WORLD MENTAL HEALTH DAY 2020

Mental Health for all:
Greater Investment-Greater Access

Investing in Mental Health

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Introduction

- There is no health without mental health; afterall, *cogito ergo sum*!
- Mental, neurological and substance use disorders account for 13% of the global burden of disease (WHO, 2012)
- Depressive and anxiety disorder rates have increased over the years by about 50% (WHO, 2016)
- Roughly 1 in 4 persons will suffer from mental disorder at some point in their lives
- Mental disorders are on the rise and will cost the global economy up to $16 trillion in 20 years (2010 - 2030) if urgent steps are not taken (WEF, 2018)
- Psychosocial problems of COVID-19 (present and future) have complicated the mix!
- About $147 billion in investment is required to scale up treatment – psychosocial counselling and antidepressant medication (Chisholm et al., 2016)

Introduction 2

- Yet,

  governments spend an average of 3% of their health budgets on health (from 1% in LICs to 5% in HICs)

"View health as an investment, not an expense."

– John Quelch

The MH treatment gap

- MH treatment gap – HIC – 50%; 75 - 85% in LMIC

These gaps are filled by: lack of treatment, ineffective treatment as well as untold hardship and pain for those who suffer from MI.

Why must we invest in mental health?

- The MH treatment gap must be bridged
- Mental health is a fundamental human right
- ‘Security’ and ‘welfare’ are the primary objectives of government
- Investment in mental health gives good returns e.g. $1 investment into scaling up treatment for common mental disorders had been found to result in $4 **in terms of improved health and productivity** (300% return!) – reduced indirect costs, reduced man-hours lost, etc.
- No sustainable development without mental health – SDG 3 (ensuring healthy lives and wellbeing across all ages)

Why must we invest in mental health? 2

- Mental health is an integral part of Universal Health Coverage – ***'leave no one behind'***
  - Equity
  - Quality
  - Financial Risk protection

Key areas of investment?

- Improved access to psychological therapies
- Mental health literacy
- Tackle stigma and social isolation
- Improved access to CAMHS including school health programmes
- Mental health of older adults
- Integrated and co-ordinated secondary care
- Peer workers/support groups
- Social/occupational support: friendships, work, education
- Mental health and emergency preparedness e.g. COVID-19
- Staff wellbeing – ‘who guards the guards’

