mais

spécialement dans les pays à revenu faible et moyen. (Lancet Global Mental Health et al., 2007; WHO, 2001).

En plus, pour aider ces pays dans l'amélioration de la prestation de soins pour la santé mentale, l'OMS à créé le programme mhGAP. Il s'agit d'un programme intégral avec un outil d'utilisation facile, conçu pour aider les pays à moindres ressources à intégrer les prestations de soins pour les troubles MNS dans les budgets de soins non spécialisées.

Cette étude vise à répondre aux besoins en termes d'amélioration de la prestation de soins pour la santé mentale dans des milieux à ressources faibles avec un modèle qui guide les planificateurs de programmes dans la mise en place du composent psychosocial du programme mhGAP dans les milieux à ressources faibles. Pour apporter quelques clarifications sur l'utilisation du modèle, une visite de terrain au Costa Rica a été conduite et des lignes d'action pour l'amélioration de la prestation de services de soins psychosociaux au Costa Rica ont été identifiés.

II. Problème de recherche

La prévalence élevée de troubles MNS dans le monde ainsi que l'absence de des problématiques de santé mentale dans les priorités des programmes de santé publique des pays a donné lieu à un imposant écart de traitement dans le monde entier (Whiteford et Baxter, 2013, p 1575;. L'OMS, 2001a). Aujourd'hui, la plupart de personnes autour du monde qui ont une maladie mentale n'ont pas Accès aux soins efficaces (Thornicroft & Tansella, 2013, p. 849). Cet écart est particulièrement lourd dans les pays à revenu faible et moyen, mais s'étend aussi aux milieux à ressources faibles dans les pays à revenu élevé. L'allocation budgétaire insuffisante pour améliorer la prestation de soins pour la santé mentale est un obstacle très difficile à surmonter dans les pays où le budget global de la santé mentale comprends entre 1% et 2% du budget national de la santé et où l'essentiel du budget alloué à la santé mentale est utilisé pour fournir des soins datés et coûteux dans des établissements spécialisés et de long séjour, tels que les hôpitaux psychiatriques (OMS, 2001b, p. 3).

L'insuffisance de ressources humaines qualifiées disponibles pour la prestation de soins pour la santé mentale au sein des régions rurales et éloignées doit être prise en compte comme l'un des principaux obstacles lorsqu'on s'engage dans des efforts visant à réduire l'écart de traitement des personnes atteintes de troubles mentaux. Dans la plupart des LAMICs, les prestataires de soins spécialistes en santé mentale sont en nombre très limité et opèrent la plupart du temps au sein d'installations spécialisées dans les principales villes, ce qui rend l'accès aux soins difficile pour la majorité de la population (Kakuma et al., 2011, p. 1654). Le manque de main-d'œuvre qualifiée est un énorme défi lorsque les gouvernements cherchent à suivre les recommandations d'experts concernant l'extension de la couverture des soins de santé mentale via l'intégration des soins pour la santé mentale avec les soins généraux. En outre, il a été constaté que les décideurs en charge de la planification pour l'extension des programmes de santé mentale n'ont pas l'expertise technique pour prendre des décisions avec une perspective de santé publique (Lancet global mental health et al., 2007, p. 1250). Comprendre le fonctionnement des systèmes de santé, en termes d'organisation des services interdépendant est essentiel pour que les planificateurs de programmes et les décideurs puissent prendre des décisions adaptées, et proposer des stratégies rentables et à faible coût répondant aux besoins de santé publique et aux ressources locaux. Ainsi, malgré l'écrasante écart de traitement et le manque de ressources pour la prestation de soins pour la santé mentale, il y a actuellement des preuves suffisantes prouvant l'existence de moyens innovants rentables et à faible

coût pour des prestations de soins de bonne qualité dans des milieux à ressources faibles (OMS, 2008).

Les stratégies utilisées ne doivent pas seulement être rentables et à faible coût mais aussi durables, car les programmes de santé publique ne peuvent offrir des avantages que si elles sont en mesure de soutenir les activités au fil du temps (Schell et al., 2013, p. 7). La durabilité est comprise comme «le petit ensemble de facteurs organisationnels et contextuels qui renforcent la capacité de maintenir un programme de santé publique au fil du temps» (ibid.). C'est la capacité d'un programme de santé mentale pour maintenir sa programmation et les avantages pour la santé des populations au fil du temps qui détermine sa pertinence. Viser la durabilité est essentiel lors de la planification pour l'extension des services de santé mentale aux milieux à ressources faibles, parce que si un programme n'a pas la capacité de développement durable, il peut y avoir un gaspillage d'argent et de ressources, ainsi qu'un dommage porté à la confiance entre le programme et la communauté et une limitation de la capacité du programme à atteindre ses objectifs de santé publique (Goodman & Steckler, 1989, cités par Schell et al., 2013, p. 8).

