**Mental Health Policy and Service Guidance Package**

# THE MENTAL HEALTH CONTEXT

*"Efforts to improve mental health must take into account recent developments in the understanding, treatment and care of people with mental disorders, current health reforms and government policies in other sectors."*

World Health Organization, 2003

Mental Health Policy and
Service Guidance Package

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*"Efforts to improve mental health must take into account recent developments in the understanding, treatment and care of people with mental disorders, current health reforms and government policies in other sectors."*

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# Preface

This module is part of the WHO Mental Health Policy and Service guidance package, which provides practical information to assist countries to improve the mental health of their populations.

## What is the purpose of the guidance package?

The purpose of the guidance package is to assist policy-makers and planners to:

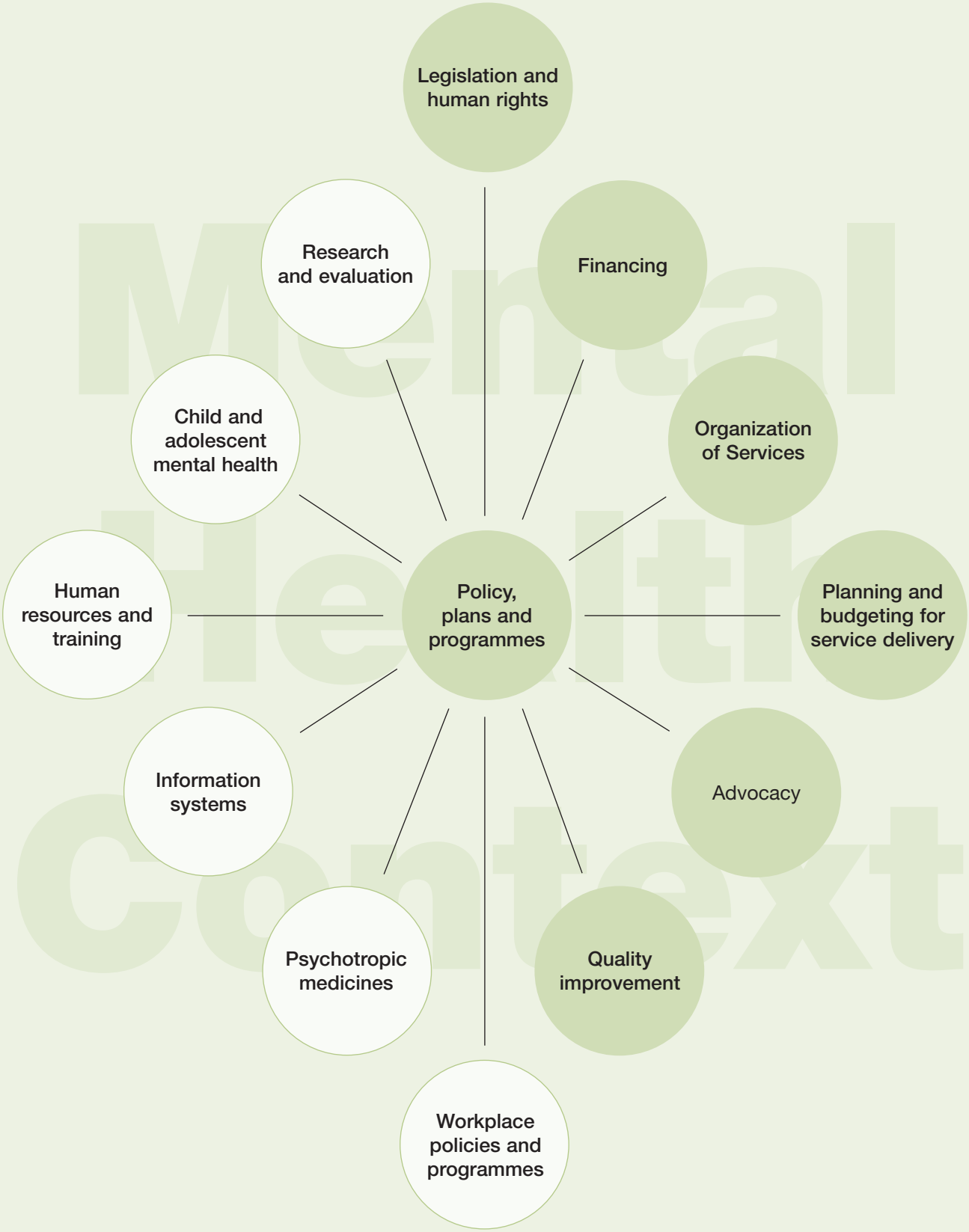
- develop policies and comprehensive strategies for improving the mental health of populations;
- use existing resources to achieve the greatest possible benefits;
- provide effective services to those in need;
- assist the reintegration of persons with mental disorders into all aspects of community life, thus improving their overall quality of life.

## What is in the package?

The package consists of a series of interrelated user-friendly modules that are designed to address the wide variety of needs and priorities in policy development and service planning. The topic of each module represents a core aspect of mental health. The starting point is the module entitled The Mental Health Context, which outlines the global context of mental health and summarizes the content of all the modules. This module should give readers an understanding of the global context of mental health, and should enable them to select specific modules that will be useful to them in their own situations. Mental Health Policy, Plans and Programmes is a central module, providing detailed information about the process of developing policy and implementing it through plans and programmes. Following a reading of this module, countries may wish to focus on specific aspects of mental health covered in other modules.

The guidance package includes the following modules:

> The Mental Health Context
> Mental Health Policy, Plans and Programmes
> Mental Health Financing
> Mental Health Legislation and Human Rights
> Advocacy for Mental Health
> Organization of Services for Mental Health
> Quality Improvement for Mental Health
> Planning and Budgeting to Deliver Services for Mental Health


Legislation and human rights
Financing
Organization of Services
Planning and budgeting for service delivery
Advocacy
Quality improvement
Workplace policies and programmes
Psychotropic medicines
Information systems
Human resources and training
Child and adolescent mental health
Research and evaluation
Policy, plans and programmes
still to be developed

The following modules are not yet available but will be included in the final guidance package:

- Improving Access and Use of Psychotropic Medicines
- Mental Health Information Systems
- Human Resources and Training for Mental Health
- Child and Adolescent Mental Health
- Research and Evaluation of Mental Health Policy and Services
- Workplace Mental Health Policies and Programmes

## Who is the guidance package for?

The modules will be of interest to:

- policy-makers and health planners;
- government departments at federal, state/regional and local levels;
- mental health professionals;
- groups representing people with mental disorders;
- representatives or associations of families and carers of people with mental disorders;
- advocacy organizations representing the interests of people with mental disorders and their relatives and families;
- nongovernmental organizations involved or interested in the provision of mental health services.

## How to use the modules

- They can be used **individually or as a package**. They are cross-referenced with each other for ease of use. Countries may wish to go through each of the modules systematically or may use a specific module when the emphasis is on a particular area of mental health. For example, countries wishing to address mental health legislation may find the module entitled Mental Health Legislation and Human Rights useful for this purpose.

- They can be used as a **training package** for mental health policy-makers, planners and others involved in organizing, delivering and funding mental health services. They can be used as educational materials in university or college courses. Professional organizations may choose to use the package as an aid to training for persons working in mental health.

- They can be used as a framework for **technical consultancy** by a wide range of international and national organizations that provide support to countries wishing to reform their mental health policy and/or services.

- They can be used as **advocacy tools** by consumer, family and advocacy organizations. The modules contain useful information for public education and for increasing awareness among politicians, opinion-makers, other health professionals and the general public about mental disorders and mental health services.