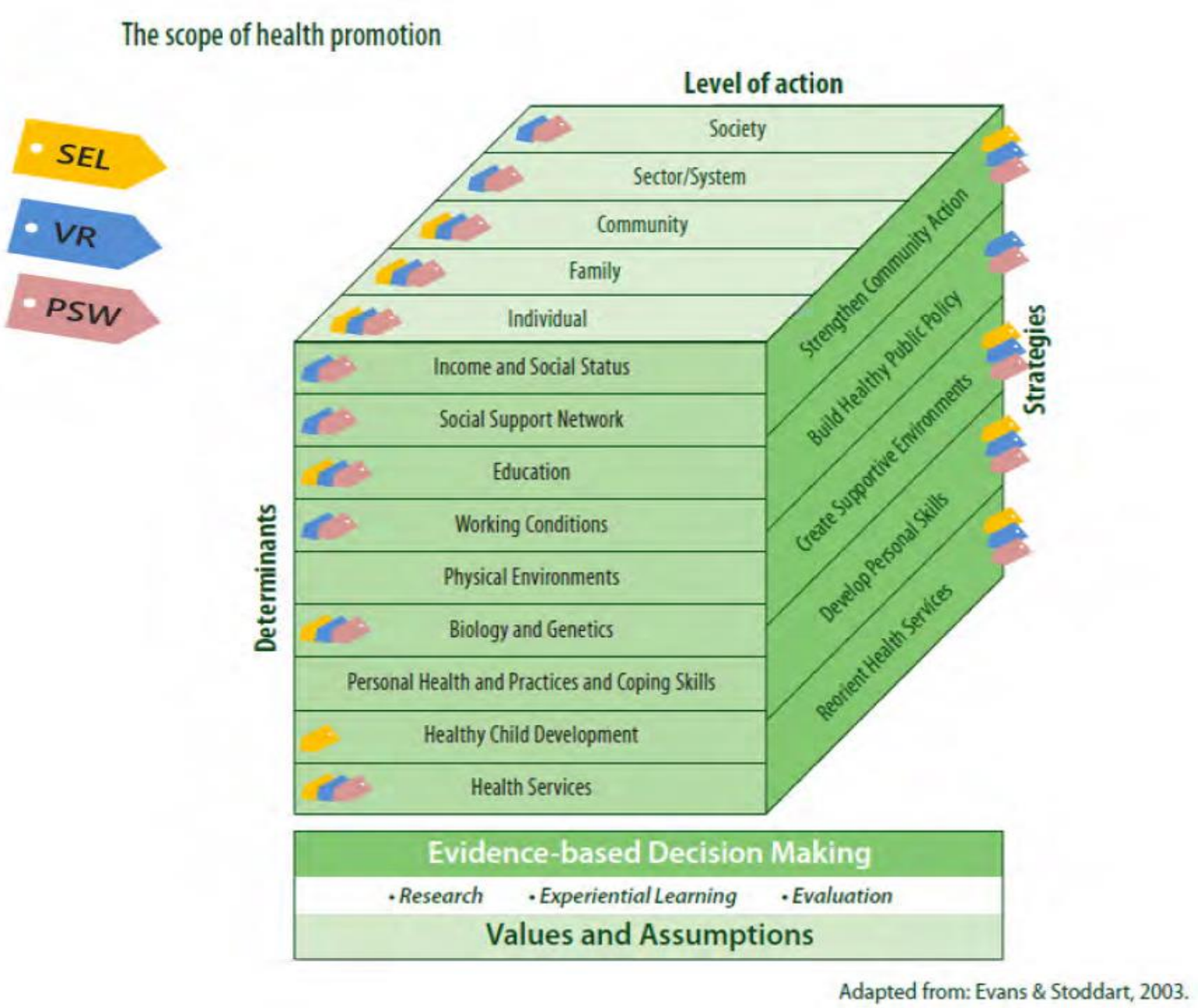
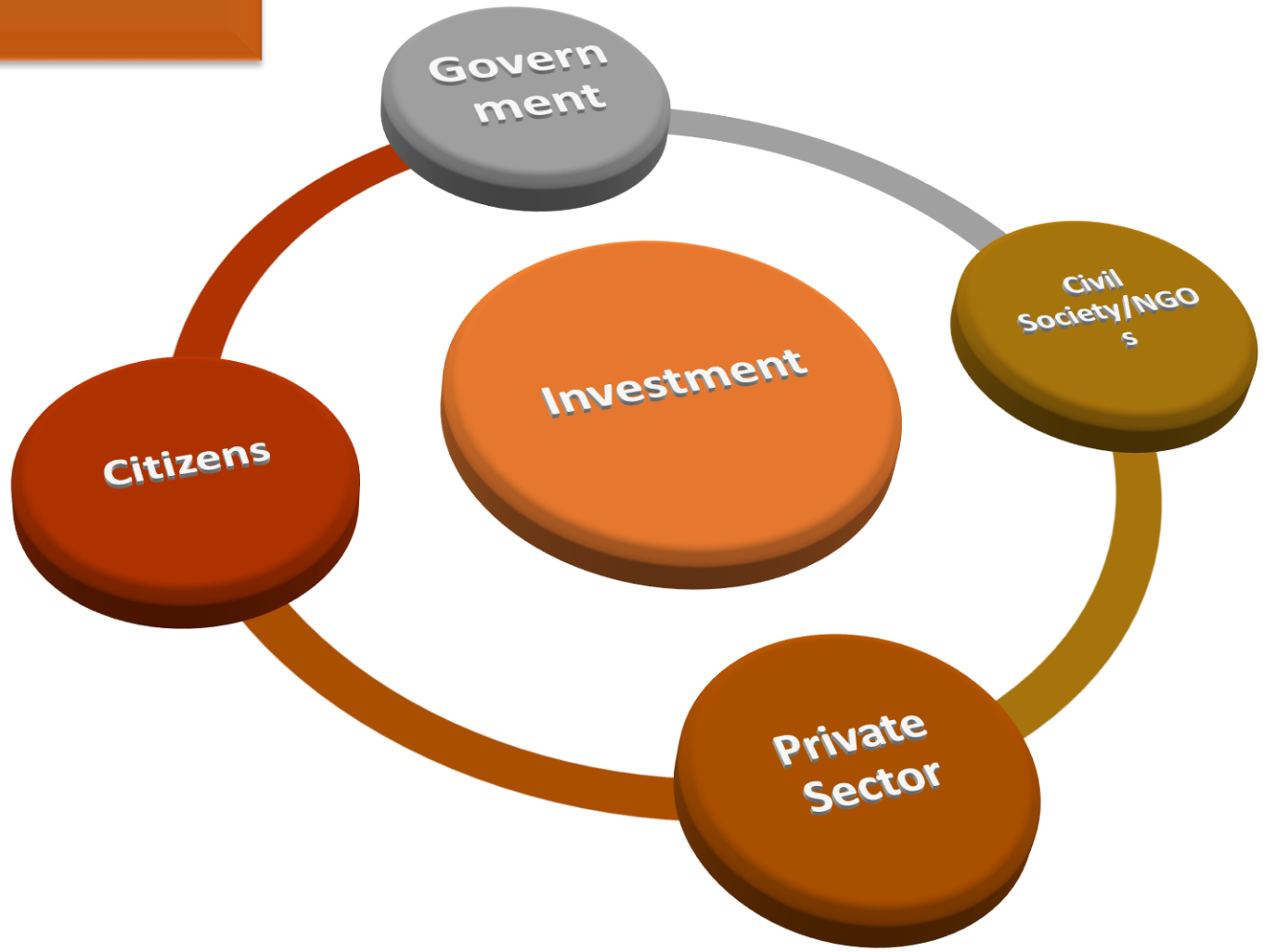


Figure 1. The scope of health promotion.