D'autre part, dans la dernière décennie, une série de programmes internationaux déclinés en guides ont été élaborés pour aider les cliniciens à fournir des soins de santé mentale de bonne qualité dans les pays à ressources limitées. Le programme mhGAP a été conçu par l'OMS pour aider les pays à revenu faible et moyen à l'élargissement des soins pour la santé mentale par le biais d'un outil facile à utiliser pour la gestion intégrée des troubles MNS dans les établissements de santé non spécialisés. Il est considéré comme étant le panier de soins le plus complet pour le traitement des troubles MNS disponible à ce jour. Le guide offre une gamme complète de recommandations pour faciliter les soins de haute qualité dans les établissements de santé non spécialisés. Toutefois, même si il est très précis en termes de préconisations, il ne formule pas de recommandations pratiques (OMS, 2010a). À ce jour, «il y a peu de ressources basées sur des preuves et pas d'outils validés pour aider les praticiens de programmes de santé publique de s'assurer que leurs programmes seront durables dans le temps» (Schell et al., 2013, p. 7). Par conséquent, bien que des données suffisantes sur la bonne qualité, le coût-efficace et le faible coût des traitements soient disponible, il n'existe pas d'approches stratégiques et efficaces de mise en œuvre qui tiennent compte de la disponibilité actuelle des ressources dans des milieux à ressources faibles. La recherche est donc nécessaire pour identifier les moyens durables et efficaces pour l'amélioration des services de santé mentale (Eaton et al., 2011).

Alors, comment améliorer l'accès aux soins pour la santé mentale dans les milieux à ressources faibles de manière durable?

Selon l'OMS, quand on veut soigner les troubles MNS, la pharmacothérapie n'est qu'un aspect du traitement. Elle doit toujours être prévue en combinaison avec la psychothérapie et la réadaptation psychosociale (OMS, 2001a, p. Xvii). Le programme mhGAP, prend en compte ces trois aspects des soins et les systématise dans un guide d'intervention facile à utiliser appelée la mhGAP-IG. Ce guide a été développé pour être utilisée par les fournisseurs de soins généraux (médecins généralistes, médecins de famille, infirmières, et techniciens de santé) travaillant dans des établissements de soins primaires et secondaires afin de les guider dans le processus d'évaluation des patients et la définition du plan de traitement et la prestation de soins. Assurer des interventions sous forme de paniers de soins a été identifié comme l'option la plus rentable en termes de formation, mise en

œuvre et supervision des agents de santé, car beaucoup d'interventions vont naturellement ensemble et peuvent être livrées par la même personne au même moment (OMS, 2008, p. 10).

Le mhGAP-IG inclut des interventions pharmacologiques, non-pharmacologiques et psychosociales pour la prévention et la gestion de neuf troubles MNS considérés prioritaires. Le guide inclut aussi un ensemble d'interventions psychosociales plus avancées constituées de différentes formes de psychothérapie. La section des interventions avancées a la particularité que sa livraison requiert des ressources humaines supplémentaires en raison de sa complexité et du temps nécessaire pour sa mise en place. (OMS, 2010a). Le programme mhGAP a identifié comme prioritaires les troubles dépressifs, la psychose, l'épilepsie et les convulsions, les troubles du développement, la démence, les troubles liés à la consommation d'alcool ou de drogues ainsi que les troubles d'automutilation et le suicide. Ces troubles ont été choisis car ils représentent un fardeau très lourd (en termes de mortalité, de morbidité et d'invalidité); parce qu'ils représentent d'importants coûts économiques; et parce qu'ils sont associés à des violations des droits de l'homme. Chaque intervention a été sélectionnée sur la base de preuves quant à l'effectivité, le coût-efficacité, l'équité, les considérations éthiques, y compris le respect des droits de l'homme, la faisabilité et l'acceptabilité dans des milieux à ressources faibles (OMS, 2008, 2010a). Le guide propose des protocoles de soins basés sur les plus actuelles et robustes preuves disponibles sur le traitement des troubles MNS (OMS, 2010a).

Cependant, cet outil n'est pas destiné aux planificateurs de programmes et la mise en œuvre effective du Programme mhGAP aux milieux à ressources faibles nécessite un processus d'adaptation pour lequel l´OMS n'a pas fourni de lignes directrices. Les planificateurs doivent trouver les moyens d'adapter le programme à leur milieu et d'améliorer la façon dont les services de santé sont organisés localement (OMS, 2001a, p. Xiii). Bien que des recommandations concrètes ont été faites sur les stratégies efficaces pour faire face aux obstacles les plus courants, tels que l'intégration de la santé mentale dans les soins primaires et la diversification des ressources humaines pour surmonter l´insuffisance de ressources (Eaton et al., 2011), le manque d'expertise en gestion de la santé publique parmi les planificateurs rend la tâche de les mener à bien encore plus complexe.

La Roue de la santé mentale Globale (en Anglais: the Wheel of Global Mental Health) (Samuel, Schuetz-Mueller, Katz, sous presse) identifie sept éléments interdépendants qui expliquent la relation entre les éléments clés nécessaires lors de l'embarquement sur la pratique de la santé mentale dans les pays à ressources faibles: les besoins, les aspirations, les ressources humaines et les autres ressources de l'hôte, ainsi que les aspirations et les ressources du collaborateur et le rôle de l'agent local. Ils sont disposés comme une roue du fait qu'un changement dans l'un des composants affecte dynamiquement l'état de l'autre. Selon ce modèle, lors de l'engagement dans des efforts visant à renforcer les services de santé mentale, il y a généralement deux parties. L'une qui représente l'établissement de santé local, ou une organisation qui veut mettre en place un service spécifique pour la santé mentale, l'hôte; et une autre partie représentée par les partenaires de l'hôte dans l'accomplissement de son but, les collaborateurs (Samuel et al., sous presse). L'utilisation de la Roue de la santé mentale globale comme cadre permet une meilleure compréhension des besoins, des aspirations, des rôles et des ressources de chacun des intervenants lors de la planification pour mettre en place un programme de santé mentale au sein d'un système de santé dans un milieu à ressources faibles.