## Format of the modules

Each module clearly outlines its aims and the target audience for which it is intended. The modules are presented in a step-by-step format so as to assist countries in using and implementing the guidance provided. The guidance is not intended to be prescriptive or to be interpreted in a rigid way: countries are encouraged to adapt the material in accordance with their own needs and circumstances. Practical examples are given throughout.

There is extensive cross-referencing between the modules. Readers of one module may need to consult another (as indicated in the text) should they wish further guidance.

All the modules should be read in the light of WHO's policy of providing most mental health care through general health services and community settings. Mental health is necessarily an intersectoral issue involving the education, employment, housing, social services and criminal justice sectors. It is important to engage in serious consultation with consumer and family organizations in the development of policy and the delivery of services.

Dr Michelle Funk

Dr Benedetto Saraceno

# THE MENTAL HEALTH CONTEXT

## 1. Introduction

Mental disorders account for a significant burden of disease in all societies. Effective interventions are available but are not accessible to the majority of those who need them. These interventions can be made accessible through changes in policy and legislation, service development, adequate financing and the training of appropriate personnel.

With this message the *World health report 2001* makes a compelling case for addressing the mental health needs of populations. Through this document and the Mental Health Global Action Project, WHO is striving to shift mental health from the periphery of health policies and practice to a more prominent position in the field of global public health. Policy-makers and governments are becoming increasingly aware of the burden of mental disorders and the need for immediate action to address it.

The Mental Health Policy and Service Guidance Package has been developed by WHO as a component of the Mental Health Global Action Project in order to assist policy-makers and service planners in addressing mental health and to help Member States with the implementation of the policy recommendations in *The World Health Report 2001*. The present module is the first in the guidance package. It describes the context in which mental health is being addressed and the purpose and content of the package.

## 2. The burden of mental disorders

### 2.1 The global burden of mental disorders

Mental disorders account for nearly 12% of the global burden of disease. By 2020 they will account for nearly 15% of disability-adjusted life-years lost to illness. The burden of mental disorders is maximal in young adults, the most productive section of the population. Developing countries are likely to see a disproportionately large increase in the burden attributable to mental disorders in the coming decades. People with mental disorders face stigma and discrimination in all parts of the world.

### 2.2 Economic and social costs of mental disorders

The total economic costs of mental disorders are substantial. In the USA, the annual direct treatment costs were estimated to be US$ 148 billion, accounting for 2.5% of the gross national product. The indirect costs attributable to mental disorders outweigh the direct treatment costs by two to six times in developed market economies, and are likely to account for an even larger proportion of the total treatment costs in developing countries, where the direct treatment costs tend to be low. In most countries, families bear a significant proportion of these economic costs because of the absence of publicly funded comprehensive mental health service networks. Families also incur social costs, such as the emotional burden of looking after disabled family members, diminished quality of life for carers, social exclusion, stigmatization and loss of future opportunities for self-improvement.

### 2.3 Vulnerable groups

The burden of mental disorders does not uniformly affect all sections of society. Groups with adverse circumstances and the least resources face the highest burden of vulnerability to mental disorders.

### 2.4 Resources and funding for mental health

Mental health services are widely underfunded, especially in developing countries. Nearly 28% of countries do not have separate budgets for mental health. Of the countries that have such budgets, 37% spend less than 1% of their health budgets on mental health. Expenditure on mental health amounts to under 1% of the health budgets in 62% of developing countries and 16% of developed countries. Thus there is a significant discrepancy between the burden of mental disorders and the resources dedicated to mental health services.

## 3. Historical perspective

In order to gain an understanding of the origins of the current burden of mental disorders and of trends in care and treatment it is necessary to adopt an historical perspective. This helps to reveal the reasons for the failure of previous reform efforts and illustrates the wide variation in the way services have evolved in developed and developing countries.

In many societies, religious or spiritual explanations have dominated the way in which people with mental disorders have been treated for centuries. The early 17th century saw the rise of secular explanations of madness as a physical state. Increasing numbers of poor people with mental disorders were confined in public jails, workhouses, poorhouses, general hospitals and private asylums in Europe and what is now North America between 1600 and 1700.

The early medical explanations of madness did not encourage compassion or tolerance but implied that this impaired physical state was self-inflicted through an excess of passion and thus justified punishment. During the first part of the 18th century the dominant view of mentally disturbed people as incurable sub-humans justified the poor living conditions and use of physical restraints in places of confinement. The pressure for reform of these institutions coincided with the rise in humanitarian concerns during the 18th century, and many institutions introduced moral treatment programmes.

The success of moral treatment led to the building of many asylums in European countries and the USA. Since the 1950s, the discrediting of mental asylums on humanitarian grounds led to the growth of the community care movement and a process of reducing the number of chronic patients in state mental hospitals, downsizing and closing some hospitals, and developing alternatives in the form of community mental health services. This process is commonly known as deinstitutionalization.

Several countries around the world have witnessed a marked shift from hospital-based to community-based systems. Deinstitutionalization is not the mere administrative discharging of patients, however, but a complex process where dehospitalization should lead to the implementation of a network of alternatives outside psychiatric institutions. In many developed countries, unfortunately, deinstitutionalization was not accompanied by the development of appropriate community services.

In many developing countries, mental health services of the Western kind began with the state or colonial powers building mental hospitals in the late 19th or early 20th century. In general, mental hospital systems have been less comprehensive in their coverage of populations in developing countries than in developed countries. Some developing countries have been able to upgrade basic psychiatric hospital services and establish new psychiatric units in district general hospitals or to integrate basic mental health services with general health care by training primary care workers in

mental health. In most developing countries, however, psychiatric services are generally scarce, cover a small proportion of the population and face an acute shortage of trained human resources as well as appropriate institutional facilities.

There are grounds for optimism that the 21st century will bring a significant improvement in the care of persons with mental disorders. Advances in the social sciences have given new insights into the social origins of mental disorders such as depression and anxiety. Developmental research is shedding light on the difficulties that arise from early childhood adversity and adult mental disorder. Clinicians have access to more effective psychotropic medication for a range of mental disorders. Research has demonstrated the effectiveness of psychological and psychosocial interventions in hastening and sustaining recovery from common mental disorders such as depression and anxiety, as well as chronic conditions such as schizophrenia.

## 4. Recent developments in the understanding, treatment and care of people with mental disorders

During the last five decades there have been significant changes in our understanding of mental disorders. This is attributable to a combination of scientific advances in treatment and an increasing awareness of the need to protect the human rights of people with mental disorders in institutional care settings and in the community.

### 4.1 The interface between physical and mental disorders

Perceptions of the relationship between physical and mental disorders have changed. This has been a key development. It is now widely acknowledged that this relationship is complex, reciprocal and acts through multiple pathways. Untreated mental disorders result in poor outcomes for co-morbid physical illnesses. Individuals with mental disorders have an increased risk of suffering from physical illness because of diminished immune function, poor health behaviour, non-compliance with prescribed medical regimens and barriers to obtaining treatment for physical disorders. Moreover, individuals with chronic physical illness are significantly more likely than other people to suffer from mental disorders.

### 4.2 Effective treatments for mental disorders

Effective treatments exist for many mental disorders, including depression, schizophrenia, and alcohol-related and drug-related disorders. The *World health report 2001* presents evidence of the effectiveness of various treatments for mental disorders.

## 5. Trends in global health reform and implications for mental health

The last 30 years have seen major reforms in the general health and mental health sectors. Decentralization and health financing reforms are the two key changes that have affected general health systems. These issues are important for mental health because there is an increasing awareness of the need for adequate funding of mental health services and an emphasis on integrating mental health services into general health care systems.