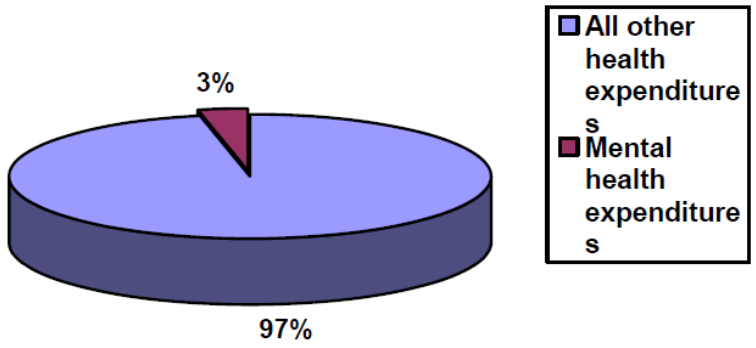
Investing in Mental Health Promotion

All hands must be on deck

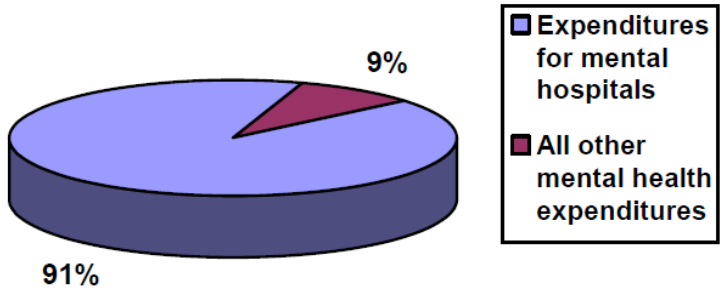


Nigerian Mental Health System

GRAPH 1.1 HEALTH EXPENDITURE TOWARDS MENTAL HEALTH

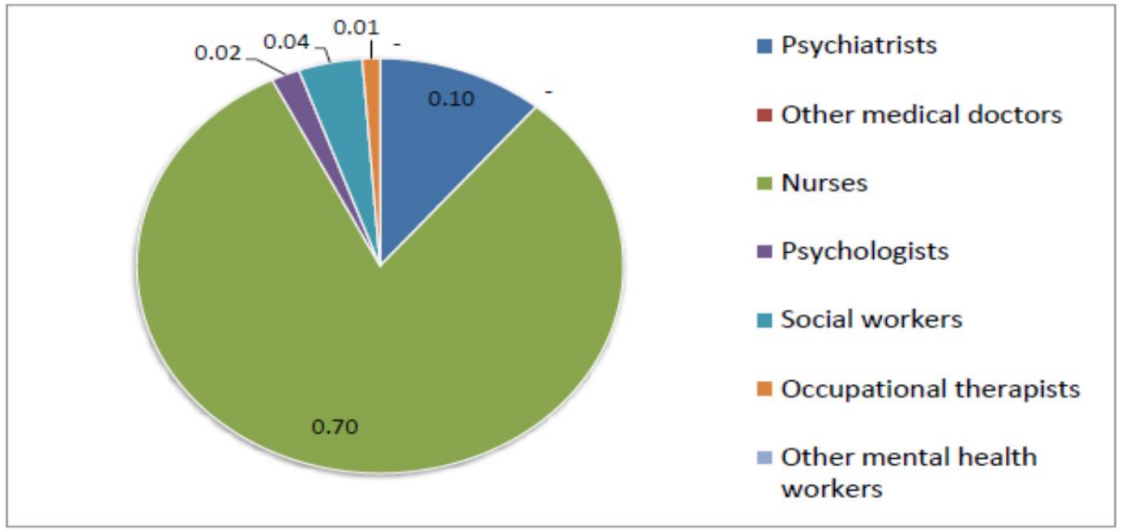


GRAPH 1.2 MENTAL HEALTH EXPENDITURE TOWARDS MENTAL HOSPITALS

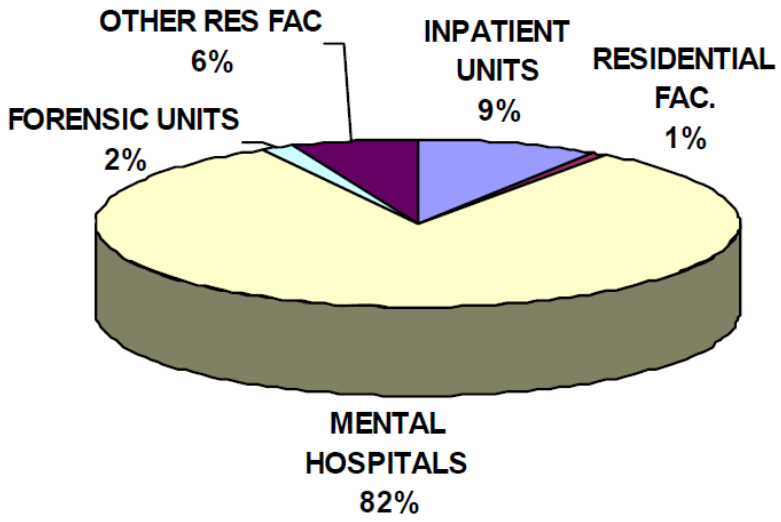


3.99 beds/100,000 population

Mental health workforce (rate per 100,000 population)



GRAPH 2.1 - BEDS IN MENTAL HEALTH FACILITIES AND OTHER RESIDENTIAL FACILITIES



Source: WHO, 2006

Mental Health ATLAS 2017 Member State Profile

Nigeria

Total population *(UN official estimate)* : [a]	181,181,744
WHO Region:	AFR
Income group: [b]	Lower Middle Income
Total mental health expenditure per person (reported currency)	Not reported
Availability / status of mental health reporting	Not reported or not available

Burden of mental disorders *(WHO official estimates)*

Disability-adjusted life years (per 100,000 population) [c]	1,986.85
Suicide mortality rate (per 100,000 population) [d]	9.5

MENTAL HEALTH SYSTEM GOVERNANCE

Mental health policy / plan

Stand-alone policy or plan for mental health:	Yes
(Year of policy / plan):	2013
The mental health policy / plan contains specified indicators or targets against which its implementation can be monitored	No
Policy / plan is in line with human rights covenants (self-rated 5-point checklist score; 5 = fully in line)	5
Plan or strategy for child and/or adolescent mental health	No
(Year of policy / plan):	Not reported

Mental health legislation

Stand-alone law for mental health:	No
(Year of law):	None or not reported
The existence of a dedicated authority or independent body to assess compliance of mental health legislation with international human rights	Does not exist
Law is in line with human rights covenants (self-rated 5-point checklist score; 5 = fully in line)	3

Multisectoral Collaboration

There is ongoing collaboration in the area of mental health with Service users and family or caregiver advocacy groups	No

****No reliable data on MH financing in Nigeria**

RESOURCES FOR MENTAL HEALTH

Mental health financing

The care and treatment of persons with major mental disorders (psychosis, bipolar disorder, depression) included in national health insurance or reimbursement schemes in your country	No
