Mental disorders constitute a huge global burden of disease, and there is a large treatment gap, particularly in low-income and middle-income countries. One response to this issue has been the call to scale up mental health services. We assess progress in scaling up such services worldwide using a systematic review of literature and a survey of key national stakeholders in mental health. The large number of programmes identified suggested that successful strategies can be adopted to overcome barriers to scaling up, such as the low priority accorded to mental health, scarcity of human and financial resources, and difficulties in changing poorly organised services. However, there was a lack of well documented examples of services that had been taken to scale that could guide how to replicate successful scaling up in other settings. Recommendations are made on the basis of available evidence for how to take forward the process of scaling up services globally.

Introduction

The past two decades have seen an unprecedented increase in efforts to address global inequalities in physical health care, particularly as part of the UN’s Millennium Development Goals (MDGs) initiative. Resources targeting HIV/AIDS, tuberculosis, malaria, and maternal and child health have increased substantially. Development assistance for health grew from US$5.6 billion in 1990 to $21.8 billion in 2007, with several common components: an increase in the range of services offered; services that improved access to mental health care. The Series concluded with a call for global action to increase access to mental health care—process referred to as scaling up. This process is to involve all stakeholders, including decision makers to ensure their support and to facilitate sustainability of services, as well as people using mental health services.

In 2007, The Lancet presented a Series of papers on global mental health that reviewed the global state of mental health systems, summarised the evidence for effective treatments, identified barriers to service improvement, and examined existing and required resources for mental health care. A process referred to as scaling up. In this report, we assess global progress in scaling up of mental health care in low-income and middle-income countries since 2007. Definitions of scaling up typically refer to an objective with several common components: an increase in the number of people receiving services (coverage); an increase in the range of services offered; services that are built on a scientific evidence base, usually with a service model that has been shown to be effective in a similar context; services made sustainable through policy formulation, implementation, and financing (strengthening of health systems).

Scaling up has also been used to refer to a process, which includes mobilisation of political will, human resource development, an increase in the availability of essential medicines, and monitoring and evaluation. WHO has described scaling up 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 programme development on a lasting basis”. Much research on scaling up focuses on resource availability, identification of barriers, and service delivery issues. We have followed this outline in our report. Progress in scaling up of services could most accurately be measured by comparing change in effective coverage—ie, the proportion of people with a mental disorder who receive appropriate treatment. However, such information...
relating to coverage is not widely published in governmental or scientific literatures, particularly from low-income and middle-income countries. The absence of available baseline prevalence and service use data in these countries makes accurate measurement of coverage impossible, although recent data suggest that across the range of mental disorders, only a third of people with mental health disorders are treated in high-resource countries, and as few as 2% of people with such conditions are treated in some low-income and middle-income countries.

We therefore used a combination of a systematic review of published literature and a survey of key informants (panel 1). We aimed to gather as comprehensive and up-to-date a view as possible of the extent of scaling up of mental health services in countries with low and middle incomes. Additionally, we have been able to identify many programmes from which we drew out themes related to challenges and practical solutions for making progress in scaling up of services.

The literature review and survey identified many examples of services being scaled up (see webappendix pp 10–19), but few met all of our criteria. There were some published descriptions of services that were scaled up to cover increased population numbers (eg, in Brazil, Chile, and China), but most reports described early stages of reorganisation of services or preparation of policy and legislation. This outcome could in part be attributable to the length of time needed to plan, implement, and evaluate programmes. Almost half the respondents to the survey reported that progress in

Panel 1: Systematic review and survey

Methods

To capture a global perspective, we included English, Spanish, and French language publications in each of the literature searches. We were not able to include literature published exclusively in other languages, including Mandarin Chinese, Portuguese, or Russian, because of resource limitations. With the exception of global organisations (eg, WHO and the World Psychiatric Association), much of what is published is only in English. This factor constitutes a major barrier to sharing and accessing of information for people who are not fluent in English.

Systematic review

A systematic review of the published and grey literature was undertaken (by LM) to identify evidence of scaling up of mental health services in low-income and middle-income countries since 2007. “Scaling up” and “LAMIC” are not widely used terms, and so we used search terms that were deliberately broad, and information for each country was also searched for individually. Countries with low and middle incomes were defined with the World Bank classification (countries with low incomes, lower-middle incomes, and upper-middle incomes were included)—144 countries in total.