### 5.1 Decentralization

The process of decentralization began in the industrialized countries and has proceeded to influence the shape of systems in developing countries. The decentralization of public health services to the local government level has been rapidly adopted by developing countries for a number of reasons, including changes in internal economic and political

systems in response to economic globalization pressures, the perception that services planned according to local needs can more appropriately address those needs, and, in some instances, system disruptions caused by civil disturbances and the displacement of populations.

### 5.2 Health finance reforms

Health finance reforms have largely been driven by a desire to improve access to health care, advance equity in health service provision and promote the use of cost-effective technologies so as to obtain the best possible health outcomes for populations. However, financing reforms have also been seen by governments as a method of controlling the cost of providing health care and spreading the cost to other players, especially the users of services. Health financing reforms include changes in revenue collection based on the concept of pooling and reforms in the purchasing of health services.

The **opportunities** for mental health in health sector reform include:

- the integration of mental health services into general health services;
- increasing the share of health resources for mental health in line with the burden imposed by mental disorders.

The **risks** for mental health in health sector reform include:

- the marginalization of mental health services;
- the fragmentation and exclusion of services for people with mental disorders through decentralization;
- increased out-of-pocket payments that would harm the interests of people with mental disorders, as they are unlikely to have the resources to pay for services;
- pooling systems such as public and private insurance schemes, which may exclude treatment for mental disorders and thus disadvantage people with such disorders.

## 6. Government policies outside the health sector which influence mental health

The mental health of populations and societies is influenced by many macrosocial and macroeconomic factors outside the traditional health sector. Governments can and do influence many of these factors at the policy level. The direction of government policies, actions and programmes can have both positive and negative effects on the mental health of populations. Governments, policy-makers and planners frequently ignore or are unaware of the mental health impact of changes in social and economic policies.

The needs of persons with mental disorders transcend traditional sectoral boundaries. Poverty is one of the strongest predictors of mental disorders. Both relative and absolute poverty negatively influence mental health. Many global trends, e.g. urbanization, have negative implications for the mental health of populations. Socioeconomic factors are interlinked and the cascading effects of policy changes in one sector on other sectors may influence mental health either positively or negatively. Governments should implement mechanisms for monitoring the effects on mental health of changes in economic and social polices.

## 7. Mental health policy and service guidance package: purpose and summary of the modules

The current global context of mental health is one of an increasing burden of mental disorders, inadequate resources and funding for mental health, and opportunities to remedy this situation through recent developments in the treatment of mental disorders. Trends such as health sector reform and macroeconomic and political changes have important implications for mental health.

In this situation, governments have a crucial role in ensuring the mental health of their populations. Recent advances in the knowledge and treatment of mental disorders mean that the goal of improving the mental health of populations is attainable if appropriate action is now taken.

The Mental Health Policy and Service Guidance Package should help countries to take action and address these mental health issues. The package provides practical information for assisting countries to develop policies, plan services, finance those services, improve the quality of existing services, facilitate advocacy for mental health and develop appropriate legislation.

The package has been developed by experts in the field of mental health policy and service development in consultation with a wide range of policy-makers and service planners. It has been reviewed by ministries of health and nongovernmental organizations representing national and international consumers, families and professionals.

It consists of a series of interrelated user-friendly modules designed to address the wide variety of needs and priorities in policy development and service planning. The topic of each module is a core aspect of mental health.

The following sections provide outlines of the modules.

### 7.1 Mental Health Policy, Plans and Programmes

An explicit mental health policy is an essential and powerful tool for a mental health section in a ministry of health. When properly formulated and implemented through plans and programmes, policy can have a significant impact on the mental health of populations. This module sets out practical steps that cover the following areas:

- Developing a policy
- Developing a mental health plan
- Developing a mental health programme
- Implementation issues for policy, plans and programmes

Specific examples from countries are used to illustrate the process of developing policy, plans and programmes throughout the module.

### 7.2 Mental Health Financing

Financing is a critical factor in the realization of a viable mental health system. It is the mechanism whereby plans and policies are translated into action through the allocation of resources. The steps in mental health financing are set out in this module as follows.

- Step 1: Understand the broad context of health care financing.
- Step 2: Map the mental health system in order to understand the level of current resources and how they are used.

- Step 3: Develop the resource base for mental health services.
- Step 4: Allocate funds to address planning priorities.
- Step 5: Build budgets for management and accountability.
- Step 6: Purchase mental health services so as to optimize effectiveness and efficiency.
- Step 7: Develop the infrastructure for mental health financing.
- Step 8: Use financing as a tool for changing the delivery of mental health services.

Specific examples from countries are used to illustrate the process of developing policy, plans and programmes throughout the module.

### 7.3 Mental Health Legislation and Human Rights

Mental health legislation is essential for protecting the rights of people with mental disorders, who comprise a vulnerable section of society. This module provides detailed guidelines for the development of mental health legislation.

The module begins by setting out the activities that are required before legislation is formulated. The content of legislation is then described, including substantive provisions for specific mental health legislation and substantive provisions for other legislation impacting on mental health. Process issues in mental health legislation are then outlined, including drafting procedures, consultation and the implementation of legislation.

### 7.4 Advocacy for Mental Health

Mental health advocacy is a relatively new concept, developed with a view to reducing stigma and discrimination and promoting the human rights of people with mental disorders. It consists of various actions aimed at changing the major structural and attitudinal barriers to achieving positive mental health outcomes in populations.

This module describes the important of advocacy in mental health policy and service development. The roles of various mental health groups in advocacy are outlined. Practical steps are then recommended, indicating how ministries of health can support advocacy.

### 7.5 Quality Improvement for Mental Health

Quality determines whether services increase the likelihood of achieving desired mental health outcomes and whether they meet the current requirements of evidence-based practice. Quality is important in all mental health systems because good quality ensures that people with mental disorders receive the care they require and that their symptoms and quality of life improve. This module sets out practical steps for the improvement of the quality of mental health care.

- Step 1: Align policy for quality improvement.
- Step 2: Design a standards document, in consultation with all mental health stakeholders.
- Step 3: Establish accreditation procedures in accordance with the criteria of the standards document.
- Step 4: Monitor the mental health service by means of the standards document and accreditation procedures.
- Step 5: Integrate quality improvement into service management and service delivery.
- Step 6: Reform or improve services where appropriate.
- Step 7: Review quality mechanisms.

## 7.6 Organization of Services for Mental Health

Mental health services make it possible to deliver effective interventions. The way these services are organized has an important bearing on their effectiveness and the ultimate fulfilment of the aims and objectives of national mental health policies. This module begins with a description and analysis of the current forms of mental health service organisation found around the world. The current status of service organisation is reviewed and recommendations are made for organising mental health services, based on creating an optimal mix of a variety of services. The main recommendations are to:

- integrate mental health services into general health care systems;
- develop formal and informal community mental health services;
- promote and implement deinstitutionalization.

## 7.7 Planning and Budgeting to Deliver Services for Mental Health

The purpose of this module is to present a clear and rational planning model for assessing the needs of local populations for mental health care and planning services. The steps in planning and budgeting are set out in a cycle:

- Step A: Situation analysis.
- Step B: Needs assessment.
- Step C: Target-setting.
- Step D: Implementation.

Using practical examples throughout, the module aims to provide countries with a set of planning and budgeting tools to assist with the delivery of mental health services in local areas.

