Paper II: Innovation in Deinstitutionalization

A WHO Expert Survey

Julian Eaton, CBM International, Togo
julian.eaton@cbm-arow.org

Acknowledgements

JoAnne Epping-Jordan (Editor)
Mark van Ommeren/S. Saxena (WHO, Geneva)
Gordon Shen (University of California at Berkley, USA)

Steering Group

Julian Eaton (Chair. CBM International, Togo)
José Miguel Caldas de Almeida (Nova University of Lisbon)
John Mahoney (University of Melbourne)
Shoba Raja (Basic Needs, India)
Benedetto Saraceno (NOVA University of Lisbon, Portugal)

Emily Ng (Analysis. University of California at Berkley, USA)

Ghana case study

Fondation d'Harcourt

This is not effective or humane care

It is possible to do better

Community-based services

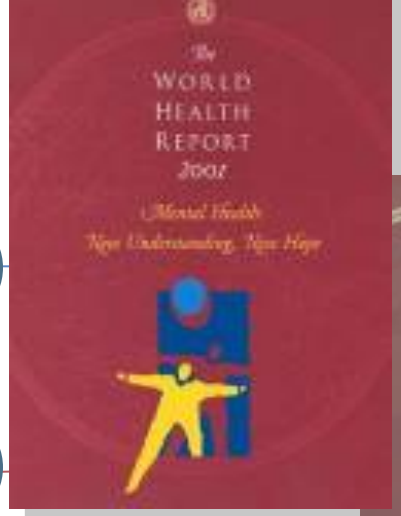
Most countries have not made this transition

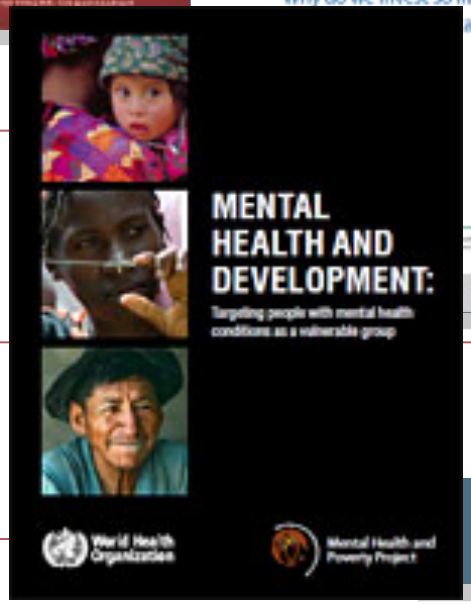
- Despite recognition that the family and community provide the most appropriate environment for healing and acceptance

- Despite many years of evidence and advice from WHO, and other experts

- Despite consensus of decentralized and community-based services as the best model