Searches covered the period from January, 2007, to November, 2010, inclusive, and used Medline, Embase, Global Health, PsycExtra, PsycInfo, Cochrane Database and DARE, Africa-Wide Information, Index Medicus EMRO, Index Medicus South East Asia, LILACS, IndMed, KoreaMed, and WHOLIS. Search terms used are listed on webappendix p 1. The titles and abstracts of retrieved publications were screened for relevance to scaling up, to treated prevalence, or to the WHO Mental Health Global Action Programme initiative. Further, International Psychiatry, World Psychiatry, and International Journal of Mental Health Systems were hand-searched, since they were not fully indexed by these databases.

In addition to the scientific databases, we undertook a web search using Google for relevant papers using the terms “scaling up”, “psychiatry”, and “mental health”. References of all relevant studies and publications were scanned to identify any further relevant publications. The Google search, but not references from it, was restricted to PDF articles. The WHO Assessment Instrument for Mental Health Systems was also searched and all reports published from 2007–10 were retrieved (table 1).

Survey

To obtain additional unpublished information, we identified expert key informants with knowledge at the national level of mental health services in low-income and middle-income countries. To a list provided by the WHO Mental Health and Substance Abuse Department (Geneva, Switzerland), we added a wider range of relevant stakeholders including users of services. The very small number of people in many countries qualified to be included in the sample made random selection of people impossible. The web questionnaire (webappendix pp 2–9) included a brief introduction of its purpose, a definition of terms, and 15 questions on progress in scaling up services, resources available, new materials to support scaling up, new alliances for scaling up, and obstacles and lessons learnt.

Participants were emailed and asked to respond to the survey through the www.surveymonkey.com website, or by completing an attached version of the survey. The questionnaire was made available in English, French, and Spanish. Data were analysed (by JE and MS) by grouping free-text data and coding according to categories, with counts undertaken where relevant.

Of the 142 people contacted, 87 (61%) responded, and their characteristics are shown in table 2. Respondents were mainly senior figures at the country level who could reasonably be expected to know about activities beyond their own organisation. 59 countries were represented in the survey, of which 19 (32%) were in the WHO Africa region, 16 (27%) in the Americas region, eight (14%) in the eastern Mediterranean region, six (10%) in the western Pacific, five (8%) in southeast Asia, and five (8%) in Europe. Of these, 20 (34%) countries had low incomes, 20 (34%) lower-middle incomes, 16 (27%) upper-middle incomes, and three (5%) high incomes (figure 1).
their country towards scaling up of services since 2007 had been “good” or “very good” (figure 2A).

Political will and the prioritisation of mental health
At the core of global27,28 and national29–31 efforts to scale up services is the need for decision makers and political leaders to understand the issues, recognise their importance, and prioritise action to address mental health needs.32 Our survey identified some improvement in awareness of mental health issues among leaders during the past 3 years, with more than half of respondents reporting “more” or “much more” awareness (figure 2B). Yet about 40% of respondents, from 26 (44%) countries, identified continuing poor awareness and low priority or poor commitment by political leaders as major barriers to development of mental health services.

“[There is a] lack of political will to provide a workable mental health policy, introduce reforms in health service delivery, and poor funding at all levels of government.” (Nigeria)

Survey respondents cited the absence of a national government mental health policy, strategy, or programme as a key barrier to implementation.33,34,35,36 However, many countries are now updating their mental health policy or legislation (webappendix pp 20–25). Mental health policy is an important component of scale up of services,15 although it is not in itself sufficient.16 An analysis of mental health policies in Ghana, South Africa, Uganda, and Zambia, for example, found them to be weak (in draft form or unpublished) and inadequately implemented. They often lacked feasible plans and adequate resource commitments.17 We also identified examples (see case study of Uganda, panel 2) in which significant progress was achieved without a recent or complete national policy.

“There appears to be a disconnect in Government regarding expressed interest and support for mental health services and the lack of tangible expressions manifested by resource availability and policy implementation.” (Liberia)
Legislation provides a clear legal framework that assures respect for human rights as a condition of care, and can also be a lever for change.\(^3\) The UN Convention on the Rights of Persons with Disabilities specifically includes the rights of people with psychosocial disabilities,\(^4\) but there was no evidence that this instrument has yet been effectively used in any country included in the survey.