# Aims and target audience

This module is the first of a series making up the Mental Health Policy and Service Guidance Package, developed as part of WHO's Mental Health Policy Project. It describes the global context of mental health and the purpose of the guidance package. The modules of the guidance package are summarized to provide an overview of the material in each.

This module is intended for policy-makers, planners, service providers, mental health workers, people with mental disorders and their families, representative organizations and all other stakeholders in mental health. It should give readers an understanding of the global context of mental health and should enable them to select modules that will be useful to them in their particular situations.

# 1. Introduction

Mental disorders account for a significant burden of disease in all societies. Effective interventions are available but are not accessible to the majority of the people who need them. These interventions can be made accessible through changes in policy and legislation, service development, adequate financing and the training of appropriate personnel.

*The World health report 2001 makes a compelling case for addressing the mental health needs of populations around the world.*

It is with this message that the *World health report 2001* makes a compelling case for addressing the mental health needs of populations around the world (World Health Organization, 2001b). This report is aimed at increasing public and professional awareness of the burden of mental disorders and their costs in human, social and economic terms. It concludes with a set of 10 recommendations that can be adopted by every country in accordance with its needs and resources (Box 1).

Through the *World health report 2001* and other initiatives, WHO is striving to shift mental health from the periphery of health policies and practice to a more prominent position in the field of global public health. Policy-makers and governments are becoming increasingly aware of the burden of mental disorders and of the need for immediate action to address it.

*WHO is striving to shift mental health to a more prominent position in the field of global public health.*

**Box 1. Recommendations in *World health report 2001***

- Provide treatment in primary care
- Make psychotropic medicines available
- Give care in the community
- Educate the public
- Involve communities, families and consumers
- Establish national policies, programmes and legislation
- Develop human resources
- Link with other sectors
- Monitor community mental health
- Support more research

During the 54th World Health Assembly, health ministers participated in round table discussions on the challenges they faced in respect of the mental health needs of their populations. They acknowledged that their countries' mental health situations were substantially determined by the socioeconomic and political contexts. The ministers wished to consider mental health from the "broader perspective of promotion and prevention" as well as from the "more focused approach towards mental disorders". They also acknowledged the need to integrate mental health care into primary care, to reduce the marginalization of mental health in general health services and to reduce the stigmatization and exclusion of people with mental disorders.

In recognition of the above the 55th World Health Assembly called on Member States to:

- endorse resolution EB109.R8, committing countries to strengthening the mental health of their populations;
- increase investments in mental health both within countries and in bilateral and multilateral cooperation, as an integral component of the well-being of populations;
- endorse and support WHO's Mental Health Global Action Project.

WHO's Mental Health Global Action Project gives expression to *The World Health Report 2001* and the ministerial round tables by providing a clear and coherent strategy for closing the gap between what is urgently needed and what is currently available to reduce the burden of mental disorders. This five-year initiative focuses on forging strategic partnerships so as to enhance countries' capacities for comprehensively addressing the stigma and burden of mental disorders.

WHO has developed the Mental Health Policy and Service Guidance Package as a component of the Mental Health Global Action Project. The aims of the package are to assist policy-makers and service planners to address mental health and to help Member States to implement the policy recommendations in *The World Health Report 2001*.

The present module is the first in the series comprising the Mental Health Policy and Service Guidance Package. It describes the context in which mental health is being addressed and the purpose and contents of the package. The modules so far produced are listed in Box 2 and described in Section 6. Other modules under development are listed in Box 3.

**Box 2. Currently available modules in the Mental Health Policy and Service Guidance Package**

- Mental Health Policy, Plans and Programmes
- Mental Health Legislation and Human Rights
- Organization of Services for Mental Health
- Planning and Budgeting to Deliver Services for Mental Health
- Mental Health Financing
- Advocacy for Mental Health
- Quality Improvement for Mental Health

**Box 3. Modules being developed as part of the Mental Health Policy and Service Guidance Package**

- Improving Access and Use of Psychotropic Medicines
- Mental Health Information Systems and Monitoring
- Human Resources and Training for Mental Health
- Research and Evaluation of Mental Health Policy and Services
- Child and Adolescent Mental Health
- Mental Health Policy and Programmes for the Workplace

# 2. The burden of mental disorders

In order to gain an understanding of the context within which the guidance package is being developed it is important to be aware of the current global burden of mental disorders. This section reviews the available evidence on the burden of mental disorders, the economic and social costs and the resources available for mental health services.

## 2.1 The global burden of mental disorders

Numbers cannot do justice to the pain and suffering caused by mental disorders. Worldwide, 121 million people suffer with depression, 70 million with alcohol-related problems, 24 million with schizophrenia and 37 million with dementia. Until the last decade, however, other health priorities and a lack of sophisticated measures for estimating the burden of mental disorders resulted in the distress of millions of people, their families and carers all over the world going unnoticed.

Several developments have brought the substantial underestimation of the burden of mental disorders to greater public awareness. These include the publication of the World Development Report: investing in health (World Bank, 1993) and the development of the disability-adjusted life-year for estimating the global burden of disease, including years lost because of disability (Murray & Lopez, 1996, 2000). According to 2000 estimates, mental and neurological disorders accounted for 12.3% of disability-adjusted life-years, 31% of years lived with disability and 6 of the 20 leading causes of disability worldwide (World health report 2001).

*Mental and neurological disorders accounted for 12% of the disability-adjusted life-years lost because of illness or injury in 2000.*

It is estimated that the burden of mental disorders will grow in the coming decades. By 2020 mental disorders are likely to account for 15% of disability-adjusted life-years lost. Depression is expected to become the second most important cause of disability in the world (Murray & Lopez, 1996). Developing countries with poorly developed mental health care systems are likely to see the most substantial increases in the burden attributable to mental disorders. The impressive reductions in rates of infant mortality and infectious diseases, especially in developing countries, will result in greater numbers of people reaching the age of vulnerability to mental disorders. The life expectancies of people with mental disorders can be expected to increase, and gradual gains in life expectancy can be expected to result in increasing numbers of older people suffering from depression and dementia.

*It is estimated that the burden of mental disorders will rise to 15% of disability-adjusted life-years lost by 2020.*

Other possible reasons for the increase in the burden of mental disorders include rapid urbanization, conflicts, disasters and macroeconomic changes. Urbanization is accompanied by increased homelessness, poverty, overcrowding, higher levels of pollution, disruption in family structures and loss of social support, all of which are risk factors for mental disorders (Desjarlais et al., 1995). Rising numbers of people all over the world are exposed to armed conflicts, civil unrest and disasters, leading to displacement, homelessness and poverty. People exposed to violence are more likely than others to suffer from mental disorders such as post-traumatic stress disorder and depression, possibly leading to drug and alcohol abuse and increased rates of suicide (World health report, 2001).

*Some of the reasons for the increase in the burden of mental disorders include rapid urbanization, conflicts, disasters and macroeconomic changes.*

In many developing countries the rush for economic development has had multiple consequences. Economic restructuring has led to changes in employment policies and sudden and massive rises in unemployment, a significant risk factor for mental disorders such as depression and for suicide (Platt, 1984; Gunnell et al., 1999; Preti and Miotto, 1999; Kposowa, 2001). This highlights the way in which policy changes in one sector (economic policy) create unanticipated or unintended problems in another, i.e. the health sector. Some authors have presented a scenario of increasing mental ill-health that is associated with urbanization, particularly in developing countries (Harpham & Blue, 1995).