La Roue de la santé mentale globale
(mis au point par Samuel, Schuetz-Mueller & Katz, sous presse)
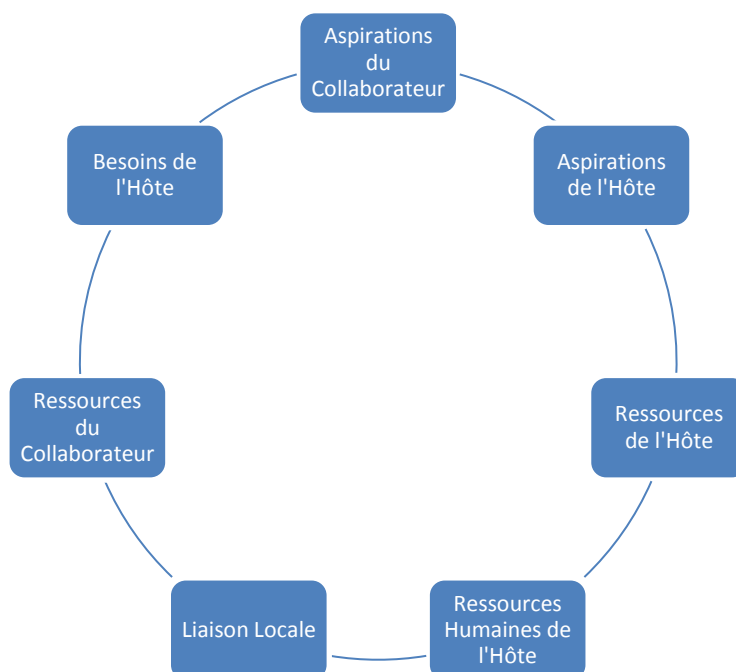
Afin de rendre le programme pérenne, l'obtention et le maintien de ressources tout au long des étapes de planification et de mise en œuvre d'un programme sont des prérequis obligatoires. Dans la plupart des milieux à faibles ressources, les spécialistes de la santé mentale sont insuffisantes, voire inexistantes, et les fournisseurs de soins généraux sont surchargés, de sorte que l'obtention d'une main-d'œuvre durable avec une formation adéquate pour les soins de santé mentale devient une tâche complexe. En plus, si on considère que tous les médicaments nécessaires sont disponibles dans l'établissement de soins primaires ou secondaires où le Programme mhGAP sera mis en œuvre, l'exécution du volet pharmacologique du programme reste moins problématique. L'évaluation, le diagnostic et la prescription de médicaments pour les troubles MNS ne varie pas beaucoup d'une pharmacothérapie pour d'autres maladies actuellement gérés dans les établissements de santé non spécialisés, ce qui implique peu de besoins en termes de ressources humaines. En plus la pharmacothérapie n'est pas considéré comme une tâche très exténuante et peut être facilement apprise et délivré par les médecins de soins généraux (Kakuma et al., 2011). Cependant, la question de la rareté des ressources humaines devient plus pressante lorsque les interventions à délivrer prennent plus longtemps à apprendre et à fournir, tels que les interventions psychosociales basiques et avancées pour les troubles MNS inclus dans le mhGAP-IG.

Afin d'améliorer véritablement l'accès aux soins pour les personnes atteintes de troubles MNS, et de suivre les recommandations internationales concernant les trois composants de base pour le traitement des troubles MNS, l'extension des soins pour la santé mentale doit toujours inclure la prise en charge psychosociale. L'intégration du volet psychosocial du programme mhGAP n'est pas aussi facile à exécuter dans des milieux où les prestataires de soins ont très peu de temps par patient et presque pas de formation et d'expérience fournissant ce type d'interventions. Les planificateurs et les acteurs locaux sont confrontés à la tâche d'identifier les ressources humaines disponibles localement, sachant que ces dernières doivent être capables de fournir ces interventions dans le cadre de leur système de santé.

Le plus souvent, les planificateurs et les autres parties prenantes dans les milieux à ressources faibles travaillent avec des budgets très limités pour la mise en place des services de santé mentale. Lors de la planification pour l'amélioration de ces types de soins, l´adoption d'une approche à faible coût (low-cost) qui assure la qualité de soins est essentielle. Même si elles n'étaient pas utilisées traditionnellement pour les soins de santé mentale, des stratégies visant à maximiser les ressources locales existantes en utilisant des méthodes innovantes basées sur des preuves et à faible coût sont disponibles (Kakuma et al., 2011). Néanmoins, les planificateurs locaux et les décideurs dans les milieux à ressources faibles ne sont pas nécessairement au courant et continuent à choisir des stratégies moins efficaces et plus chères. Le développement de modèles pragmatiques qui guident clairement la mise en œuvre de programmes de santé mentale est donc nécessaire (Thornicroft & Tansella, 2013). En plus, un effort doit être fait pour qu'ils soient rendus disponibles à ceux qui ont besoin de soutien.