The survey provided a wealth of recommendations to challenge poor government commitment. The main messages were to be persistent, use all relevant evidence of need and of effective interventions, respond pragmatically to opportunities as they arise, use strong stakeholder advocacy groups,\(^3\),\(^\text{41}\) and clearly allocate responsibility for implementation of plans,\(^\text{42}\) including through local management structures.\(^7\)

Poor knowledge and stigmatising beliefs among the general population were also identified as key barriers, reducing willingness to seek help.\(^5\)\(^,\text{14,44}\) Key strategies to change attitudes and helpseeking behaviour were engagement of people using mental health services, their families, and the general community,\(^8\) as well as specific target groups including respected leaders such as village elders\(^9\)\(^,\text{19}\) and traditional health-care providers.\(^8\) Methods included protesting against misinformation and discrimination, sharing of information through direct contact, or use of media.\(^8\) One service model in Nigeria, for example, included a mental health awareness campaign that led to increased use of community mental health services.\(^9\)

At a global level, the central advocacy messages have been to draw attention to the mental health treatment gap,\(^6\)\(^,\text{10}\) reinforce the need to scale up services,\(^2\)\(^,\text{12}\) call for policy and legislation on mental health,\(^7\) and show that evidence-based systems of care should be implemented in the community.\(^7\)\(^,\text{11}\) One initiative strengthening the case for prioritisation of mental health is Grand Challenges in Mental Health. This systematic identification of priorities in mental health is part of the Global Alliance for Chronic Disease. Availability of this kind of evidence has the potential to raise the profile of mental health on the global health and development agenda.\(^7\)

Several new organisations have emerged at national, regional, and global levels whose stated aim is to enable scaling up of services (webappendix pp 26–27). These groups include academic or research bodies, advocacy organisations, and journals. Civil society and non-governmental organisations were repeatedly identified in the survey as playing a key part in strengthening capacity, mobilising funds, and facilitating the implementation of new programmes (figure 2C).

Several global programmes that aim to support efforts to scale up services were identified in the literature review and survey. The Mental Health Gap Action Programme (mhGAP) is the WHO’s flagship project in mental health.\(^*\) The objectives of the programme are to reinforce the commitment of stakeholders to increase the allocation of financial and human resources for the care of people with mental, neurological, or substance misuse disorders and to achieve increased coverage of evidence-based interventions, especially in countries with low and lower-middle incomes.\(^7\)

The World Psychiatry Association (WPA) 2008–11 Action Plan is based on a systematic survey of international leaders in psychiatry from almost

---

\(\text{For the UN Convention on the Rights of Persons with Disabilities see }\)http://www.un.org/disabilities/convention/conventionfull.shtml\n
\(\text{For more on Grand Challenges in Mental Health see}\) http://grandchallengesgmh.nimh.nih.gov

---

Figure 1: Countries represented by respondents to the survey
60 countries, of which two-thirds have low and middle incomes. The results emphasise strengthening of specialist care while also task sharing (also known as task shifting) in primary care to maximise coverage, increasing access to psychological therapies and social interventions, and the active involvement of people using mental health services and their families. On the basis of these findings, the WPA is implementing a training programme in selected low-income countries.

The Movement for Global Mental Health emerged in 2008 after publication of The Lancet’s Series on global mental health. This coalition includes people using mental health services, professionals, and institutions ranging from universities to non-governmental organisations. It aims to be a social movement advocating scale-up of mental health services and protection of human rights.

**Organisation of services**

Existing structures into which mental health services fit often do not facilitate evidence-based interventions. The continued dominance of large psychiatric hospitals in many countries is at odds with the evidence, which suggests that most services should be delivered in decentralised locations with deinstitutionalisation and integration between the community and hospitals, and appropriate referral systems incorporating secondary and tertiary care. There still remains an important role for tertiary hospitals in provision of specialised beds (which remain in short supply compared with need).
One model for decentralisation is in Ethiopia, where nurses are trained to assume a range of extended roles in district settings, from prescription of drugs to community mental health education. Integration of mental health into primary care has commenced in five regions of Egypt as part of the country’s Health Sector Reform Programme. This programme includes staff training with follow-up, supervision, and a referral system to support primary care doctors. In Kenya, the mental health programme that was established in 2001 is now in its second phase involving training, supervision, and medicine supply. Panel 3 shows a case study in the occupied Palestinian territory.

