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Lean economies and innovation in mental health systems

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Learning from lean economies to develop innovative mental health systems?

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Poor access to mental healthcare is widely reported, though differs according to socio-political and economic contexts. Many European governments are persisting with austerity measures, but recent years have seen unprecedented public investment in emerging economies, including BRICS (Brazil, Russia, India, China, South Africa). Rapid growth in BRICS has now halted, e.g. following China's stock market crash and Brazil's economic recession. These precarious global transitions influence burden and demand for services. Innovations prompted by these transitions, in both high- and low-resource countries, could help us meet population needs more effectively during times of economic shock, whether scarcity or affluence.

Shifts to related sectors

Austerity can present an opportunity to be more innovative[1] and some of its potential impacts might be averted by prioritising investment to protect public mental health. In Finland and the US, where social benefits were maintained and enactment of parity laws improved access to mental healthcare, adverse events seen during economic crises, including increased suicide, were avoided.[1,2] When there are threats to the mental health system, some tasks, can be efficiently shifted to related sectors (including early education, housing, primary care, employment).[3,4] With sufficient training, community workers can provide effective first-line care for people with severe mental illness including psychosis[3,5] and help reduce the risk of perinatal depression. Although task-shifting is not suitable for all individuals, a tiered approach could support identification of common mental illness allowing limited specialised resources to be allocated to more complex cases. When coordinated, such actions can protect positive mental health, creating *psychosocial care networks* capable of influencing incidence, persistence and intractability of mental illness.

Promoting cross-sector psychosocial care networks

BRICS have historically invested little in mental compared to physical health, but have been increasingly responsive to calls for augmenting or re-deploying spending. Given their leaner economies, doing so has required innovation from which richer countries might learn. In particular, five factors might be adapted from some BRICs to establish effective psychosocial care networks to promote mental health at multiple socio-ecological levels: (i) Services being fully embedded in communities, incorporating community mental health workers, supported family members, and service delivery through non-traditional platforms; (ii) judicious use of highly specialised workers who might be better placed in teaching/supervision/consultative roles rather than direct care provision; (iii) better task-sharing with non-traditional providers; (iv) active outreach and, (v) attention to social determinants.

Over recent decades, Brazil has developed the "Psychosocial Care Network" a policy for integrating primary care (ESF) and community-based specialty mental health clinics, thereby providing a model for reducing the treatment gap.[6] Several features promote access. ESF uses decentralised units deeply connected to the community and close to people's homes. Family health teams, mainly comprising lay health workers, but also a primary care physician and nurse, actively monitor living conditions, health status and provide first-line treatment. Mental health teams support family health teams through training, supervision, referrals and home visits[5]. A particularly novel aspect of the psychosocial care network is systematic home visits to support people who may need treatment but do not seek help. This outreach could facilitate early intervention and reduce the treatment gap for a critical group.

In addition to careful investment and service design, the social environment, including social capital and cohesion, needs to be considered, both as a resource and for impact on access. Mental health service efficacy is sensitive to cultural, societal, political, and personal contexts and values. Research in low-income settings in the US has shown investment in collaborative community partnerships, alongside service developments, is crucial for improving engagement and outcomes.[7] Moreover, mobilising communities through training laypersons to engage people with mental illness has demonstrated improvements in public mental health[8] and is particularly important in the context of limited effectiveness of current drug and psychological therapies. Social context helps explain variations in care and help-seeking, independent of healthcare resources.[9] .