Despite a growing body of evidence





2001

2005

2007

2008

2009

2010 +

Rise in alliances and advocacy networks

mhGAP country implementation

Lancet series 2011

mhGAP Int Guide / Training materials

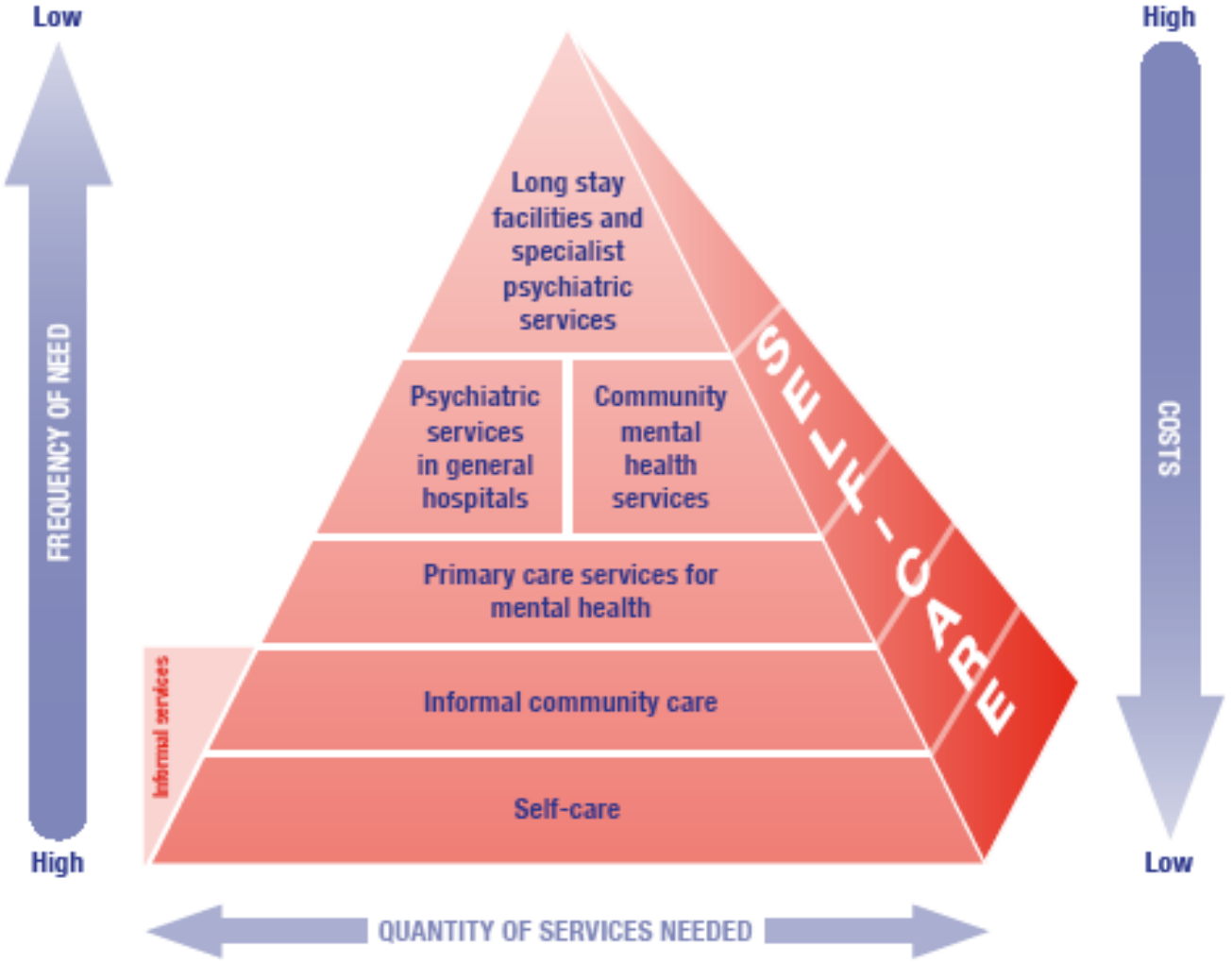
QualityRights

WHO Global Mental Health Action Plan 2013

Balanced and Efficient Mental Health Services

Reality is:

- Scarcity
- Inefficiency
- Inequity



World Health Organisation

Institutional mental health care

- Continues to exist in the vast majority of countries
- Consumes most of the mental health budget
- Operates at a high cost per service user
- Diverts human and financial resources from community-based services
- Too far for most people to reach, so serves only a small fraction of those in need
- Leads to human rights violations

What works?

- To move from this:

- To this:

Let’s ask the experts*

** Those who have been substantially involved in expanding community-based mental health services, and/or downsizing mental hospital-based care*

Methods

- Purposive and snowball methods of sampling
- 78 expert respondents (52% of sample)
- Asked to respond concerning experience in a particular country where they had worked
- Questionnaire on the *perceived usefulness* of different methods
  - Closed-ended, ordinal response scale questions about 24 pre-defined methods*
  - Opportunities to write freely about other methods that worked (and that didn't work) in this country

*based on literature review of published and grey literature

Respondent Demographics

		N (% rounded)
Country income group (World Bank)		
	Low	18 (23%)
	Lower-middle	28 (35%)
	Upper-middle	13 (16%)
	High	20 (25%)
Geographic region (World Health Organization)		
	WHO African Region	20 (25%)
	WHO Region of the Americas	8 (10%)
	WHO South-East Asia Region	12 (15%)
	WHO European Region	19 (24%)
	WHO Eastern Mediterranean Region	6 (8%)
	WHO Western Pacific Region	14 (18%)
Gender		
	Male	57 (72%)
	Female	20 (25%)

Average 24 years experience

Respondent backgrounds

Current affiliation		
	Government	29 (37%)
	International NGO	16 (20%)
	National/local NGO	31 (39%)
	Academia	34 (43%)
	International organization	8 (10%)
	User or family association	6 (8%)
	Other	12 (15%)

Quantitative results

- High correlations between methods for expanding community-based services and downsizing institutions
- Ratings generally higher for expanding community-based services than for downsizing institutions
- What these results might mean:
  - Deinstitutionalization is not an inevitable outcome of expanding community-based services
  - Deinstitutionalization is resisted and hard to do