Poor knowledge of mental illnesses among primary health-care staff and scarcity of mental health specialists for liaison and supervision have been identified as key concerns. Task sharing has proved to be an effective strategy in other areas of health, such as immunisation uptake and management of tuberculosis and HIV. There is growing evidence that lay people and health workers can also provide care traditionally delivered by psychiatrists. However, several of the respondents to the survey stated that unless staff receive ongoing training and supervision, motivation to undertake mental health work is lost. Some innovative approaches in India and Niger addressed the need for staff supervision by using telephones to facilitate communication.

The difficulty of giving increased responsibilities to busy primary health-care staff is often cited. A possible solution is the integration of mental health care with services for people with long-term (chronic) conditions, since services for individuals with chronic conditions share many of the characteristics of services for people with mental and neurological disorders. There is also a strong consensus that mental health should be integrated with other systems, such as social care and education.

Task sharing always necessitates substantial training, but where there is high staff turnover, this investment might be wasted. Some reports called for task sharing with families, carers, and volunteers, empowering them to play a more informed part in caring for people with mental illnesses in the community—a training investment less likely to risk so-called brain drain. This peer support is also favoured by organisations of people using mental health services, families, and carers, but this strategy should avoid reducing choice by replacing proper provision of professional services on which people also rely.

Many health information systems (which can include various population-based data sources [eg, censuses or household surveys] or health-facility based sources [eg, public health surveillance, health services data]) do not include mental, neurological, and substance misuse disorders. This factor makes it more challenging for mental health to be regarded as an integral part of the overall health system, as well as jeopardising efficient mobilisation of essential drug supplies, and implying low demand for mental health services.

Even services based on simple packages of care need a sustainable supply of psychotropic drugs, and the systems to provide this supply are often weak in low-income settings. In the short term, non-governmental organisations can find innovative ways of ensuring a supply of drugs, but ultimately the solution is to strengthen systems for sustainable provision of essential drugs. The availability of psychological therapies is even less than for pharmacological interventions, and is an area with a weak evidence base in low-income and
In a systematic review of community mental health programmes in Africa, only a fifth of relevant programmes included any evaluation, and our findings accord with this assessment. Of the 56 respondents who described new mental health programmes in their countries, only 22 (39%) reported completed evaluations. Most research into scaling up of services emphasises two issues: first, there are gaps in metrics and evaluation along with inadequate and incomparable primary data sources and analyses; and second, even well researched pilot projects are rarely scaled up. For example, two randomised controlled trials (in Pakistan and India) evaluated community workers in delivery of care for perinatal depression and dementia, respectively. Despite being high-quality studies with positive results, there was not sustained success at integration of such services in health systems after the research trials. This finding emphasises that close collaboration between research groups, government, non-governmental organisations, and other stakeholders is essential from the outset, and that consideration of practical sustainability issues is vital for making services research influential in the real world.

### Resources

#### Financial resource allocation

If services are to be scaled up, a substantial increase in resources and more efficient use of the resources that exist is needed. Absence of funding remains the dominant reported impediment to programme implementation. Tracking of financial resource allocation is one key way to judge political commitment to scaling up of mental health services (panel 4). In some cases, increased allocations of funds have been achieved, as in Chile and Brazil.

#### Access to evidence-based information: guidelines

The literature review and survey respondents identified several guidelines that have been produced to assist scale up of services (webappendix pp 28–29). Some cover incorporation of mental health interventions into other sectors, such as the Inter-agency Standing Committee guidelines on emergency interventions, and the WHO Community-Based Rehabilitation Guidelines. Others relate to a specific component of mental health work—e.g., working with children in war-affected areas.

One series covering treatment of a range of mental illnesses in low-income and middle-income countries was published in *PLoS Medicine* after consultation with more than 100 experts in 46 countries, and describes how non-specialist health workers can deliver effective treatments for mental and neurological disorders in resource-poor settings, and how to integrate this approach into primary care settings with the treatment of other chronic disorders. The targeted disorders included attention-deficit hyperactivity disorder, epilepsy, depression, schizophrenia, alcohol misuse disorders, and dementia.