Par conséquence, en raison de la complexité accrue de l'expansion des soins psychosociaux dans les milieux à ressources faibles, le développement d'un modèle pratique et peu coûteux pour la prestation de soins psychosociaux qui peut être utilisé comme complément pour la mise en œuvre du Programme mhGAP aiderait les parties prenantes dans le processus de prise de décision pour la mise en place du programme. Ce modèle devrait être élaboré en suivant les recommandations actuelles en santé mentale globale et les stratégies pour renforcer les services de santé mentale dans les milieux à ressources faibles. Par la suite, en organisant les donnés d´une façon simple, les planificateurs de programmes et d'autres intervenants clés travaillant dans ces milieux auraient mieux accès à l'information concernant des stratégies efficaces pour améliorer l'accès aux soins pour les troubles MNS dans des milieux à ressources faibles afin d'aider à la réduction de l'écart de traitement.

III. Objectifs et Méthodologie de l'étude

1. Déclaration d´intention

Cette étude a l'intérêt de répondre aux besoins de combler les écarts de traitement des troubles mentaux, neurologiques et liés à l'utilisation de substances psychoactives en aidant dans les efforts d'accroître l'accès aux soins pour la santé mentale dans les milieux à ressources faibles. L´étude propose l´élaboration d'un modèle pratique et peu coûteux pour la prestation des soins pour être utilisé comme complément du Programme mhGAP, en particulier en termes de prise en charge psychosociale. Il a-été développé du point de vue des planificateurs de programmes de santé dans le but d'aider les acteurs locaux qui travaillent dans les milieux à ressources faibles lorsqu'ils doivent prendre des décisions qui concernent l'adaptation et la mise en œuvre du programme mhGAP ainsi que d'autres programmes ou paniers de soins basés sur des preuves disponibles pour les troubles MNS.

2. Objectifs principaux

a) Développer un modèle à faible coût pour la prestation de soins psychosociaux qui prend en charge l'implémentation du Programme mhGAP afin d'accroître l'accès aux soins dans les milieux à ressources faibles.

b) Fournir un exemple d'utilisation du modèle dans un cadre de santé réel.

3. Objectifs spécifiques

a) Déterminer un ensemble de soins psychosociaux de base et à faible coût qui permettent d'améliorer l'accès aux soins pour les personnes souffrantes de troubles mentaux, neurologiques et liés a la consommation de substances psychoactives dans les milieux à ressources faibles.

b) Identifier les ressources de base minimales nécessaires pour fournir efficacement des soins psychosociaux dans les milieux à ressources faibles.

c) Déterminer une structure organisationnelle peu coûteuse et flexible pour offrir des soins psychosociaux dans des établissements de santé non spécialisés.

d) Déterminer des lignes d'action pour la mise en œuvre du modèle pour la prestation de soins psychosociaux au Costa Rica.

4. Méthodologie

Puisque il n'y a pas des preuves abondantes sur la façon de mettre en œuvre avec succès des programmes de soins pour la santé mentale et psychosociale dans les milieux à ressources faibles, et du fait que le développement de modèles pragmatiques pour guider la mise en œuvre ont été recommandées (Thornicroft & Tansella, 2013), cette étude exploratoire a utilisé des méthodes qualitatives pour développer un modèle pratique et à faible coût pour la prestation de soins psychosociaux afin d'aider dans la mise en place du volet psychosocial du programme mhGAP dans les milieux à ressources faibles.

Pour élaborer ce modèle, l'information a été intégrée à partir de deux sources: (a) un examen de la littérature actuelle pertinente et (b) une série d'entretiens réalisées auprès d'experts de la santé mentale ayant de l'expérience dans des milieux à ressources faibles dans les pays à revenu faible et moyen. La justification de cette approche hybride est de développer un modèle fondé sur la connaissance expérimentale de spécialistes de la santé mentale qui travaillent sur le terrain mais également suivre des recommandations basées sur de preuves trouvées dans la littérature publiée.

L'étude a été développé en deux phases. La première phase consistait à développer le modèle pour la prestation de soins psychosociaux à partir de la collecte de données concernant les interventions de soins psychosociaux ainsi que de modes de prestation de soins à faible coût; la deuxième phase a été la définition des lignes d'action pour la mise en œuvre du modèle au Costa Rica. Chacun des phases a eu des étapes de collecte et d'analyse des données séparées.