How the majority of persons with mental disorders pay for mental health services	Persons pay mostly or entirely out of pocket for services and medicines
The government's total expenditure on mental health as % of total government health expenditure	None or not reported

Human resources for mental health

Total number of mental health professionals (gov. and non-gov.)	None or not reported
Total mental health workers per 100,000 population	None or not reported
Total number of child psychiatrist (gov. and non-gov.)	None or not reported

Mental health workforce (rate per 100'000 population)

Psychiatrists	None or not reported
Child psychiatrists	None or not reported
Other specialist doctors	None or not reported
Mental health nurses	None or not reported
Psychologists	None or not reported
Social workers	None or not reported
Occupational therapists	None or not reported
Speech therapists	None or not reported
Other paid mental health workers	None or not reported

Funding in the Nigerian Mental Health System

- **Less than 6% of GDP** is spent on health
- Roughly **1% of health budget is spent on mental health**
- About 90% of the mental health budget goes to specialist (Neuropsychiatric) hospitals providing 82% of total beds in the country (paltry 4:100,000 versus 50:100,000 in HICs (WHO, 2018)
- **70% of Health expenditure** is out-of-pocket
- **66% of the population lives below poverty line**
- NHIS coverage is less than 5%; **coverage for mental health problems is for 21 days??**
- Urban: rural population is now 50%:50%; yet **health services are skewed towards urban centres** – hindrance to access

Funding in the Nigerian Mental Health System

- Health is on the concurrent legislative list
- States have a key role in funding both secondary and primary care levels (PHC is essentially LG responsibility).
  - E.g. the Aro primary care mental health Programme for Ogun State (APCMHP) relies on partnership funding from the state – Ogun state provides PHC workers and facilities; Aro (Federal funding) provides supervision/support by nurse supervisors, booster training, linkage with specialist consultations (all these translate to funds); also Aro provided the seed funding for the Drug revolving scheme supporting the programme
  - States must provide partnership funding in order to access PHC funds under the BHCPF

Where will the investment funds come from?