The mhGAP Intervention Guide for eight priority mental, neurological, and substance misuse disorders in non-specialised health settings was published in October, 2010. These guidelines were the result of a systematic process of evidence collection and evaluation.

### Middle-income countries

In Chile, scaling up of evidence-based depression care needed an increase in full-time psychologists in primary care centres of 344% from 2003 to 2008.

### Evaluation and effect

Although respondents accepted the importance of evaluation in principle, most programmes were not evaluated. In a systematic review of community mental health services in Africa, only a fifth of relevant programmes included any evaluation, and our findings accord with this assessment. Of the 56 respondents who described new mental health programmes in their countries, only 22 (39%) reported completed evaluations.
using the GRADE methodology. The recommended interventions aim to be feasible and acceptable in low-income and middle-income countries, and should be integrated into existing systems. The mhGAP Intervention Guide is now available in English, French, and Spanish.

**Staff training**

In most low-income and middle-income countries, the ratio of people who need mental health care to the number of qualified psychiatrists is so disproportionate that there is no prospect of psychiatrists being able to deliver the care that is needed in the foreseeable future. In India, if every psychiatrist worked full-time, they would succeed in treating less than 10% of people with mental health needs. In countries with low and middle incomes, the psychiatrist should also be a public mental health practitioner, influencing policy makers, overseeing training, and providing support, supervision, and expertise as needed. Shortage of these skills among mental health leaders has been identified as a major barrier to progress in mental health service reform.

This deficit in leadership and public health skills among mental health professionals is addressed by emerging training options (webappendix pp 30–33). One example is the Sangath Leadership in Mental Health Course, and a similar course is run in Nigeria (University of Ibadan), with a focus on Africa. Related courses include the International Diploma in Mental Health Law and Human Rights run by the Indian Law Society, the International Masters in Mental Health Policy and Services run by the University of Lisbon in Portugal, and the Global Mental Health courses at the London School of Hygiene and Tropical Medicine, King’s College London, and the University of Melbourne, Australia.

**Challenges and lessons learned**

Five major barriers to scaling up of mental health services in countries with low and middle incomes have been previously identified: (1) absence of financial resources and government commitment; (2) overcentralisation; (3) challenges of integration of mental health care into primary care settings; (4) scarcity of trained mental health personnel; and (5) shortage of public health expertise among mental health leaders. We examine whether these barriers remain the crucial challenges, and summarise what progress has been made in scaling up.

The central message of the need to scale up evidence-based services in low-income and middle-income countries has been disseminated and has started to be translated into policy, legislation, strategies, and programmes. We found evidence that political leaders and decision makers are giving increased priority to mental health care in some countries, accompanied by an increase in funding by some international development and research agencies, although this change is not yet widespread.

**Panel 4: Change in financial resources for scaling up of services**

Although systems tracking Development Assistance for Health are becoming more sophisticated, systematic measurement of financing for mental health remains difficult. Mental health is often not identified as a subcategory within non-communicable diseases (NCDs), a diverse category including tobacco control and injuries. Despite recognition of the growing relative effect of NCDs on disability and mortality, less funds were given by government donors in 2008 than in 1995, and WHO spending on NCDs decreased by a third between 2002 and 2008. Where NCD aid funds are intended for mental health activities, this information is rarely disaggregated in reports, although it can be found in the field.

Overall, there is no evidence of a substantial shift in financial investment in mental health care in low-income and middle-income countries, since 50% of survey respondents felt that securing funds for mental health work was no easier than in 2007, with other respondents equally divided between reporting that it was easier or harder (figure 2D). Examples of funding for service implementation identified included national and local governmental agencies (for instance, in Indonesia, Ghana, Kenya, India, and Brazil) as well as UN agencies such as UNICEF and WHO (in particular, the WHO Mental Health Global Action Programme). Other sources included mental health projects funded by donor agencies such as the African Development Bank, African Medical and Research Foundation, Australian Aid Agency, UK Big Lottery Fund, European Commission for Humanitarian Aid and Civil Protection, and the EU Development Fund, as well as funds allocated through international non-governmental organisations such as BasicNeeds, CBM International, Comic Relief UK, and International Medical Corps.

Some new funding sources for research were identified, including from the Wellcome Trust, UK Medical Research Council, global mental health research programmes by the National Institute of Mental Health, as well as international research fellowships by the Fogarty Program at the US National Institutes of Health (NIH). Funding from NIH to mental health increased by 8% between 2007 and 2010, but we could not establish what proportion was devoted to low-income and middle-income countries.