1) *Phase 1: Élaboration du Modèle de Prestation de Soins Psychosociaux*

Pour la première phase la série d'articles du Lancet sur la santé mentale globale publiés en 2007 et 2011 a été récupérée et étudiée. En plus, une revue de la littérature publiée sur l'extension des services de santé mentale dans les milieux de santé non- spécialisées a été conduite pour identifier les éléments de preuve qui étaient disponibles après 2011. La revue a porté sur la période allant de Novembre 2011 à Mars 2014 compris, et a inclus les bases de données suivantes: WHOLIS, PubMed, PsychInfo, Cochrane Database, Ebsco Health Policy Reference Center, PubMed and Web of Science. Les titres et les résumés de toutes les publications récupérées ont été étudiés et les articles on été sélectionnés selon leur pertinence sur l'extension des services de santé mentale, les modèles pour la prestation de soins de santé et les programmes de soins psychosociaux dans les milieux de santé

non spécialisés. Cette revue de la littérature a été utilisée pour construire le cadre conceptuel de l'étude et pour enrichir le modèle en comparant et contrastant avec des données d'entretiens.

En plus, dix entretiens qualitatifs ont été conduits pour comprendre du point de vue des experts en santé mentale les exigences et les processus qui sous-tendent la planification, la mise en œuvre et la durabilité de l'expansion des services de santé mentale dans les milieux à faibles ressources. Un guide d'entretien qualitatif semi-directif basé sur les données obtenues pendant la revue de littérature a été développé, avec une version pour l'intervieweur et l'interviewé. Les entretiens portaient sur les possibles stratégies à faible coût qui permettraient de mettre en place des services de soins psychosociaux dans les milieux à faibles ressources. La Roue de la santé mentale globale (Wheel of Global Mental Health), développée par Samuel et al. (sous presse), a été utilisée pour élaborer le guide d'entretien, et comprenait des questions pour chacune des composantes de la roue. Les entretiens ont été enregistrés et transcrits verbatim pour ensuite procéder à la codification par catégories. Les catégories préétablies par la Roue de la Santé Mental Globale ont été reprises pour la codification et des sous-catégories ont été identifies selon les donnés obtenues.

Les experts, qui étaient des personnes possédant une expérience universitaire ou de terrain en santé mentale, planification ou mise en œuvre des programmes de santé ou de l'administration des soins de santé travaillent actuellement dans des différents pays (USA, Costa Rica, Panama, Belize, Saint-Vincent and the Grenadines, Japan, Liberia, et India) et ont de des antécédents et de l'expérience dans les soins de santé mentale dans les milieux à faibles ressources dans les pays suivants: Argentine, Belize, Brésil, Colombie, Costa Rica, Chine, Éthiopie, Inde, Japon, Kazakhstan, Liberia, Mexique, Mozambique, Nigeria, Panama, Rwanda, Saint-Vincent-et-les Grenadines, Afrique du Sud, Tanzanie et États-Unis. L'échantillonnage ne se présente pas comme une sélection exhaustive ou aléatoire, mais plutôt un moyen d'obtenir des informations inédites de personnes qui travaillent sur le terrain.

Pour l'analyse, la revue de littérature et les données obtenues à partir des entretiens ont été analysées qualitativement en utilisant la Roue de la Santé Mentale Globale comme cadre. Le résultat est un Modèle pour la Prestation de Soins Psychosociaux conçu pour aider les planificateurs de programmes et les principales parties prenantes dans le processus d'amélioration de l'accès à des soins psychosociaux par le biais du Programme d'Action mhGAP à base de preuves de prise en charge psychosociale des troubles MNS aux milieux à faibles ressources.

2) Phase 2: Détermination des lignes d'action pour le Costa Rica

Du fait que "une bonne compréhension du niveau actuel de système de santé mentale dans un pays est essentielle pour la planification et renforcement du système" (Jacob et al., 2007, p. 1062), La deuxième phase de cette étude a consisté en une visite de terrain de trois semaines au Costa Rica pour recueillir des données spécifiques sur la manière d'adapter le modèle de prestation de soins psychosociaux dans le système de santé Costa Ricain.

Différentes réunions, visites et rencontres d'observation avec les parties prenantes qui travaillent au sein du système de soins de santé mentale Costa Ricain ont été organisées par le Dr. Francisco Gólcher (contrôleur institutionnel du Ministère de la Santé Costa Ricain) et le Dr. Virginia Rosabal, (coordinatrice du programme de santé mentale à la Caisse Costa Ricaine de la Sécurité Sociale) pour répondre aux besoins de cette étude en termes de collecte de données. Les interlocuteurs interpellés sont: Le secrétaire pour la santé mentale, chef du secrétariat de la santé mentale au

ministère de la Santé; la responsable du Réseau de Soins Psychosociaux à l'Hôpital Psychiatrique National; les membres de la Commission pour la Santé Mentale du Ministère de la Santé; la coordonnatrice du programme de santé mentale à la Caisse Costa Ricaine de la Sécurité Sociale (CCSS); la responsable du service de travail social et psychologie de à l'hôpital Monseñor Sanabria, un hôpital régional dans la province de Puntarenas; le psychiatre à la clinique Carlos Duran, une clinique de quartier dans la capitale du Costa Rica, et ancien coordonnateur du programme de santé mentale au CCSS; le personnel de l'Institut des troubles liés a la consommation d'alcool et drogues (IAFA) et le Centre national pour la prise en charge des mineurs toxicomanes (Centro Nacional de Atencion Integral en Drogas para Personas Menores de Edad).