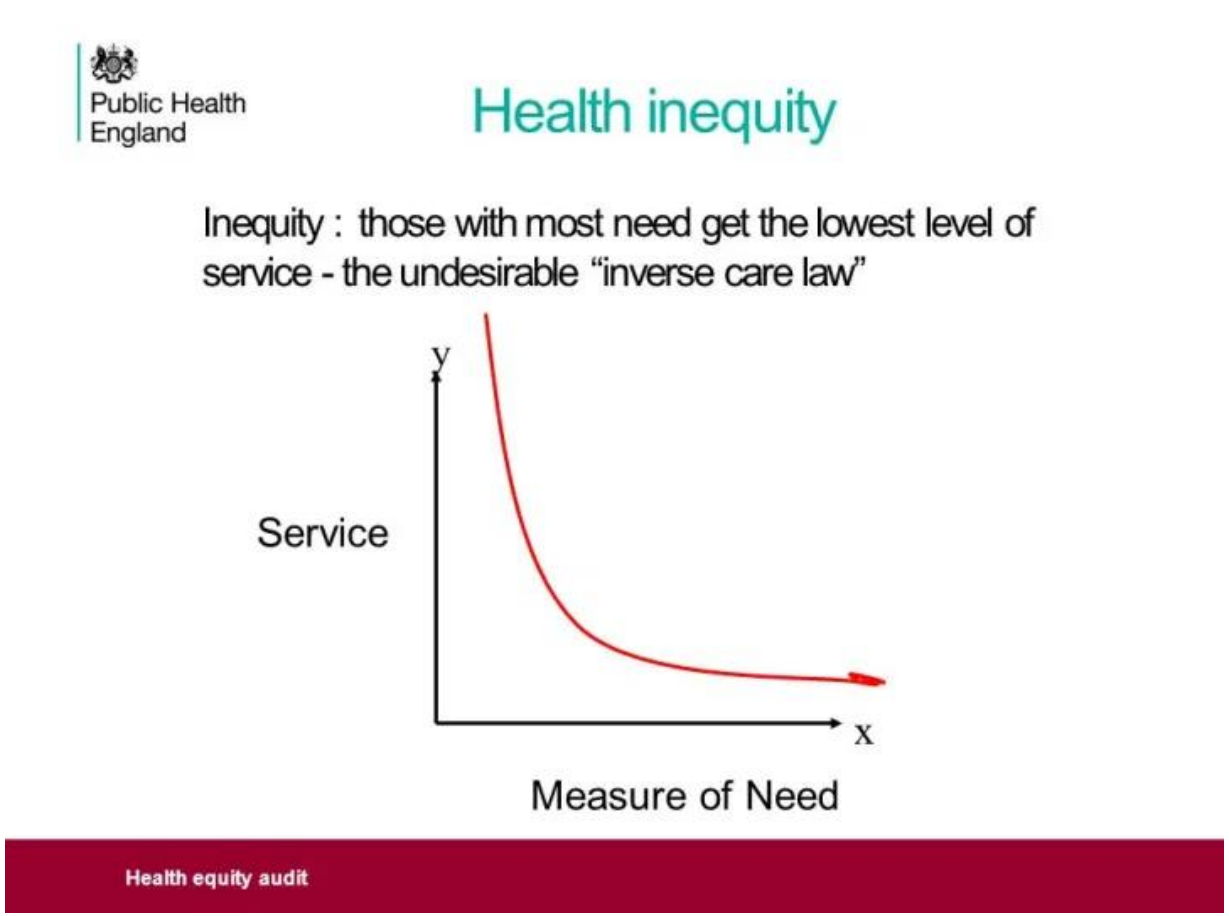
- Annual Health budget (N132 billion in 2021)
- Statutory transfers in respect of health funding – BHCPF (not less than 1% of the consolidated revenue fund per section 11 of the National Health Act, 2014)
- Grants, other donor funds
- Out-of-pocket expenditure
- Employer-assisted healthcare coverage

Funding in the Nigerian Mental Health System

- **BHCPF = N35.03 billion in 2021 budget (0.4% of projected revenue**
- **The BHCPF is statutorily required (under s. 11 of the National Health Act, 2014) to meet the following:**
  1. 50% - **NHIS to cover 'Basic Healthcare package'**
  2. 20% - **Essential drugs, vaccines, etc.**
  3. 15% - **Develop infrastructure, provide for transportion, etc. at primary care level**
  4. 10% - **manpower development/training at primary healthcare level**
  5. 5% - **emergency healthcare**
- All items apply to mental healthcare – especially if operational at primary care level

- **NHIS and Mental Healthcare**
  - Health insurance should be CONTRIBUTORY and MANDATORY – see the Ghanaian example
  - Voluntary schemes are unlikely to grow as expected
  - Health insurance should be large pools – community-based health insurance schemes are easier to manage but negate the principle of size in pooling (WHO position)
  - Duration of treatment must be revised
  - Unemployed mentally ill should be taken into consideration – govt. to contribute through BHCPF

How do we approach this investment?