There has been some progress in reorganisation of services by decentralisation and integration into primary health care, in standardisation of models of service delivery (including through an increasing number of well designed trials of complex interventions), and in understanding of the policy environment needed to make scaling up more feasible. There is now experience in several countries in engagement with the whole health system to ensure the necessary resources, such as personnel training and medicine supply, are widely available.
Figure 3: Important steps in strategic scaling up of mental health services in low-income and middle-income settings

1. **Situation analysis**

   - Gather information about needs in defined population/area and identify priorities for scaled services to address.
   - Identify available resources:
     - Human resources
     - Strengths of existing health system
     - Sustainable funding
     - Map relevant local government, non-government, and private sector agencies in the area.
   - Engage with local stakeholders including patients and caregivers to understand their needs and improve ownership and use of the services.
   - Review official policy, strategies in the country for compatibility of planned services.
   - Work with regional/local government and secure commitment to participation in process.
   - Find best available epidemiological data to understand needs.

2. **Planning**

   - Define priority conditions for service provision.
   - Review evidence for treatment that is appropriate for the local context (acceptable, affordable, feasible).
   - Design a method of service delivery that fits in with existing health system.
   - Develop consensus amongst key stakeholders about the priority conditions requiring services.
   - Use available evidence-based guidelines of relevance to low-income and middle-income settings.
   - Adapt guidelines as necessary to local culture, priorities, and resource availability.
   - Develop a strong planning and implementation group with effective representation from all stakeholders and external experts.
   - Develop linkages with existing community service resources (traditional healers, faith-based organisations, family and peer groups).
   - Identify the barriers to scaling up and develop risk management plans.

3. **Implementation**

   - Build coalition of stakeholders to oversee sustainable, long-term scaling up of balanced care.
   - Design a method of service delivery that fits in with existing health system.
   - Identify the barriers to scaling up and develop risk management plans.
   - Strengthen management structures at national and district levels to implement and oversee scaling up.
   - Include advocacy for sustainable resources in their remit.
   - Foster strong voice for advocacy by empowering patient organisations and civil society (eg, human rights).
   - Engage with other relevant programmes (health and non-health) to integrate mental health in their activities (education, social welfare) for mental health promotion and service delivery.
   - Implement scaling up strategy according to evidence and results of situation analysis.
   - Develop community awareness about mental health, identification, promotion, prevention, human rights/stigma, how to access services, include patients in this process.
   - Target community leaders, vulnerable groups, religious and other healers, and general population.
   - Deliver evidence-based medical, psychological, and social interventions that are accessible and affordable.
   - Ensure that relevant staff are appropriately trained and receive ongoing structured supervision.
   - Ensure good communication throughout referral system and that patients are followed up.
   - Integrate mental health into existing health information systems.

4. **Evaluation**

   - Monitor/evaluate the intervention and modify strategy according to findings.
   - Integrate mental health into existing health information systems.
   - Involve all stakeholders (government, staff, and patients) in evaluation, and planning of modifications to services that result.
   - Develop partnership with academic institutions for formal evaluation and research.
   - Disseminate findings to all local stakeholders.
   - Disseminate findings for advocacy at regional and national level.
   - Disseminate findings in the public domain—scientific publications or reports on internet.
There are many examples of training of community and primary health-care staff to take on mental health activities, and even of new grades of staff or reallocation of roles. However, ensuring that trained personnel continue to devote time to mental health activities in the long term remains a challenge, although refresher training and robust supervision structures might improve this situation. Focal personnel dedicated to mental health or chronic diseases (for example, at the district level) might also improve the commitment to delivery of services in a sustainable way.

Although there are examples of services that are being taken to scale, few have been evaluated and shown to be delivering care of a consistent standard to increased numbers of people. Crucially, this finding means that the evidence base for proven strategies for scaling up that are replicable remains weak.

The way forward
A systemic and strategic approach to scaling up is needed (figure 3). Specific interventions to increase coverage of mental health services need to be part of a broader and integrated process. This approach will need strong advocacy for financial commitment and will need to ensure that relevant elements of health infrastructure are strengthened to allow services to be sustained in the long term.