Pour définir les lignes d'action pour l'implémentation du modèle au Costa Rica, les données ont été systématisées utilisant la Roue de la santé mentale Global (Samuel et al., sous presse) comme cadre ainsi que l'approche systémique et stratégique développé par le Mouvement pour la santé mentale globale pour l'extension des services de santé mentale dans les pays à revenu faible et moyen (Eaton et al., 2011) en tant que méthode de vérification des aspects pertinents.

IV. Résultats et Discussion

1. Le Modèle pour la Prestation de Soins Psychosociaux dans des milieux à ressources faibles.

Le Modèle pour la Prestation de Soins Psychosociaux dans des milieux à ressources faibles a été développé en intégrant les résultats de la revue de littérature et des interviews aux experts en santé mentale. Il est organisé selon les sept composantes de la Roue de la santé mentale globale (Samuel et de al., Sous presse) qui est utilisée pour organiser les données par rapport aux besoins, aux aspirations et aux ressources disponibles pour réaliser des projets de santé mentale en milieux à faibles ressources. Il prend en compte la perspective de l'hôte et celle de possibles partenaires ou collaborateurs qui seraient fiables pour l'appui de l'hôte dans le processus de combler les lacunes de prestation de services de soins pour la santé mentale. Dans un effort pour maintenir une approche pragmatique, le modèle fournit aux décideurs d'une série de points de décision guidée par des menus de recommandations et de considérations pour chacune des composantes du modèle. Les composants du modèle et de ses points de décision sont interdépendants et ne sont pas destinés à être utilisé de façon hiérarchique ou dans un ordre précis. Il est important de comprendre le modèle dans son ensemble avant de prendre des décisions, étant donné que l'un va affecter les autres.

3) Les considérations contextuelles

Lorsque l'on veut mettre en place un programme de santé mentale qui comprend les soins psychosociaux comme un de ses composants principaux, tels que le mhGAP Programme, le Modèle pour la Prestation de Soins Psychosociaux a besoin que les planificateurs de programmes procèdent à une analyse du contexte dans lequel le programme doit être mis en place. Il faut donc comprendre comment le système de santé fonctionne, ainsi que son contexte politique, social et économique. Cette démarche permet d'identifier les possibles voies de mise en œuvre. Un aperçu contextuel permet de déterminer comment les troubles MNS sont actuellement compris et traités localement et, le cas échéant, d'éduquer les fournisseurs de soins et la population sur des moyens culturellement respectueux et encore plus adéquates et efficaces de prestation de soins aux personnes atteintes de troubles MNS. Chaque contexte où le programme mhGAP sera utilisé et

adapté est inscrit dans un système de santé, avec des besoins et aspirations spécifiques au sujet de ces besoins, et une grande diversité d'accès aux ressources pour réaliser et développer le programme. Prendre connaissance sur chacun des aspects et comprendre comment ils sont reliés entre eux est indispensable pour que les planificateurs puissent prendre des décisions éclairées et maximiser les chances de succès durable.

4) Les besoins de l'Hôte

Le composant "Besoins de l'Hôte" fait référence à la nécessité de soins psychiatriques en termes de prévalence du trouble par rapport à l'accès aux soins dans un emplacement spécifique (Samuel et al., Sous presse). Il s´agit du besoin global satisfait et non satisfait. Comme les besoins épidémiologiques sont très variables dans les milieux a ressources faibles, il n'est pas possible de définir avec précision si un trouble est plus lourd à un endroit précis sans la réalisation d'études épidémiologiques sur la morbidité, la mortalité et les incapacités dues aux troubles MNS, et qui tiennent compte du fardeau économique qu'ils ont pour le pays. Cela permettrait d'informer les planificateurs de programmes pour qu'ils puissent prendre des décisions qui maximisent l'utilisation du budget alloué pour la prestations de soins pour la santé mentale. Néanmoins, ces types d'études sont très coûteuses en termes financiers et techniques et prennent du temps à être conduites. Le fait est que les pays à faibles ressources n'ont pas accès a ce type d'études et finissent donc par prendre des décisions d'allocation budgétaire sans vraiment savoir quelles troubles sont les plus lourds, en termes financiers et de santé.

Pour ce composant, le Modèle propose un point de décision pour guider le choix de la population Cible. Il fournit aux planificateurs quatre différentes option pour décider si la priorité pour l'investissement sera donnée à un trouble spécifique, un ensemble de troubles (par exemple tel que recommandé par le Programme mhGAP -IG), pour une population spécifique (par exemple, populations les plus vulnérables selon l'âge), ou si les services de santé mentale seront fournis sans distinction de diagnostic.

5) Les Aspirations de l'Hôte

Ce composant du modèle a le but spécifique de rassembler les membres d'une communauté et les objectifs qu'ils ont en termes d'amélioration d'accès aux soins de santé mentale. Ceci est particulièrement important si l'on considère que "un tiers de tous les pays n'ont pas de politique de santé mentale, et en Afrique, la moitié des de pays n'en ont aucune" (Samuel et al., Sous presse). Deux axes constituent cette composante; les premier est l'amélioration de la prise de conscience sur la santé mentale; le second est l'amélioration de l'accès aux soins. Les deux axes sont liés, puisque les fournisseurs de soins à domicile et les parties prenantes doivent comprendre le fardeau des troubles MNS dans leur localité afin de pouvoir améliorer l'accès aux soins pour la population.