- Dealing with inverse care scenarios will improve 'allocative efficiency'
  - Most of those who suffer from mental disorders require care at the primary care level
  - **Integrate mental health care into primary care – improves access, availability, and affordability; reduces stigma! Seamless care.**
  - See projects in Nigeria: Osun state pilot, Aro PCMHP, Lagos state experience

Methods: *Applying a population based expansion of pilot- tested integration model of Aro Primary Care Mental Health Programme (APCMHP) for Ogun State, 80 PHC workers were trained using adapted mhGAP intervention guide to assess and treat/refer 5 priority conditions: Psychosis, Depression, Epilepsy, Alcohol and Substance abuse and Other Significant Emotional Complaints (OSEC).There was mental health service provision in 40 designated PHC centers across Ogun state. There was support and supervision of the trained health workers by field supervisors, supplementary training and re-training for skill sustenance, periodic stakeholders meeting with Local Government Service Commission, zonal consultants' review, financial and other resources commitment by the hospital, monthly programme evaluation and monitoring by the faculty members. We reviewed caseload of patients managed by trained PHC Workers since commencement of the programme in November 2011 till October 2017 (6 years period) using descriptive statistics. Appropriate ethical approval was obtained.*

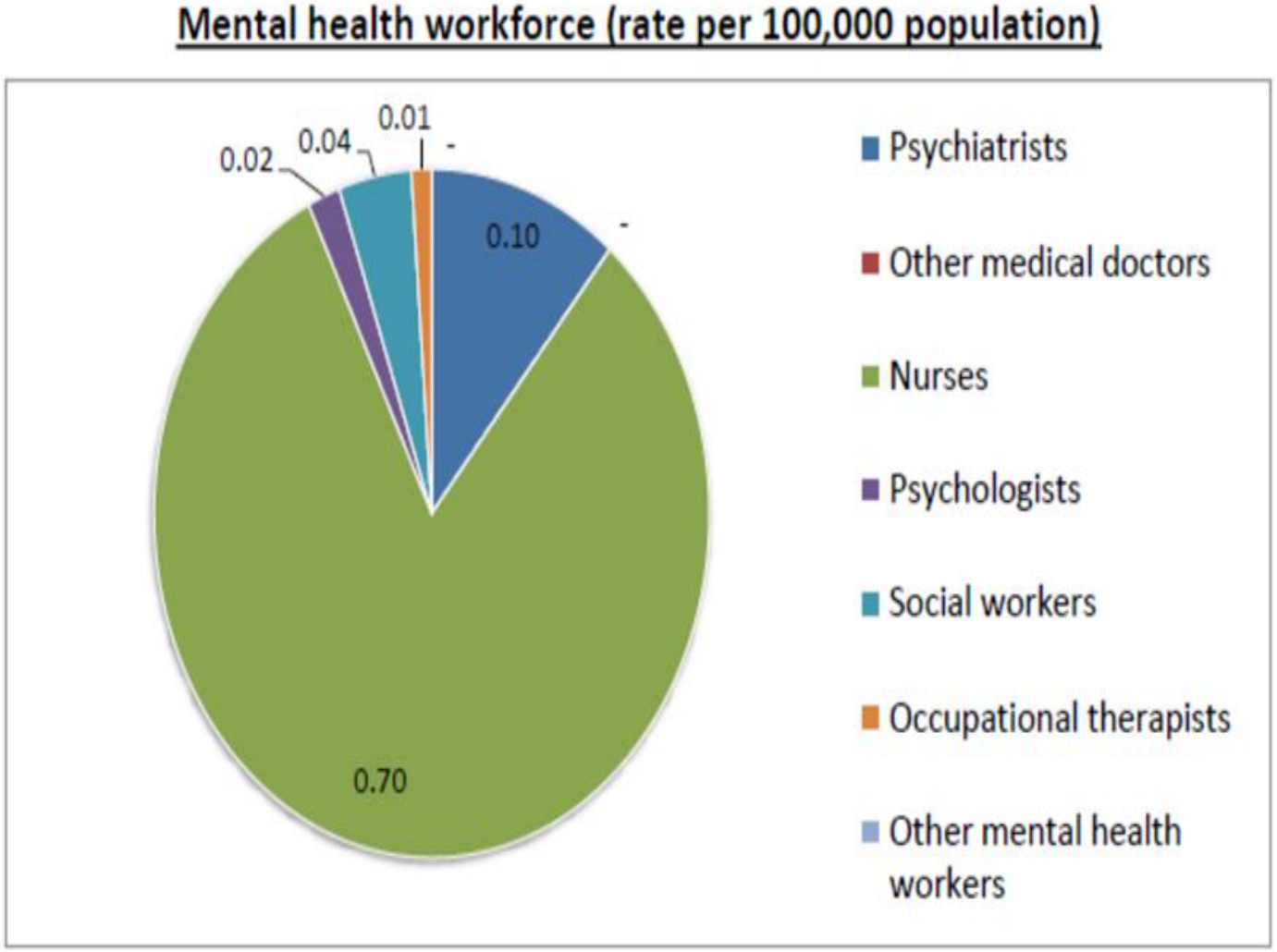
Results: *During the six-year period (November 2011-October 2017), 2194 cases (average of 366 new cases yearly) were identified and treated by Trained Health Workers (THWs). About 90% of cases were Psychosis and Epilepsy. There was a steady attrition of THWs and at the end of the sixth year only 29% of the THWs remained within the programme. Treatment outcomes were fair as over 50% of patients had ≥ 3 follow-up visits, symptom remission of ≥ 30% and a subjective improvement in Global Ratings.*