Task sharing is the means to most efficiently use low numbers of trained personnel. A high proportion of need can be met with simple packages of care delivered in non-hospital settings by non-specialists. Primary health-level staff need to be better trained and supported to identify and manage mental disorders. The specific roles they should have, the training and supervision they need, and the way that they relate to the overall health system are important questions to be evaluated.

Specialist mental health staff are needed at the district level. The composition of personnel will vary depending on available resources, and preferably should consist of a multidisciplinary team, but at least a prescribing clinician. In many of the countries represented in our survey, the mere decentralisation of any mental health expertise to district level (rather than only the very largest cities) would have an enormous effect on access to care. Such staff would not only provide clinical services, training, and supervision for non-specialist staff in primary care, but also a managerial function to ensure that the health system facilitates integration of mental health services.

Mental health professionals and practitioners need to broaden their roles. Besides being traditional clinicians, specialist staff also need to accept responsibility for planning, training, supervision, and advocating with decision makers in their area of expertise. To achieve this goal, specialists themselves need access to relevant training in these skills.

Scaled up services need to be evaluated, and the lessons learnt from evaluation then generalised. The evaluation of innovative programmes can make an important contribution to the case for scaling up. Although contextually appropriate services will always differ, effective models will be those that show the best performance for relevant outcomes. To achieve this aim, the evaluation methods used need to be feasible in the context of low financial resources, and routine collection of relevant information is needed.30 Many countries have used WHO-AMIS, for example, to make initial assessments of their mental health care systems.31 Further refinement and repeated use of this system would add substantially to our ability to measure progress in scaling up. WHO should facilitate coordination of this process, drawing on a network of local experts at country level.

A new paradigm of public mental health is needed. Strong partnerships need to be built between well resourced research institutions and researchers and practitioners in low-income and middle-income countries. This approach should be based on the principles of local capacity building to ensure high scientific standards and participation by all stakeholders, including people using mental health services.

Since 2007, a substantial amount of evidence has shown how feasible and effective services for people with mental illness in low-income and middle-income countries can be. Scaling up of such services can be achieved by tackling, in an integrated way, poor political will, scarcity of resources, and inefficiently organised services, so that care is made available to people who were previously unable to access it. The challenge remains to scale up these services so that an increased number of people benefit, but we have moved a long way in a short time towards this end.

Contributors
JE conceptualised the paper with support from SS and GT. LM undertook the systematic literature review. JE and MS undertook the survey of key informants. FB drafted the panel on financial resources, CN drafted the case study on Uganda, and SC drafted the case study on Palestine. The final report was written by JE with input from all authors and particular editorial support from SS and GT. All authors have seen and approved the final version.

Conflicts of interest
We declare that we have no conflicts of interest.

Acknowledgments
We thank the respondents to the survey (listed on webappendix pp 34–37) for sharing their knowledge of mental health services in the countries in which they work and Alex Sales (Tavistock Centre, UK) and Joel Amah (CBM, Togo) for Spanish and French translations, respectively, of the survey and associated responses. The Librarian Service at the London School of Hygiene and Tropical Medicine helped to undertake the systematic review. For the case study of West Bank and Gaza, we thank Nargiza Khodjaeva (Technical Officer on Mental Health, WHO Office in Jerusalem), Hazem Ashour (President of Mental Health Unit of the Ministry of Health in the West Bank), and Mustafa Elmasri (WHO local consultant in Gaza) for their contributions. GT is supported in relation to a National Institute for Health Research (NIHR) Applied Programme grant awarded to the South London and Maudsley NHS Foundation Trust, and in relation to the NIHR Specialist Mental Health Biomedical Research Centre at the Institute of Psychiatry, King’s College London and the South London and Maudsley NHS Foundation Trust. CT holds a visiting professorship at the University of KwaZulu Natal in Durban. MS is supported by a PhD studentship grant from the UK Medical Research Council. FB is supported by a Wellcome Trust Research Fellowship...
Grant. The views expressed in this review are those of the authors and do not necessarily represent the decisions, policies, or views of their respective institutions.

References
17 Thornicroft G. Most people with mental illness are not treated. Lancet 2007; 370: 607–08.
43 Patel V. From evidence to action in global mental health; task shifting: a practical strategy for scaling up mental health care in developing countries. South Afr J Psychiatry 2008; 14: 108.