*There is a hidden burden of stigma and discrimination.*

In addition to the obvious suffering caused by mental disorders there is a hidden burden of stigma and discrimination. In both low-income and high-income countries the stigmatization of people with mental disorders has persisted throughout history. It is manifested as bias, stereotyping, fear, embarrassment, anger, rejection or avoidance. For people suffering from mental disorders there have been violations of basic human rights and freedoms, as well as denials of civil, political, economic and social rights, in both institutions and communities. Physical, sexual and psychological abuse are everyday experiences for many people with mental disorders. They face rejection, unfair denial of employment opportunities and discrimination in access to services, health insurance and housing. Much of this goes unreported and therefore the burden remains unquantified.

**Key points: Global burden of mental disorders**

- Mental disorders account for nearly 12% of the global burden of disease.

- By 2020, mental disorders will account for nearly 15% of disability-adjusted life-years lost to illness.

- The burden of mental disorders is maximal in young adults, who make up the most productive section of the population.

- Developing countries are likely to see a disproportionately large increase in the burden attributable to mental disorders in the coming decades.

- People with mental disorders face stigma and discrimination in all parts of the world.

## 2.2 Economic and social costs of mental disorders

*The economic and social costs of mental disorders fall on several parties.*

The economic and social costs of mental disorders fall on societies, governments, individual sufferers and their carers and families. The most obvious economic burden is that of direct treatment costs. Many mental disorders are chronic or relapsing in nature. This leads to prolonged or repeated episodes of care and treatment and imposes substantial ongoing economic costs.

*The most obvious economic burden is that of direct treatment costs.*

In developed countries the total economic costs of direct treatment for mental disorders have been well documented. In the USA, for example, annual direct treatment costs were estimated to be US$ 148 billion, accounting for 2.5% per cent of the gross national product (Rice et al., 1990). Also in the USA, direct treatment costs attributable to depression are around $12 billion (Greenberg et al., 1993). In the United Kingdom, direct treatment costs have been estimated at UK £417 (Kind and Sorensen, 1993). Comparative estimates of direct treatment costs from developing countries are not easily available but these costs are probably substantial. On the basis of data on local prevalence and treatment costs it has been estimated that the direct treatment cost of common mental disorders in Santiago, Chile (population 3.2 million) is nearly $74 million, amounting to half the mental health budget of the entire country (Araya et al., 2001).

Direct treatment costs associated with schizophrenia range from $16 billion in the USA (Rice & Miller 1996) to £1.4 billion in the United Kingdom (Knapp, 1997) and CAN$1.1 billion in Canada (Goeree et al., 1999).

*Indirect treatment costs are substantial and are higher than direct treatment costs.*

Indirect economic costs arise chiefly from lost employment and decreased productivity among people suffering from mental disorders and their carers and families. In contrast to the situation with other health conditions the indirect costs of mental disorders appear to be higher than the direct treatment costs. For example, in the USA the indirect costs of absenteeism and lost productivity attributable to depression were estimated at $31 billion, nearly three times the direct treatment costs (Greenberg et al., 1993). In the United Kingdom, indirect costs were estimated at £2.97 billion (Kind and Sorensen, 1993), nearly six times the direct treatment costs. With respect to schizophrenia in the USA, indirect treatment costs were estimated at $17.1 billion, slightly more than the direct treatment costs (Rice & Miller 1996); in the United Kingdom the corresponding figure was £1.2 billion (Knapp et al., 1997), which was similar to the direct treatment costs. In developing countries, where direct treatment costs tend to be lower than in developed countries, chiefly because of the lack of treatment, indirect treatment costs attributable to the increased duration of untreated illness and associated disability are likely to account for an even larger proportion of the total economic burden of mental disorders (Chisholm et al., 2000).

*The burden normally falls on families and carers.*

Families and carers usually have to bear most of these economic costs, except in a few well-established market economies with comprehensive, well-funded systems of public mental health care and social welfare. Where families bear the economic burden, however, governments and societies ultimately pay a price in terms of reduced national income and increased expenditure on social welfare programmes. As shown above, indirect costs, e.g. those associated with lost productivity, outweigh direct treatment costs. Thus the economic logic for societies and countries is stark and simple: treating mental disorders is expensive but leaving them untreated is more expensive and a luxury that most countries can ill afford.

*Treating mental disorders is expensive but leaving them untreated is more expensive and a luxury that most countries cannot afford.*

*The social costs of mental disorders are also substantial.*

The social costs include: a diminished quality of life for people with mental disorders and their families and carers; alienation and crime among young people whose childhood mental health problems are not sufficiently addressed; and poor cognitive development in children of parents with mental disorders.

**Key points: Economic and social burden of mental disorders**

- The total economic costs of mental disorders are substantial. In the USA, direct treatment costs were estimated to be US$ 148 billion, accounting for 2.5% of the gross national product (Rice et al., 1990).

- The indirect costs attributable to mental disorders outweigh the direct treatment costs by two to six times in developed market economies.

- The indirect costs are likely to account for an even larger proportion of total treatment costs in developing countries, where the direct treatment costs tend to be low.

- In most countries, families bear a significant proportion of the economic costs because of the absence of a publicly funded network of comprehensive mental health services.

- The costs of not treating mental disorders outweigh the costs of treating them.

- Families also incur social costs, such as the emotional burden of looking after disabled family members, a diminished quality of life for carers, social exclusion, stigmatization and a loss of future opportunities for self-improvement.

## 2.3 Vulnerable groups

The burden of mental disorders does not uniformly affect all sections of society. Groups with adverse circumstances and the least resources face the highest burden of vulnerability to such disorders. These groups include: women, especially abused women; people living in extreme poverty, e.g. slum dwellers; people traumatized by conflicts and wars; migrants, especially refugees and displaced persons; children and adolescents with disrupted nurturing; and indigenous populations in many parts of the world. Members of each of these groups face an increased risk for mental disorders. Moreover, it is not uncommon for many of the vulnerabilities to be present simultaneously in the same individuals.

*Vulnerable groups face a disproportionately high burden of mental*

Different vulnerable groups may be affected by the same problems. Members of these groups are more likely than other people to be unemployed, to face stigmatization and to suffer violations of their human rights. They also face significant access barriers, e.g. with regard to the availability and cost of treatment of satisfactory quality for their mental disorders. Negative stereotyping and bias among health providers further reduces the likelihood of receiving appropriate attention for their mental health needs (Cole et al., 1995; Shi, 1999).

## 2.4 Resources and funding for mental health

Mental health services are widely underfunded, especially in developing countries. Nearly 28% of countries do not have a separate budget for mental health. Of the countries with separate mental health budgets, 37% spend less than 1% of their total health budgets on mental health. Less than 1% of total health budgets is spent on mental health by 62% of developing countries and 16% of developed countries (World Health Organization, 2001a).

*Mental health services are underfunded in most countries.*

Thus there is a significant discrepancy between the burden of mental disorders and the resources devoted to mental health services. Effective interventions for many mental disorders are now available and the potential exists for successfully managing mental disorders (see below; the module entitled *Organization of Services for Mental Health*; and *World health report 2001*). Despite this evidence, only a small minority of the people in need receive care and treatment from mental health services.

*In spite of evidence of effective interventions for mental disorders the funding of mental health services is inadequate.*

It is therefore necessary for mental disorders to be taken into account in health policies and plans. In particular there should be parity with physical disorders when resources and funds are being allocated to mental health services, in keeping with the proportionate burden of mental disorders,.