Research Article

International Journal of Psychiatry

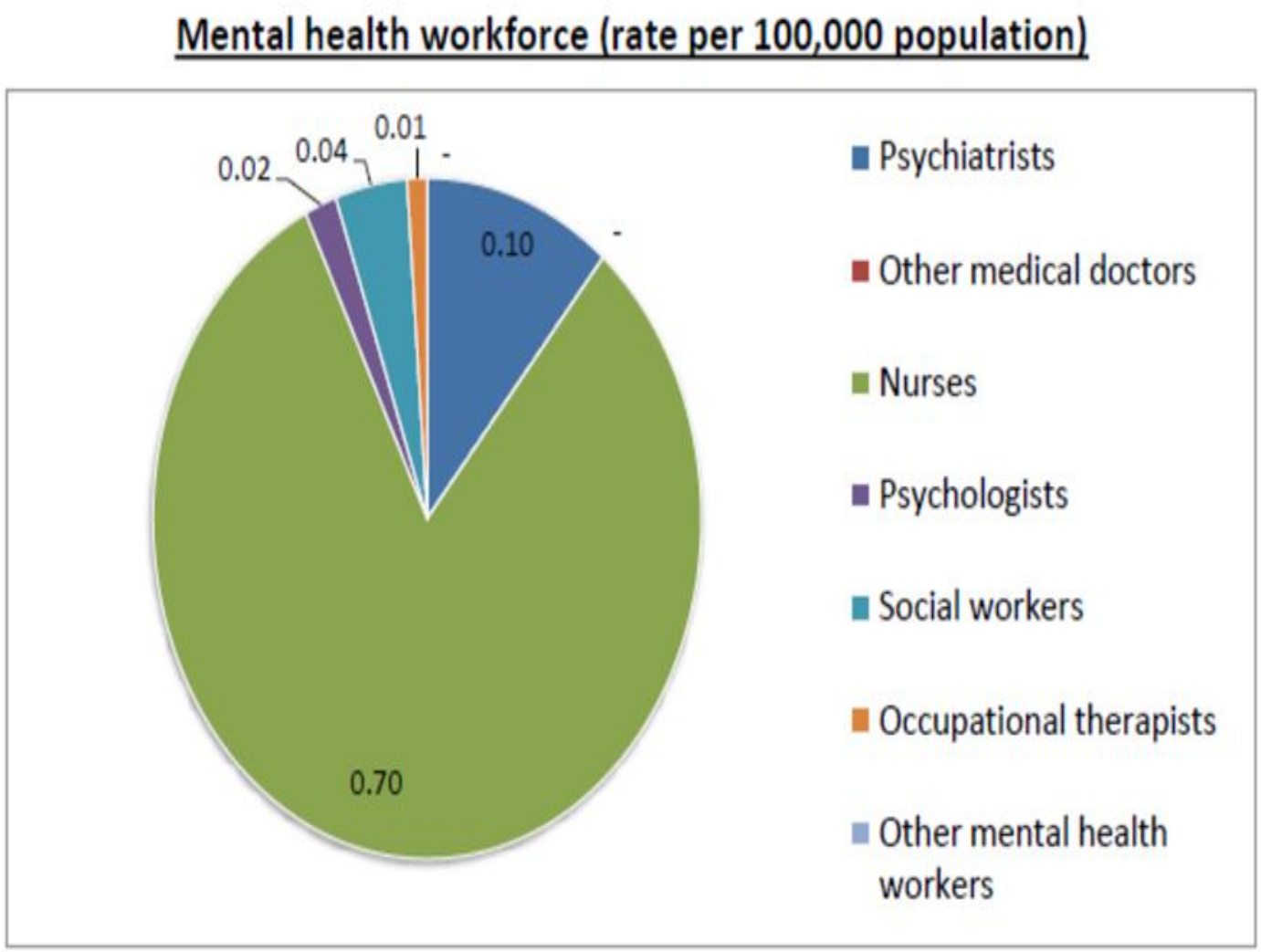
Integrating Mental Health into Primary Care Using a Population Based Approach: Six Years Outcome of Aro Primary Care Mental Health Programme for Ogun State, Nigeria