Most highly-rated methods

Rank	Method for downsizing institution-based services	Percentage of respondents rating method as 'quite useful' or 'very useful'
1	Mobile clinics/outreach services	67.4%
2	Psychiatric beds outside mental hospitals (e.g. in general hospitals)	64.3%
3	Discharge planning/hospital to community residence transfer programmes	58.3%
4	Residential care in the community	57.7%
5	Stopping new admissions in institutions or 'closing the front door'	56.5%
6	Reducing admissions through new admissions procedures	55.8%
6	Local catchment area or hospital-level plans	55.8%
6	Supported employment	55.8%
9	National or regional mental health policy, strategies, plans	54.2%
10	Self-help and user groups	51.0%

Qualitative results

- Derived from content analysis of open-ended responses, independently electronically coded

  (GS, EN)
- Several additional themes emerged
  - Managing the workforce
  - Financing
  - Rallying support
  - Capitalizing on moments of openness to change

Country examples in Annex 1

1. Managing the workforce

- Mentioned by > 25% of respondents
- Key aspects:
  - New cadres, task shifting (sharing), other re-organizations
  - Training *and supervision*
  - Strengthening motivation and morale

First multidisciplinary mental health team in Jordan

2. Financing

- Double funding and/or bridge financing
- Ring-fencing funds for mental health
- Direct financing towards desired change
- Incentives for deinstitutionalization and innovation

3. Rallying support

"Decisions must be supported at the highest possible level, involving most levels possible, and with the enough political and budgetary support."

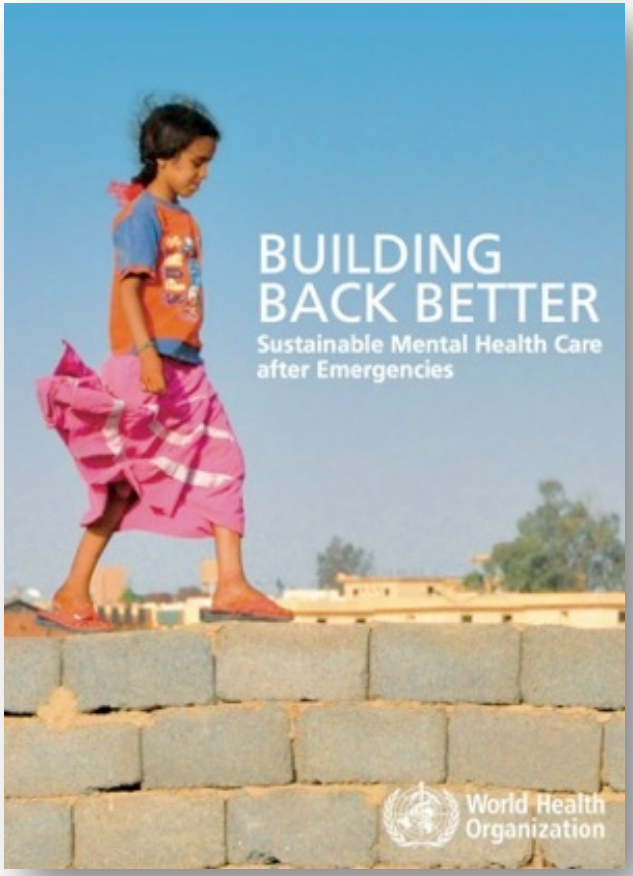
Mauricio Gómez-Chamorro
Chile

"Political decisions and verbal intentions proclaimed by political decisions makers [carry little or no weight] as long as they are not financed."

Wolfgang Rutz
Sweden

4. Capitalizing on moments of openness to change

- Emergency situations provide opportunities
- Changes in political leadership
- Change agents, those with a personal link to the issue



5. Political skill

- Can be taught
  - Social astuteness
  - Interpersonal influence
  - Networking
  - Ability to establish alliances
- Being there for the long term
- Relationships
- Relationships
- Relationships

Summary of results

- No single 'formula'
- Some top-down, some bottom-up
- Some decisive and immediate, others gradual - all sustained
- Community-based services key part of mix
- Political skill applied towards:
  - Managing the workforce
  - Aligning financing mechanisms
  - Rallying support
  - Capitalizing on moments of openness to change

Based on the survey, five **principles for deinstitutionalization** were identified:

1. Community-based services must be in place
2. The health workforce must be committed to change
3. Political support at the highest and broadest levels is crucial
4. Timing is key
5. Additional financial resources are needed

1. Community-based services must be in place

- Clinical services, stable accommodation, social support services
- Prevents neglect, homelessness, and/or incarceration of service users
- Can be initiated by institution itself

but …

establishing community-based services does not lead necessarily to deinstitutionalization – targeted efforts are needed

2. The health workforce must be committed to change

- Consultation and participation with all levels from the outset
- Convincing psychiatrists is key

"It is obviously easier to establish something new from scratch than to transform/change something into something else."