*Mental disorders should have parity with physical disorders when resources and funds are being allocated.*

There is also a need for equity and fairness in the distribution of resources within the mental health sector. For example, 25% of countries do not have access to basic psychiatric medications at the primary care level and 37% do not have community-based mental health facilities (World Health Organization, 2001a). Even within countries there is an unequal distribution of facilities and professionals between rural and urban regions. (*See Organization of Services for Mental Health*.) For nearly 70% of the world's inhabitants there is access to under one psychiatrist per 100 000 population. In many countries the needs of vulnerable groups, e.g. women, indigenous ethnic minorities and victims of abuse and trauma, are neglected.

# 3. Historical perspective

In order to gain an understanding of the origins of the current burden of mental disorders and of the trends in care and treatment it is necessary to consider the history of the subject. This reveals both the reasons for the failure of previous reform efforts and the wide variation in the way services have evolved in developed and developing countries.

*For centuries, religious explanations were given for the behaviour and experiences of people with mental disorders.*

For centuries, religious or spiritual explanations have determined the way in which people with mental disorders have been treated in many societies. During the Middle Ages, people in European countries viewed mental problems as having supernatural causes associated with demonic or divine possession. The early 17th century saw the rise of secular explanations of madness as a physical state. Increasing numbers of poor people with mental disorders were confined in public jails, workhouses, poorhouses, general hospitals and private asylums across Europe and what is now North America between 1600 and 1700 (Busfield, 1996; Jones, 1996; Goodwin, 1997).

*In 17th century Europe, people with mental disorders were incarcerated.*

The early medical explanations of madness did not encourage compassion or tolerance but implied that this impaired physical state was self-inflicted through an excess of passion, so justifying punishment. During the first part of the 18th century the dominant view of mentally disturbed people as incurable subhumans was used to justify the poor living conditions and the use of physical restraints in places of confinement (Jones, 1996). The pressure for reform of these institutions coincided with the rise in humanitarian concerns in the 18th century, and many institutions introduced moral treatment programmes (Breakey, 1996a).

*Moral treatment programmes led to the rise of mental asylums.*

The success of moral treatment led to the building of many asylums in European countries and the USA. However, most of these large public institutions were unable to replicate the success of the dedicated pioneers of moral treatment. Financial constraints, large numbers of patients and the lack of cost-effective alternatives to moral therapy meant that these state mental hospitals quickly became custodial institutions.

*De-institutionalization followed the rise of the human rights movements.*

The 20th century saw a change in emphasis from custody and protection to the care and treatment of people with mental disorders and the development of a more humane approach. After the Second World War the human rights movement expanded and focused attention on gross violations of basic human rights, including violations against people with mental disorders. Research showed that mental asylums had little therapeutic impact and that they sometimes exacerbated mental disability. Internationally, there was an increased awareness of the poor living conditions and inadequate treatment and care available in many asylums and of the necessity for governments to protect the rights of people with mental disorders. The discrediting of mental asylums on humanitarian grounds led to a process of reducing the number of chronic patients in state mental hospitals, the downsizing and closing of some hospitals, and the development of community mental health services as alternatives, a process known as deinstitutionalization.

*There has been a marked shift from hospital-based to community-based systems in several countries.*

Several countries have witnessed a marked shift from hospital-based to community-based systems, leading to an important decrease in the numbers of mental hospital beds and, in some cases, to the complete closure of psychiatric hospitals. In Italy the 1978 Mental Health Reform provides an illustration of this trend. Thus in Trieste the psychiatric hospitals were closed and replaced by a wealth of community-based services providing medical care, psychosocial rehabilitation and treatment for acute episodes. Protected housing and employment schemes were introduced so that people with mental disorders had greater opportunities for integration into the community. Among other cities around the world which have developed comprehensive mental health services in

the community are Melbourne in Australia, Santos and Rio Grande do Sul in Brazil, Lille in France, Siauliai in Lithuania, Asturias and Madrid in Spain, and London and Birmingham in the United Kingdom.

However, deinstitutionalization is not merely the administrative discharge of patients. It is a complex process in which dehospitalization should lead to the implementation of a network of alternatives outside mental hospitals. In many developed countries, unfortunately, deinstitutionalization was not accompanied by the development of appropriate community services (Thornicroft & Tansella, 1999). It was often mistakenly believed that alternative forms of community treatment would be more cost-effective than the increasingly expensive custodial care of chronic inpatients, or that they would enable governments to spread the cost of treatment to other role players (Breakey, 1996b,c; Sharfstein, 1996; Goodwin, 1997).

*De-institutionalization has not been accompanied by adequate community provision in many developed countries.*

It has become increasingly clear that if adequate funding and human resources for the establishment of alternative community-based services do not accompany deinstitutionalization, people with mental disorders may have access to fewer mental health services and existing services may be stretched beyond capacity. Recent reports from the United Kingdom and the USA indicate that service provision is in a state of disorganization because of budgetary constraints and confusion among key role players as to who is responsible for the funding and provision of community mental health services (Sharfstein, 1996; Freeman, 1996; Redmond, 1998).

In many developing countries, mental health services of the Western kind began when the state or colonial powers built mental hospitals in the late 19th century or the early 20th century. In general, mental hospital systems have provided less comprehensive population coverage in developing countries than in developed countries. Some developing countries have been able to upgrade their basic psychiatric hospital services and establish new psychiatric units in district general hospitals (Kilonzo & Simmons, 1998; Alem et al., 1999; Somasundaram et al., 1999; Sidandi et al., 1999), or have integrated basic mental health services into general health care by training primary care workers in mental health (Kilonzo & Simmons, 1998; Somasundaram et al., 1999). In most developing countries, however, psychiatric services are scarce, they cover a small proportion of the population and they face acute shortages of trained personnel and appropriate institutional facilities.

*Although asylums were built in many developing countries during colonial times the coverage of populations has generally been less extensive than that in developed countries.*

There are grounds for believing that the 21st century will see a significant improvement in the care of persons with mental disorders. Advances in the social sciences have given new insights into the social origins of mental disorders such as depression and anxiety. Developmental research is shedding light on the difficulties that arise from early childhood adversity and adult mental disorders (Brown & Harris, 1993; Kessler et al., 1997; Maughan & McCarthy, 1997). Clinicians now have access to more effective psychotropic medications for a range of mental disorders. Research has demonstrated the effectiveness of psychological and psychosocial interventions in hastening and sustaining recovery from common mental disorders such as depression and anxiety, as well as from chronic conditions such as schizophrenia.

*Recent developments provide an opportunity to significantly improve the care of persons with mental disorders.*

**Key points: Historical perspective**

- Deinstitutionalization has not necessarily been followed by an adequate provision of alternative community-based resources in developed countries.

- As a rule in developing countries mental health services are scarce, they cover a small proportion of the population and they face acute shortages of financial and human resources.

- A key task for developing countries is to extend the coverage of mental health services so as to reach a substantial proportion of their populations by integrating such services with general primary and secondary care.

- Highly effective psychotropic medications and psychosocial interventions are now available for a range of mental disorders

- Research has demonstrated the effectiveness of psychological and psychosocial interventions in many mental disorders.

# **4.** Recent developments in the understanding, treatment and care of persons with mental disorders

During the last five decades there have been significant changes in our understanding of mental disorders. This is attributable to a combination of scientific advances in treatment and an increasing awareness of the need to protect the human rights of people with mental disorders in institutional care settings and in the community.

*During the last five decades there have been significant changes in our understanding of mental disorders.*

## **4.**1 **Interface between physical and mental disorders**

It is now widely acknowledged that the relationship between mental disorders and physical disorders is complex and reciprocal and that it acts through multiple pathways. This is a key development.