Le premier axe est constitué de deux points de décision: l'identification des parties prenantes clés et la définition des méthodes pour favoriser la prise de conscience. Cet axe comporte trois branches principales: les parties prenantes pour l'implémentation, les messages clés pour créer la conscience, les méthodes possibles pour accroître la sensibilisation dans les milieux à faibles ressources.

Le deuxième axe est constitué de quatre points de décision: la réorganisation de la structure de prestations de soins avec un panel de recommandations pour la réorganisation du système de soins pour la santé; la définition de l'établissement de santé non spécialisé selon différentes modalités;

choix de services psychosociaux avec un panel de caractéristiques suggérées pour les interventions psychosociales et un panel d'interventions psychosociales; le dépistage, couplé à diverses considérations pour sélectionner l'outil de dépistage; et la définition de voies de référence claires avec différentes stratégies pour les optimiser.

6) Ressources Humaines de l'Hôte

La rareté des ressources humaines est l'un des plus grands obstacles pour l'amélioration des services pour la santé mentale dans les pays à faibles ressources. L'accès très limité à une formation adéquate en prestation de soins pour la santé mentale dans les pays à revenu faible et moyen avec une médiane de 0,05 psychiatre et 0,16 infirmier psychiatrique pour 100.000 habitants (Saxena et al., 2007, p. 881) et la quantité tout aussi insuffisante de psychiatres de l'enfant, infirmiers psychiatriques, travailleurs sociaux et autres professionnels de la santé mentale disponibles (Samuel et al, sous presse;. experts A, B, C, D, H, I et J, communication personnelle, mai 2014) complique la tâche d'amélioration de l'accès aux services de santé mentale pour les populations qui ont le plus besoin.

Très souvent les milieux à faibles ressources manquent de plateformes adéquates pour former le personnel de santé mentale. La Roue de la santé mentale globale recommande l'utilisation d'alternatives à faible coût et rentables tels que la formation d'agents de santé communautaires pour devenir agents de santé mentale (Samuel et al., sous presse). Le Modèle pour la Prestation de Soins Psychosociaux a mis la diversification de la main-d'œuvre en santé mentale à sa base. En conséquence, une série de décisions sont proposées pour que les planificateurs puissent définir une stratégie afin d'obtenir les ressources humaines à faible coût qui est en harmonie avec leurs besoins et aspirations.

Pour ce composant, le Modèle propose trois points de décision: la redéfinition des rôles et responsabilités des Ressources Humaines pour redéfinir les taches des fournisseurs de soins et la relation entre les différents fournisseurs de soins; la définition de la stratégie pour l'obtention des Ressources Humaines d'obtenir des ressources humaines à faible coût; la Formation, le soutien et la supervision des Ressources Humaines afin de développer une plate-forme pour soutenir les Ressources Humaines pour la santé mentale.

7) Les Autres Ressources de l'Hôte

Assurer une allocation suffisante de ressources pour la santé mentale est une tâche difficile lorsque le budget de la santé mentale n'est pas une priorité dans la plupart des milieux à ressources faibles. Les acteurs locaux qui cherchent à élargir les soins de santé mentale doivent travailler avec des ressources très insuffisantes en termes de disponibilité de l'infrastructure et l'accès aux ressources techniques, technologiques et matérielles. Bien que très souvent l'Hôte s'intéresse beaucoup sur la nécessité d'accroître les ressources financières, il existent d'autres types de ressources qui sont également nécessaires afin d'améliorer la prestation de soins psychosociaux à des établissements de santé non spécialisés.

Pour ce composant, le Modèle propose deux points de décision: l'identification d'autres ressources nécessaires avec un menu d´options pour les autres ressources considérées comme basiques pour la prestation de soins psychosociaux; l'obtention d'autres ressources à obtenir à faible coût.

8) Les Aspirations du Collaborateur

Selon la Roue de la santé mentale globale, le collaborateur est le partenaire de l'hôte dans le processus de renforcement des services pour la santé mentale (Samuel et al., Sous presse). Beaucoup d'organisations non gouvernementales et bénévoles des milieux à ressources élevées tentent d'aider les pays à ressources faibles. Pourtant, beaucoup de fois ils ne sont pas pleinement conscients des besoins réels de l'hôte, qui tendent à être liés à l'insuffisance de ressources et la limitation d'accès aux soins. Il y a un manque manifeste de considération dans la planification opérationnelle sur comment les organisations à but non lucratif ainsi que les bénévoles peuvent être complémentaires au sein d'un système de soins complexe (Younes et al, 2005;. Badrakalimuthu et al, 2009;. Pollock, 2010; Wahlbeck et al, 2011;... mentionné par Thornicroft & Tansella, 2013, p 856) Étant donné que, très souvent, les collaborateurs ont accès à des ressources que l'hôte n'a pas, l'établissement de collaborations pourrait être d'un grand soutien pour les pays à ressources faibles qui tentent d'élargir les soins pour la santé mentale. Toutefois, afin de développer un partenariat fructueux, les planificateurs doivent trouver un moyen de faire correspondre les aspirations de l'hôte avec celui du collaborateur afin que les deux parties en profitent et soient intéressées (Expert E, communication personnelle, mai 2014).