Anita Marini

Discussions on Reform, Nigeria

3. Political support at the highest and broadest levels is crucial

- Government
- Senior health leaders
- Non-Governmental Organisations
- Communities/community leaders
- Service users and their families

cf:
- Lancet 2007 Saraceno et al 'Barriers'
- Global Mental Health Action Plan

Government consultation, Yemen

4. Timing is key

Moments of openness provide opportunities to rally support and introduce reform

5. Additional financial resources are needed

"The move from an institutional-based to a community-based model of care cannot be conceived as a cost-saving process …"

Angelo Barbato

Italy

Summary

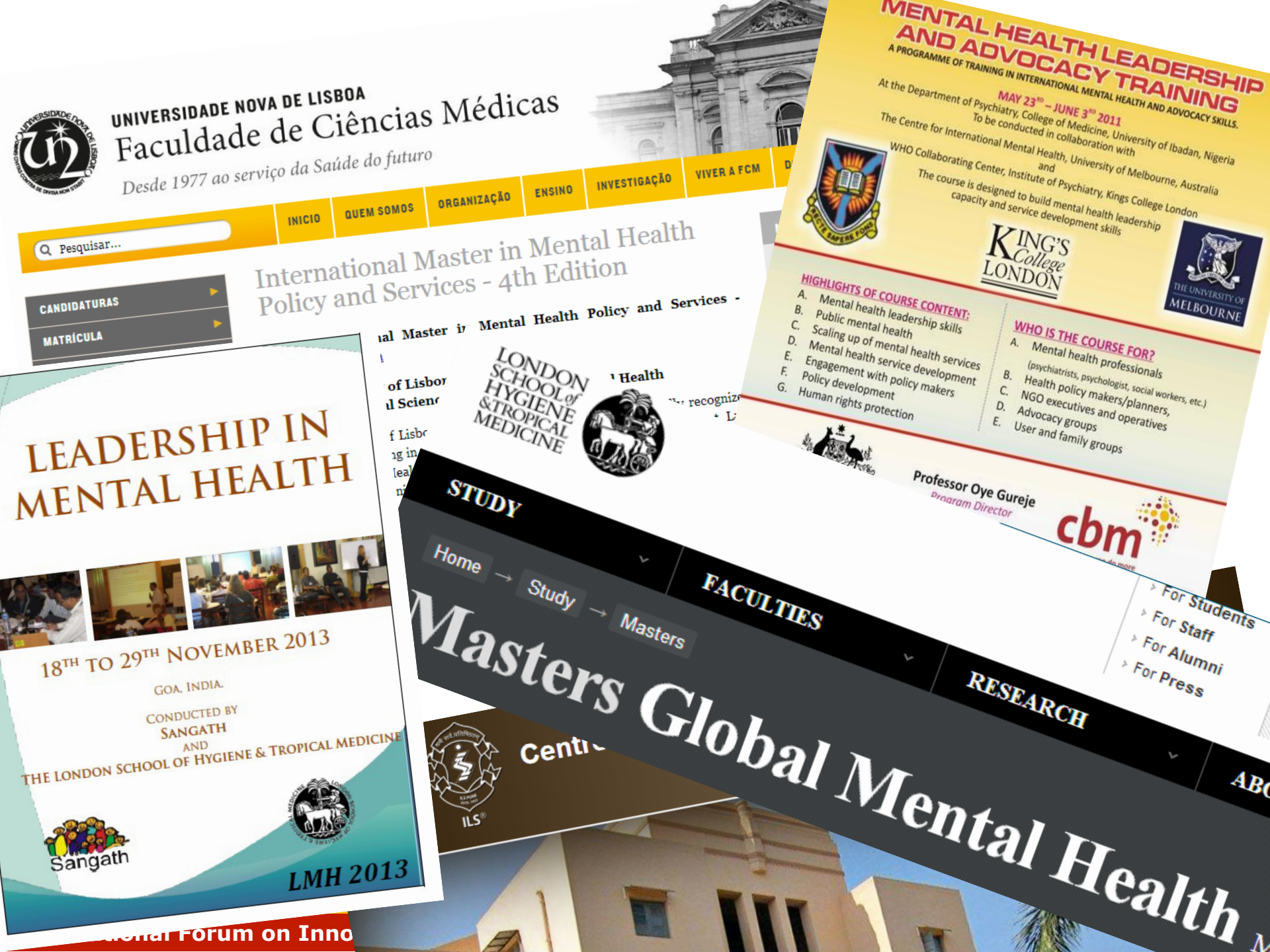
- Community-based services are widely regarded as the best approach for providing treatment and care
- Most countries continue to spend the vast majority of their scarce mental health resources on institutions
- Results of our expert survey indicate that there are several successful paths to deinstitutionalization
- Most respondents emphasized—directly or indirectly—the importance of political skill and timing

Where's the innovation?!