Mental disorders lead to poor physical outcomes, as illustrated by the significantly reduced life expectancies of persons with schizophrenia. Persons with mental disorders are less likely than other people to pay attention to symptoms of physical illness. Consequently, they delay seeking treatment for comorbid conditions such as diabetes and hypertension. They face significant barriers to receiving treatment for physical disorders because of stigma and discrimination. Mental disorders also increase the likelihood of non-adherence to treatment regimens for physical conditions, and this leads to poorer outcomes. Among people with mental disorders there is an increased biological vulnerability to suffering from physical disorders. Depression, for example, is associated with reduced levels of functioning of the immune system and consequently with an increased risk of other physical disorders (*World health report 2001*).

*Mental disorders are associated with poor physical outcomes.*

*Mental disorders have a negative effect on the outcome of comorbid physical conditions*

The reverse relationship also holds true: people suffering from chronic physical conditions have a heightened probability of developing mental disorders such as depression. Rates of suicide are higher among people with physical disorders than among other people; this is especially marked in elderly people. Increased vulnerability is frequently attributable to the social consequences of physical disability. Limitations imposed by physical illness lead to reduced employment opportunities and reductions in the quality and quantity of social networks and family life. The drugs that are used to treat many physical conditions have direct deleterious effects on psychological functioning and indirect effects on mental health through increased physical side-effects. The effects include depression, anxiety and other mental disorders in already vulnerable individuals.

*Physical disorders increase vulnerability to mental disorders.*

Mental disorders also impose a range of consequences on the course and outcome of comorbid chronic conditions, such as cancer (Spiegel et al., 1989), heart disease (Ziegelstein et al., 2000), diabetes (Ciechanowski et al., 2000) and HIV/AIDS (Reed et al., 1994). Numerous studies have demonstrated that patients with untreated mental disorders are at heightened risk for diminished immune functioning, poor health behaviour, non-compliance with prescribed medical regimens, and unfavourable disease outcomes. For example, it has been shown that depressed patients are three times more likely not to comply with medical regimens than non-depressed patients (DiMatteo et al., 2000), and that depression predicts the incidence of heart disease (Ferketich et al., 2000). (See *World health report 2001* for a more detailed discussion of this issue.)

**Key points: Relationship between physical and mental disorders**

- There is a complex two-way interplay between mental and physical disorders.

- Untreated mental disorders result in poor outcomes for comorbid physical illness.

- Persons with mental disorders have a heightened risk of suffering from physical illness because of diminished immune function, poor health behaviour, non-compliance with prescribed medical regimens and barriers to obtaining treatment for physical disorders.

- Persons with chronic physical illness are significantly more likely than other people to suffer from mental disorders.

## 4.2 Effective treatments for mental disorders

*There are effective treatments for many mental disorders, including depression, schizophrenia and alcohol- and drug-related problems.*

There are effective treatments for many mental disorders. The World health report 2001 presents the evidence for the effectiveness of various treatments for such disorders. Some of these treatments are summarized here.

Depression of varying severity can be effectively treated by antidepressant medications. Psychotherapy is as effective as antidepressants in mild to moderate depression. Depression can be effectively treated by primary care personnel using a combination of medications and psychotherapy or counselling (Sriram et al., 1990; Mynors-Wallis, 1996; Schulberg et al., 1996; Ward et al., 2000; Bower et al., 2000).

In the treatment of schizophrenia, antipsychotic medication can help to reduce symptoms and prevent relapse. Psychosocial rehabilitation and family therapy in combination with medication can reduce relapse rates from 50% to 10% (Leff & Gamble, 1995; Dixon et al., 2000).

In the case of alcohol-related problems, brief interventions directed at people who are hazardous drinkers have been shown to reduce alcohol consumption by 30% and to reduce heavy drinking over a period of 6 to 12 months or longer. It has been shown that these interventions are cost-effective (Gomel et al., 1995; Wutzke et al., 2001). For patients with more severe alcohol dependence, both outpatient and inpatient treatment options have proved effective, although outpatient treatment is substantially less costly. Several psychological treatments, including cognitive behavioural treatment, motivational interviewing and the “twelve steps” approaches associated with professional treatment, have proved equally effective (World health report 2001).

Treatment for drug dependence is cost-effective in reducing drug use by between 40% and 60% and in diminishing the associated health and social consequences, e.g. criminal activity and the risk of HIV infection (World health report 2001).

For a more detailed examination of the evidence for the effectiveness of various treatments against mental disorders, readers should see the World health report 2001.

**Key points: Effective treatments for mental disorders**

- There are effective treatments for many mental disorders.

- Depression can be successfully treated with antidepressant medication and psychological interventions.

- Psychosocial rehabilitation and family therapy in combination with medication can reduce the relapse rates for schizophrenia from 50% to 10%.

- Brief interventions directed at people who are hazardous drinkers have been shown to reduce alcohol consumption by 30%.

- Treatment for drug dependence is cost-effective in reducing drug use by 40-60%.

# **5.** Global health reform trends and implications for mental health

The last 30 years have seen major reforms in the general health sector and the mental health sector. Decentralization and health financing reforms are the two key changes that have affected general health care systems. These issues are important for mental health because there is an increasing awareness of the need for adequate funding of mental health services and an emphasis on integrating these services into general health care systems.

## **5.**1 **Decentralization**

Decentralization is the transfer of responsibility for health service provision from central to local government structures (Cassels, 1995). Before the implementation of this process, health systems were largely public structures administered directly by central government health departments. Central government was therefore responsible for the financing, policy implementation, regulation, and operation of services at the tertiary, secondary and primary levels of health systems.

*Decentralization in health service provision is part of a global trend of decentralization growing out of economic reforms.*

Decentralization began in the industrialized countries and has proceeded to influence the shape of systems in developing nations. The decentralization of public health services to the local government level has been rapidly adopted by developing countries for a number of reasons. These include: changes in internal economic and political systems in response to the pressures of economic globalization; the perception that services planned in accordance with local needs can more appropriately address them; disruptions of systems caused by civil disturbances and population displacements.

## **5.**2 **Health finance reforms**

*Health finance reforms have been driven by a desire to improve health outcomes and control the cost of health care.*

Health finance reforms have largely been driven by a desire to improve access to health care, advance equity in health service provision and promote the use of cost-effective technologies in order to obtain the best possible health outcomes for populations. However, such reforms have also been seen by governments as a means of controlling the costs of health care and of spreading them to other players, especially the users of services.

Health finance reforms include changes in revenue collection, involving the concept of pooling, and reforms in the purchasing of health services. (*See Mental Health Financing* and *Planning and Budgeting to Deliver Services for Mental Health*.)

### **5.**2.1 **Revenue collection**

*Prepayment systems are fairer than other forms of payment for health services.*

Health systems are financed from a variety of sources, including general taxation, compulsory or voluntary health insurance contributions, out-of-pocket payments, and donations. Most high-income countries rely on either general taxation or compulsory social health insurance contributions, whereas in low-income countries out-of-pocket financing is more common (*World health report 2000*). There is widespread agreement that prepayment systems of all kinds, including general taxation and compulsory or voluntary health insurance schemes, are fairer than out-of-pocket payment.

Health systems are therefore encouraged to adopt prepayment and to reduce the proportion of out-of-pocket payments. Some low-income countries or settings where prepayment capacities are inadequate could consider an element of direct contribution at the time of utilization in the form of copayment for specific interventions, so as to reduce demand. Copayment has the effect of rationing the use of specific interventions but does not necessarily reduce the demand for them.