Pour ce composant, le Modèle propose deux points de décision: l'Identification des collaborateurs et la définition des possibles volets pour la collaboration; avec un menu d'options d'opportunités de collaboration en termes financiers, techniques, matériels et de développement de programmes.

9) Les Ressources du Collaborateur

La principale raison pour laquelle l'hôte est intéressé pour développer une collaboration est que le collaborateur peut contribuer en apportant des ressources qui ne sont initialement et localement pas disponibles. En ce sens, les ressources du volet Ressources du Collaborateur de la Roue de la santé mentale globale sont incontournables pour répondre de façon significative aux besoins en santé mentale dans les LAMICs (Samuel et al., Sous presse) ainsi que pour planifier de manière adéquate les collaborations concernant l'extension des soins psychosociaux dans les milieux à ressources faibles.

10) Agent de liaison

Selon la Roue de la santé mentale globale, un agent de liaison peut être une personne ou une organisation qui a une bonne compréhension de la charge de morbidité locale, du système de soins de santé, des ressources humaines et autres, des infrastructures, de la culture, des habitudes, de la langue, la politique, l'histoire ainsi que de la stigmatisation des maladies mentales (Samuel et al., 2014). Le rôle principal de l'agent local est de relier les efforts de l'hôte avec ceux du collaborateur. Il a aussi une fonction de plaidoyer pour l'amélioration de l'accès aux soins psychosociaux.

Pour ce composant, le Modèle pour la Prestation de Soins Psychosociaux propose un seul point de décision pour choisir cet agent de liaison avec un menu d'options pour guider ce choix.

2. Lignes d´Action Recommandées pour le Costa Rica

Avec l'objectif d'illustrer l'utilisation du Modèle pour la Prestation de Soins Psychosociaux dans un contexte réel, des lignes d'action spécifiques pour chaque volet du Modèle ont été identifiées et présentées en tant que recommandations à considérer par les acteurs locaux lors de la planification

pour la mise en place de programmes pour la prestation de soins psychosociaux pour les personnes souffrantes de troubles MNS. Bien que le Costa Rica est un pays à revenu moyen-supérieur, et ne figure pas parmi les pays les plus pauvres, ni dans la liste de pays prioritaires du programme mhGAP de l'OMS, l'écart de traitement pour les personnes souffrantes de troubles MNS est grand. Les acteurs de santé costaricains ont exprimé leur besoin de soutien afin de maximiser leurs ressources et pour améliorer l'accès local aux soins pour la santé mentale. En outre, depuis la ratification de la politique nationale de santé mentale en Octobre 2012, le Ministère de la Santé et des organismes collaborateurs ont mené des efforts importants afin de mettre en place le programme mhGAP à niveau national.

V. Conclusions

Cette étude visait à répondre au besoin de réduire l'écart de traitement de troubles MNS dans les milieux à ressources faibles en soutenant les efforts d'accroître l'accès aux soins pour la santé mentale dans les pays à ressources faibles. Le Modèle pour la Prestation de Soins Psychosociaux axée sur la définition des stratégies à faible coût pour améliorer la prestation de soins psychosociaux aux établissements de santé non spécialisés. Il a été conçu pour aider les planificateurs de programmes à prendre des décisions clés pour l'adaptation et la mise en œuvre locale du volet psychosocial du programme mhGAP pour des milieux à ressources faibles.

Le Modèle comprend huit composantes interdépendants: mise en contexte, les besoins de l'hôte, les aspirations des hôtes, les ressources humaines de l'hôte, les autres ressources de l'hôte, les aspirations du collaborateur et les ressources du collaborateur. Chacun des composants a des points de décision et des menus d'options pratiques pour que les planificateurs de programmes se posent des questions clés qui vont les aider à organiser leurs ressources selon leurs besoins et aspirations locales. La plupart des recommandations vont de pair avec la mise en œuvre du programme mhGAP-IG afin d'aider à sa mise en place.

En plus, afin d'illustrer l'utilisation du Modèle pour la prestation de soins psychosociaux, le système de santé publique du Costa Rica a été étudié et le modèle a été utilisé pour identifier des lignes d'actions spécifiques visant à renforcer la mise en place du volet psychosocial du programme mhGAP.

En outre, en raison de la nature de cette étude et des ressources disponibles, un plan d'action plus détaillé n'a pas été effectué. Cependant, il est fortement recommandé que, sur la base des lignes d'action présentées ici, d'autres efforts soient déployés pour élaborer un plan d'action plus approfondi pour sa mise en œuvre.

Enfin, en intégrant une littérature vaste mais fragmentée avec les connaissances pratiques d'experts en santé mentale travaillant sur le terrain, un cadre pour faciliter le processus de prise de décision pour la mise en œuvre des programmes pour la prise en charge psychosociale des troubles MNS a été créé. En utilisant le Modèle pour la Prestation de Soins Psychosociaux les planificateurs travaillant dans des milieux à ressources faibles pourront mieux identifier leurs besoins et organiser leur ressources pour améliorer l'accès à la prise en charge psychosociale de façon durable et à moindre coût.