

## Information systems for global mental health

In a *Lancet Psychiatry* Comment,<sup>1</sup> FundaMental SDG steering group members Oye Gureje and Graham Thornicroft<sup>1</sup> called for mental health to be integrated into the post-2015 sustainable development goals (SDGs). Should this call be successful, mental health targets and indicators could be adopted to monitor progress worldwide. Yet in many low-income and middle-income countries, routine mental health information is unavailable or too rudimentary to effectively monitor essential indicators such as service coverage.<sup>2</sup> Rather than suggest that the limited availability of data precludes the adoption of mental health indicators, we consider the FundaMental SDG campaign an important rallying cry to address this information gap.

The 2013–20 Mental Health Action Plan set a target for 80% of countries to routinely collect and report on a core set of mental health indicators within their national information systems by 2020.<sup>2</sup> However, the plan is non-binding, and individual member states will not be held accountable. Current events provide an opportunity to advocate the inclusion of mental health not just in the SDGs, but also in national health agendas and information systems worldwide in order to track progress.

This advocacy must be answered with action, even though the challenges surrounding implementation of mental health information systems in low-income and middle-income countries are significant, often highly context-specific and extend far beyond the adoption of indicators.<sup>3</sup> We note three broad challenges that must be taken into account, based on our recent experiences developing a state-level mental health information system in Nigeria.<sup>4,5</sup>

The first challenge is decentralisation. Decentralisation of mental health services is a fundamental strategy to scale up coverage worldwide, usually through integration into primary care. To collect information on decentralised services, mental health information systems must extend from tertiary and secondary care, into primary care and community-based facilities, and ideally to the services of mental health workers operating outside of facilities. While most countries in the world already collect some routine data on service use and diagnosis in hospitals and outpatient facilities,

very few record data from community and primary care facilities.<sup>6</sup>

In Nigeria, the decentralisation of health information systems has been described as a problem of conflicting institutional logics.<sup>7</sup> Data must be aggregated centrally to provide meaningful information about the nation's progress toward international targets using standardised indicators, methods, and procedures. Yet the health system is not managed by the central government alone. Primary care facilities are operated by local governments in highly variable contexts, with distinct information needs, priorities, and resource constraints. Information systems must be flexible enough to generate meaningful data at every level of the health system.

The second challenge is the integration of parallel information systems. Service delivery in low-income and middle-income countries is a patchwork of public, private, and public–private operations. Monitoring these services means satisfying the idiosyncratic data needs of influential donors and delivery partners. Building an evidence base to encourage further investment requires additional data for evaluation and research. Parallel systems proliferate, placing increasing demands on already overstretched services. Meanwhile, national health information systems often fail to record data generated by private services, as is generally the case in Nigeria.<sup>8</sup>

This brings us to the third challenge: inadequate resources. For a mental health information system to be made viable, basic human, financial, and material resources must be available. Where we work in Nigeria, many primary care clinics operate without reliable access to even basic consumables, such as file folders and staplers, as well as secure storage cabinets for patient files or computers for data entry. Pay cuts are frequent, and health-worker salaries may be withheld, sometimes for months. Workloads are high and services understaffed. Resource limitations such as these can easily derail mental health information system implementation.

Strong national and international leadership can provide the impetus to standardise indicators across countries, districts, and services, and ensure the uptake of an appropriate mental health information system. This is why incorporation of mental health into SDG indicators is so crucial. However, this leadership

should be coupled with bottom-up efforts to design systems that are feasible, acceptable, and sustainable, to implement at all levels of the health system and in the most challenging settings.

There might be limitations to what even the most conscientious design can achieve if essential resources are unavailable for implementation. As Gureje and Thornicroft note,<sup>1</sup> SDGs will guide the allocation of resources by governments and donors over the next 15 years. At the service level, SDG indicators will also shape day-to-day reporting and, by extension, delivery of quality mental health services, as “what gets measured gets done”. Further investment could help us reach global targets for mental health in low-income and middle-income countries and measure our progress along the way.

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## OCTET does not prove community treatment orders are ineffective



The OCTET randomised controlled trial (RCT)<sup>1</sup> of supervised community treatment orders (CTOs) for patients with psychosis found no difference in the primary outcome of readmission to hospital in those with CTOs compared with those receiving section 17 leave under the England and Wales Mental Health Act, which provides similar levels of compulsory supervision and treatment before final discharge from hospital. Despite the authors' conclusions that CTOs do not benefit patients, they have continued to be widely used.<sup>2</sup>

As a result of legal necessity, OCTET randomised two different types of compulsory treatment, with the expectation that those assigned to section 17 would very quickly be discharged to a voluntary status. However, in practice, patients were often subject to community compulsion and treatment for many weeks with a mean of 45 days (median 8 days). Evidence

shows that CTOs might be effective but only over durations longer than 6 months.<sup>3,4</sup> Since an average admission rate of once every 2 years occurred in OCTET recruits, patients might not normally be expected to be readmitted to hospital within the mean CTO duration time of 170 days (median 183 days). As a result, the question is raised as to whether enough time was available to enable any benefits to become apparent.

The length of time under compulsion might represent a normal outcome of CTOs, rather than a limitation of the trial itself.<sup>5</sup> However, since 2011, about 4000 new CTOs have been given per year in England and Wales,<sup>6</sup> in which the prevalence of CTOs has been roughly 5000,<sup>2</sup> showing an average duration of 14 months (ie, the point prevalence divided by annual incidence). These data suggest that the short duration of CTOs in OCTET might have been related to the mechanics of the trial,