Adebowale Timothy[1], Onofa Lucky Umukoro[1], Ighoroje Maroh[1], Richard Gater[2], Ogunwale Adegboyega[1], Adesanya Daniel[3], Olaitan Funmi[1], Olopade Modupe[1], Ogunyomi Karmorudeen[1] and Anozie Smith[1]



- **Invest in training of specialised workforce**
  - Scale up training posts
- **Retain trained health workforce – avoid 'brain drain'**
  - Scale up service posts
  - Adequate remuneration
  - Ensure job security and prospects for progress on the job
- **Responsible task-shifting**
  - Reality of inadequate manpower
  - Adequate training of 'task-shiftees' – to ensure safety, clinical effectiveness, efficacy and sustainable service outcomes

"An investment in knowledge pays the best interest." Benjamin Franklin



- **Aim for Integrated and well-coordinated secondary level care of mental health problems**
  - Psychiatric units in General Hospitals
  - Strong consultation-liaison services supported by specialist hospitals

Three key areas for investment:

- Integration of mental health into primary care
- Task-shifting to non-specialists
- **Leveraging IT innovations in healthcare – how far do we go with social media apps?**

CURRENT OPINION

Innovative strategies for closing the mental health treatment gap globally

Tahilia J. Rebello[a], Andrea Marques[b], Oye Gureje[c], and Kathleen M. Pike[a]

Cost-effectiveness of an essential mental health intervention package in Nigeria

Oye Gureje[1], Dan Chisholm[2], Lola Kola[1], Victor Lasebikan[1], Shekhar Saxena[2]

[1]Department of Psychiatry, University College Hospital, PMB 5116, Ibadan, Nigeria
[2]Department of Mental Health and Substance Abuse, World Health Organization, Geneva, Switzerland

The study aimed to describe the cost-effectiveness of a selected list of interventions for common neuropsychiatric disorders in a developing country. Using depression, schizophrenia, epilepsy, and hazardous alcohol use, a sectoral approach to cost-effectiveness analysis developed by the World Health Organization was contextualized to Nigeria. The outcome variable was the disability adjusted life years (DALYs). We found that the most cost-effective intervention for schizophrenia is a community-based treatment with older antipsychotic drugs plus psychosocial support or case management. The most cost-effective interventions for depression, epilepsy, and alcohol use disorders are older antidepressants, with or without proactive case management in primary care, older anticonvulsants in primary care, and random breath testing for motor vehicle drivers, respectively. Combined into a package, these selected interventions produce one extra year of healthy life at a cost of less than US $320, which is the average per capita income in Nigeria.

Key words: Neuropsychiatric disorders, cost-effectiveness, interventions, Nigeria

(World Psychiatry 2007;6:42-48)

****Focused investment in Cost-effective mental health treatment strategies**

Broader macro-systemic issues relevant to investment in mental health

- Clearer policy direction e.g. clear National Suicide Prevention Strategy will provide the basis for funding suicide prevention
- Political will on the part of government to give effect to existing legislation supportive of mental healthcare
- The need to pass a new mental health law which will further guarantee dedicated funding for mental health care – see *National Mental Health Bill, 2019*

Broader macro-systemic issues relevant to investment in mental health 2

- Indirect investments in mental health
  - Intersectoral collaboration and funding for systems that aid in mental health promotion
    - Antenatal/perinatal services
    - Maternal/child health and nutrition
    - General health services
    - Education – including school-based health systems
    - Housing
    - Poverty reduction
    - In short, the SDG framework provides an understanding for the interdependent microsystems that impact mental health

Conclusion

- There is no health without mental health.
- Current provisions for mental health are inadequate in many countries of the world including Nigeria.
- There is need to scale up investments in integration of mental health into primary care, adequate integration of mental health into secondary care, relevant/appropriate task-shifting strategies where necessary, continuous leveraging of innovations in IT for improving access to care, clear focus on cost-effective treatment approaches and critical attention to macro-systemic factors that impact on mental health investments.
- The time to act in Nigeria is now!

“There is a tide in the affairs of men which taken at the flood, leads on to fortune; Omitted, all the voyage of their life is bound in shallows and in miseries. On such a full sea are we now afloat, And we must take the current when it serves or lose our ventures”

- Shakespeare in *Julius Caesar*

Thank you!