

Draft Terms of Reference

IMPROVING MENTAL HEALTH SERVICES IN LOW INCOME COUNTRIES

Research Programme Consortia

Background

1. Mental health problems cause immense human suffering, social exclusion, disability and poor quality of life. Globally, by 2030, the burden of disease from mental health problems is expected to rise from the 4th to the 2nd leading cause of disease burden as measured by Disability Adjusted Life Years.¹ There is a growing understanding of the importance of positive mental health and its influence, not only on poverty and social exclusion but also on the onset of and recovery from physical disorders and hence on the achievement of the Millennium Development Goals. Yet, the vast majority of people suffering from mental disorders in the developing world receive no treatment or care. The call for action on treatment and prevention of mental disorders² needs to be matched by a call to integrate mental health into primary care and wider public health and education action. Yet the evidence for practice and policy in low income countries is still very poor, particularly for areas affected by conflict, where the need is greatest.
2. Most people with mental disorders will need to be seen and treated in primary care and other routine health care settings. However, the primary health care level is often relatively weak and has limited resources, often exacerbated by HIV/AIDS and/or conflict. There is a lack of health workers and few opportunities for continuing professional development and a lack of support and supervision from the district level. People with mental disorders face many barriers to accessing mental health services, including lack of transport, limited availability/access to medicines, social stigma, negative cultural beliefs and taboos about mental illness. The informal sector (particularly traditional healers) may also either delay or facilitate access to services. The various roles played by negative cultural beliefs and the influence of the informal sector needs to be better understood. Health sector reform strategies rarely include integration of mental health concerns, despite the known linkages between mental and physical disorders. In many countries, along with a shortage of trained personnel, there is very poor access to a sustained supply of psychotropic medicines, which could substantially reduce the disease burden from mental illness if effectively used.

¹ Mathers and Loncar (2006) Projections of global mortality and burden of disease from 2002 to 2030. PLoS Medicine. Volume 6, Issue 11.

² Lancet Global Mental Health Group. Scale up services for mental disorders: a call for action. Lancet 2007; published online Sept 4. DOI:10.1016/S0140-6736(07)61242-2.

Objective

3. The **goal** of the RPC will be to produce high quality evidence that improves the health of the poorest in developing countries. The **purpose** of the RPC will be to provide evidence on how to strengthen and integrate mental health services, to identify and treat mental health disorders, and how to get mental health better reflected into annual operational health plans at the district and national levels.

Recipient

4. Outputs of the programme are designed to be made available to the global development community. The research outputs will be global public goods, to be used to shape international policy. Specific users of the information generated are likely to include: developing country governments; international development ministries in OECD countries; international organisations, such as the WHO, World Bank and civil society groups concerned with health and health service delivery issues.

Scope

5. The detailed design for the research will be done by the consortia as they develop their proposals and will form the scope of work. Indicative research areas are listed below although the actual areas covered within the RPC will be for consortia to propose through the bidding process

Method

6. The RPC will create robust **new knowledge**, and will be expected to play an important role in **synthesising existing knowledge**. The RPC will also focus on ensuring the **uptake of relevant research findings**. For example, innovative partnerships that support multi-media communication, to a wide range of targeted audiences, stakeholders and key policy fora, will be strongly welcomed.
7. The RPC will operate in ways that **strengthen the capacity of southern researchers** and institutions, to stimulate and give profile to southern-led research initiatives.
8. The RPC is expected to deliver the following **outputs**:
 - Methodologically rigorous, peer reviewed evidence;
 - A steady flow of clear, operationally relevant and accessible messages for policy makers;
 - A range of multi-media outputs to engage a range of audiences in developing countries and internationally at various levels;
 - Stronger capacity for research in developing countries;
 - Stronger policy networks, which demonstrate clearer effective demand for evidence, and which regularly draw on the research teams' advice and guidance.

Programme Management

9. The programme will be managed in accordance with the “*Terms of Reference for Research Programme Consortia*” and the “*Monitoring and evaluation – a guide for DFID contracted research programmes*” <http://www.research4development.info/dfidguidancenotes.asp>. This includes information on relationships with DFID, programme staffing, communications, monitoring and evaluation and capacity building.
10. DFID welcomes applications from southern based institutions as lead organisations in RPCs. Successful organisations at the Expression of Interest stage are eligible for up to £10,000 support to bring partners together to discuss the proposal process and prepare the full bid documentation.

Reporting

11. Reporting requirements are covered in “*Research Programme Consortia Terms of Reference*” and “*Monitoring and evaluation – a guide for DFID contracted research programmes*” <http://www.research4development.info/dfidguidancenotes.asp>

Timeframe

12. The research programme will be for six years which will include an Inception Phase of up to 1 year.

DFID co-ordination

13. DFID Research is the sole funder of the project and the Research Director will be responsible for ensuring the programme is implemented to plan.

Indicative research areas

14. A recent review in *The Lancet* highlighted the paucity of evidence to help health systems scale up feasible and effective interventions for people with mental health disorders, across all routine care settings.³ Integrating mental health services more effectively into primary and other routine health care settings will help ensure that people are treated in a holistic manner, meeting the mental health needs of people with physical disorders, as well as the physical health needs of people with mental disorders. Yet the evidence for practice and policy in low income countries is very poor, particularly for areas affected by conflict, where the need is greatest. Evidence is particularly needed on how to strengthen and integrate mental health services, to identify and effectively treat mental health disorders, and get mental health better

³ Lancet Global Mental Health Group. Scaling up services for mental disorders: a call for action. *The Lancet*, Volume 370, Issue 9594, Pages 1241 – 1252.

reflected into annual health operational plans at the district and national levels.

15. Examples of questions under this theme might include, but are not limited to:
- Strengthening and integration of primary care services to identify and treat mental health disorders.
 - Research on health policies and systems to scale up effective strategies for detection and treatment of common mental disorders in primary care and other routine health-care settings
 - Examining the human resource needs to integrate mental health services into primary care and how best to develop and sustain these services, including the need for support and supervision of front-line staff.
 - Importance of linkages between chronic diseases and mental health and ways of ensuring that a limited range of essential mental health drugs is included in approved drug lists for the primary level.
 - Importance of linkages between mental health and economic, educational and social capability.
 - Examining the gendered dimensions of mental health diagnosis, treatment, care and support. How can services be better designed to take account of this?
 - Assessing the functioning of referral services from primary level and whether patients from various backgrounds are able to gain access to more specialised services.
 - How to deliver services to young people and other hard to reach groups.
 - Training, support and supervision needed to enable existing maternal and child health workers to recognise and provide basic treatment for common maternal, child and adolescent mental disorders
 - Research on health policies and systems to integrate the management of mental disorders in children and adolescents with existing management programmes for physical diseases.
 - Research on health policies and systems to identify barriers to access to care (such as stigma) and to increase access to care.
 - The organisational and institutional solutions to better integrate mental health into routine primary care. This might include ways of strengthening government policies and examine the impact of stigma and taboo related to mental illness.
 - Reviewing the effectiveness of community based interventions to understand and tackle belief systems around the origins of illness which may be a barrier to care.
 - Quantifying the impact of missed diagnosis of mental health disorders and cross linkages with maternal health, child mortality, gender and violence.
 - Effectiveness of partnerships with the non state sector and voluntary organisations in delivering mental health services.

- Assessing the role of the informal private sector (particularly traditional healers) as both a barrier and potential referral point to mental health services and assessing the evidence base for their effective engagement by providers
- Are there regional approaches that would be helpful in developing health services? Does the prevalence of key disorders vary widely by regions and, if so, what are the implications for designing services?