In Russia, which for 100 years has had a social protection system supporting people with disabilities and those with a mental illness; developing links with sectors outside healthcare proved crucial for reform. Addressing administrative barriers and stigma among key stakeholders was shown to increase competitive employment opportunities for people with severe mental illness and decrease hospitalisations.[10] However, replicating this collaboration with other sectors across the country is problematic and political challenges remain.[10] In Brazil, anti-poverty programmes such as conditional cash transfers have decreased poverty and inequality, and indirectly improved mental health among poor families.[11]

The promise of bi-directional sharing

Given the rapidly changing global context, more diverse and adaptable strategies are needed to maintain sustainable mental health systems to meet changing population demands. Particular challenges remain in BRICs, especially around deinstitutionalisation and

the sustainability of community professionals who may be overloaded or move to other roles, e.g. nursing. Highlighting good practice (e.g. http://mhinnovation.net) can help identify successful models which could be tested and refined across diverse settings. Bidirectional diffusion of solutions across settings could encourage innovative strategies for improving mental healthcare. In particular, 'lean' economies which have experienced longer-term resource constraints could help improve coordination and utilisation of existing resources, while better resourced economies might contribute innovative approaches to measuring outcomes – essential for maintaining quality and justifying allocation of resources. Although we cannot ignore that many places lack the means to address mental illness, and strongly encourage additional investment in this area, learning to respond to demands with what is available is the current reality. Recognition and support for these solutions is also needed to spread and extend useful and practical innovations across health systems globally.

Contributors

The idea for this commentary was jointly developed by all authors. SEL drafted the manuscript and all authors revised the manuscript.

Declaration of interests

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References

1 Wahlbeck K, McDaid D. Actions to alleviate the mental health impact of the economic crisis. *World Psychiatry* 2012; **11**: 139–45.

2 Lang M. The impact of mental health insurance laws on state suicide rates. *Health Econ* 2013; **22**: 73–88.

3 Petersen I, Evans-Lacko S, Semrau M, Barry MM, Chisholm D, Gronholm P, Egbe C TG. Disease Control Priorities for mental, neurological and substance use disorders. In: Patel, V; Chisholm, D; Dua, T; Laxminarayan, R; Medina-Mora M, ed. 3rd edn. Washington DC: World Bank, 2016.

4 Wissow LS, van Ginneken N, Chandna J, Rahman A. Integrating Children's Mental Health into Primary Care. *Pediatr Clin North Am* 2016; **63**: 97–113.

5 Chatterjee S, Naik S, John S, *et al.* Effectiveness of a community-based intervention for people with schizophrenia and their caregivers in India (COPSI): a randomised controlled trial. *Lancet (London, England)* 2014; **383**: 1385–94.

6 Paula CS, Lauridsen-Ribeiro E, Wissow L, Bordin I a. S, Evans-Lacko S. How to improve the mental health care of children and adolescents in Brazil: Actions needed in the public sector. *Rev Bras Psiquiatr* 2012; **34**: 334–41.

7 Wells KB, Jones L, Chung B, *et al.* Community-partnered cluster-randomized comparative effectiveness trial of community engagement and planning or resources for services to address depression disparities. *J Gen Intern Med* 2013; **28**: 1268–78.

8 Chibanda D, Mesu P, Kajawu L, Cowan F, Araya R, Abas MA. Problem-solving therapy for depression and common mental disorders in Zimbabwe: piloting a task-shifting primary mental health care intervention in a population with a high prevalence of people living with HIV. *BMC Public Health* 2011; **11**: 828.

9 Evans-Lacko S, Brohan E, Mojtabai R, Thornicroft G. Association between public views of mental illness and self-stigma among individuals with mental illness in 14 European countries. *PsycholMed* 2012; : 1–13.

10 Jenkins R, Lancashire S, McDaid D, *et al.* Mental health reform in the Russian Federation: an integrated approach to achieve social inclusion and recovery. *Bull World Health Organ*; **85**: 858–66.

11 Clark F. Is psychiatry being used for political repression in Russia? *Lancet* 2014; **383**: 114–5.

12 Rasella D, Aquino R, Santos CAT, Paes-Sousa R, Barreto ML. Effect of a conditional cash transfer programme on childhood mortality: a nationwide analysis of Brazilian municipalities. *Lancet (London, England)* 2013; **382**: 57–64.