- A technology?
- A methodology?

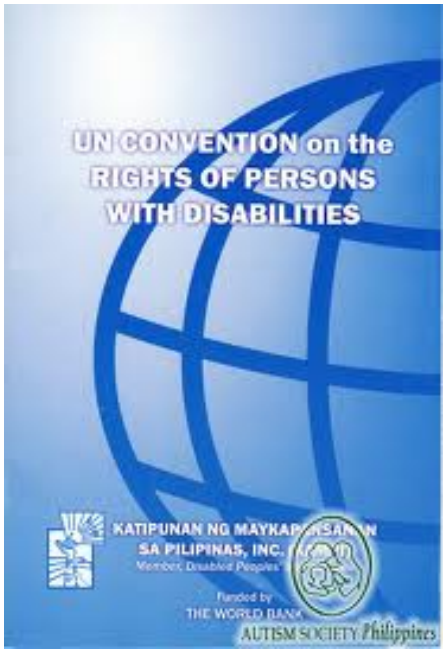
An investment in people

Equipping stakeholders in a systematic way with the necessary technical knowledge and political skills to stimulate and sustain reform


UNIVERSIDADE NOVA DE LISBOA
Faculdade de Ciências Médicas
Desde 1977 ao serviço da Saúde do futuro
INICIO
QUEM SOMOS
ORGANIZAÇÃO
ENSINO
INVESTIGAÇÃO
VIVER A FCM
Pesquisar...
CANDIDATURAS
MATRÍCULA
International Master in Mental Health Policy and Services - 4th Edition
LONDON SCHOOL of HYGIENE &TROPICAL MEDICINE
MENTAL HEALTH LEADERSHIP AND ADVOCACY TRAINING
A PROGRAMME OF TRAINING IN INTERNATIONAL MENTAL HEALTH AND ADVOCACY SKILLS.
MAY 23RD – JUNE 3RD 2011
At the Department of Psychiatry, College of Medicine, University of Ibadan, Nigeria
To be conducted in collaboration with
The Centre for International Mental Health, University of Melbourne, Australia
and
WHO Collaborating Center, Institute of Psychiatry, Kings College London
The course is designed to build mental health leadership capacity and service development skills
KING'S College LONDON
THE UNIVERSITY OF MELBOURNE
HIGHLIGHTS OF COURSE CONTENT:
A. Mental health leadership skills
B. Public mental health
C. Scaling up of mental health services
D. Mental health service development
E. Engagement with policy makers
F. Policy development
G. Human rights protection
WHO IS THE COURSE FOR?
A. Mental health professionals (psychiatrists, psychologist, social workers, etc.)
B. Health policy makers/planners,
C. NGO executives and operatives
D. Advocacy groups
E. User and family groups
Professor Oye Gureje
Program Director
cbm
LEADERSHIP IN MENTAL HEALTH
18TH TO 29TH NOVEMBER 2013
GOA, INDIA.
CONDUCTED BY
SANGATH
AND
THE LONDON SCHOOL OF HYGIENE & TROPICAL MEDICINE
Sangath
LMH 2013
STUDY
FACULTIES
RESEARCH
Home → Study → Masters
Masters Global Mental Health
For Students
For Staff
For Alumni
For Press
ILS®

Stakeholder Coalition Sierra Leone

- Strong advocacy group of stakeholders
- Strong international links but set their own agenda
- Engagement with government leaders
- Used opportunities that arose
- Raised profile of mental health
- Managing resistance by taking a long term view
- Guiding service implementation
- Reforming Sierra Leone Psychiatric Hospital



Act, Unite & Empower for Mental Health

QualityRights

Movement for Global Mental Health Position Statement on mental health in the post-2015 development agenda

Mental Health is Essential to Achieve Sustainable Development

MGMH
Movement for Global Mental Health

This position paper aims throughout to present the current best evidence in the field of global mental health and highlight the positive contribution new developments in the field can make to the overall development agenda. It was compiled with the participation of individual and organisational members of the Movement for Global Mental Health.

We call upon the United Nations and other parties drafting the Post 2015 Framework and implementation plan, as well as those who will implement proposed activities, to include the following three specific elements, all of which are essential components of the global development agenda.