### **5.**2.2 **Pooling**

Pooling is a way of spreading risks among the users of health systems. Prepayment systems of all kinds provide opportunities for pooling but the exact nature of pooling arrangements determine whether they increase access for those most in need of mental health services. Pooling is based on the principles that the healthy should subsidize the sick and that the rich should subsidize the poor. Pooling that is based purely on health risk can result in regressive subsidies from the low-risk poor to the high-risk rich, and for this reason most health systems combine risk and income cross-subsidization in order to redistribute risk and ensure equity (*World health report 2000*).

*Pooling is based on the principle of subsidy from the better-off financially or in health status to people who are worse off in these respects.*

### **5.**2.3 **Purchasing**

There is a worldwide trend towards separating the purchase and provision of health services. In the past these functions were integrated into a single organization with central control. Purchaser-provider splits have accompanied the decentralization process. Furthermore, there is a move from passive purchasing, i.e. following a predetermined budget or simply paying bills when they are presented, to active or strategic purchasing strategies. This is happening in many countries, among them Chile, Hungary, New Zealand, and the United Kingdom. The aim of strategic purchasing is to maximize the performance of health systems for individuals and populations by actively choosing to purchase specific effective interventions from the most cost-effective providers.

*There is a trend towards separating the purchase and provision of health services.*

## **5.**3 **Implications of reforms for mental health: opportunities and risks**

Health sector reforms provide a number of opportunities for mental health services but also carry significant risks. In a rational decision-making process the obvious burden of mental health and the availability of effective interventions should lead to an increased provision of financial and human resources for promotion, prevention, treatment and rehabilitation in the field of mental health. A reforming health system provides the opportunity to redirect available resources towards mental health even in circumstances where the total health resources are constant.

*Health sector reforms create both opportunities and risks for mental health services.*

Health sector reforms also provide an opportunity to integrate mental health services into general health care, especially at the primary care level. Integration with primary care increases the possibility of universal coverage (including mental health) without a substantial increase in financial and administrative inputs. Integrated care helps to reduce the stigma associated with seeking help from stand-alone mental health services.

*Health sector reforms provide an opportunity to integrate mental health services into general health care.*

In low-income countries with acute shortages of mental health professionals the delivery of mental health services through general health care is the most viable strategy for increasing access to mental health care in underserved populations. As noted above, mental disorders and physical health problems are very closely associated. People with common mental disorders such as depression and anxiety often present with somatic symptoms to general primary care services. An integrated service encourages the early identification and treatment of such disorders and thus reduces disability. Among other possible benefits are the provision of care in the community and opportunities for community involvement in care. (See Organization of Services for Mental Health.) It is a prerequisite for this strategy that general health staff acquire knowledge and skills in the field of mental health.

However, there are risks associated with health sector reform. Mental health services may become marginalized as reconfigured health systems move further away from the provision of such services.

*Health sector reforms also carry significant risks for mental health services.*

How does this happen? Mental health may fall off the agenda of local health planning because decentralization leads to the transfer of managerial and administrative responsibilities to the local level. In developing countries with an acute shortage of trained mental health professionals, local managers and administrators are unlikely to have an understanding of mental health in relation to local populations. In these circumstances, local decentralized services run the risk of ignoring or inadequately addressing mental health issues. Decentralization may therefore defeat the goal of integration of mental health services into general health services because mental health is not given the importance it deserves. A concerted effort is therefore required to include mental health on the agenda of health sector reform.

*Mental health can easily fall off the health planning agenda in decentralized health services.*

Decentralization also carries a risk of fragmentation and duplication of services, with the result that resources are used inefficiently because of a lack of economies of scale.

A further risk is that the transfer of responsibility (devolution) may lead to significant differences in the provision of mental health services between decentralized regions. Democratic societies tend to be majoritarian rather than egalitarian because of the nature of the political and decision-making processes. Decentralized regions take decision-making closer to the population and are consequently highly vulnerable to capture, i.e. the decision-making process can become driven by considerations other than those of health, responsiveness to beneficiaries and financial fairness (*World health report 2000*). Persons with mental disorders suffer multiple social disadvantages, including effective disenfranchisement in many societies. Devolution may therefore lead to the exclusion of people with mental disorders from the decision-making process and to the neglect of their needs for physical and mental health services.

Payment at the point of service delivery (out-of-pocket payment, copayment) leads to restricted access to services and is likely to exclude the poorest members of society, who, paradoxically, are the most likely to require mental health services (*World health report 2000*). Furthermore, people with mental disorders, especially people with chronic severe conditions such as schizophrenia, are unlikely to have the personal financial resources with which to pay for services. Such people depend on their carers and families to make the required payments. Difficult choices have to be made by families in developing countries with respect to the allocation of limited resources for the treatment of family members with severe mental disorders.

*Payment at the point of service delivery leads to restricted access to services and is likely to exclude the poorest members of society.*

Strategic purchasing also involves substantial risks for the provision of mental health services. The use of strategic purchasing requires information to be available on the effectiveness of alternative interventions for a particular health problem. In many countries, however, especially developing countries, such data are rarely available. Moreover, strategic purchasing requires that there is a possibility of choosing from various providers. This is unsustainable in developing countries where there is an *absolute* shortage of mental health professionals. Because of these problems the decision may be taken not to purchase *any* mental health services. For this reason, resources should be made available for collating information and conducting cost-effectiveness research on mental health interventions. Substantial investment is also necessary in order to increase the number of mental health professionals, especially in developing countries.

*Risks can can arise as a consequence of financing reforms.*

These risks should therefore be taken into account in connection with the process of decentralization. Countries should carefully consider whether it is feasible for them to implement a decentralization strategy in the presence of the risks. Physical and human resources for mental health should be available in the regions concerned if decentralization is to succeed.

One way of ensuring this at the national level is to specify both the minimum level of services for mental health to be provided by local decentralized regions and the proportion of the total health budget to be dedicated to mental health. Investment should also be made in the training of personnel in order to enable planning, management and budgeting for mental health services.

**Key points: Health sector reforms - opportunities for mental health**

- Integration of mental health services into general health services.

- Increasing the share of health resources for mental health in line with the burden imposed by mental disorders.

**Key points: Health sector reforms - risks for mental health**

- Marginalization of mental health services.

- Decentralization can lead to the fragmentation and exclusion of services for people with mental disorders.

- A move towards out-of-pocket payments harms the interests of people with mental disorders as they are unlikely to have the resources to pay for services.

- Pooling systems such as public and private insurance schemes may exclude treatment for mental disorders and thus disadvantage people with such disorders.

# 6. Government policies outside the health sector which influence mental health

The mental health of populations and societies is influenced by many macrosocial and macroeconomic factors that lie outside the traditional health sector. Governments can and do influence many of these factors at the policy level. The direction of government policies, actions and programmes can both positively and negatively affect the mental health of populations. Governments, policy-makers and planners often do not take into account or are unaware of the consequences for mental health of changes in social and economic policies.

*Government policies at the macro level can have both positive and negative effects on mental health.*

**Poverty** is one of the strongest factors affecting mental health. In both market economies and developing countries it is both a cause and effect of mental disorders. Poor people experience environmental and psychological adversity that increases their vulnerability to mental disorders (Patel, 2001). They also face significant barriers to mental health services in the forms of unaffordability, unavailability and low responsiveness of health services to their needs. People with mental disorders, especially chronic conditions, are at risk of homelessness, unemployment and social exclusion, all of which increase the risk of poverty. Government policies aimed at reducing absolute and relative levels of poverty are likely to have a significant positive impact on mental disorders.

*Poverty is a strong determinant of mental disorders.*

**Urbanization** is associated with an increase in mental disorders. Urbanization increases the risk of homelessness, poverty and exposure to environmental adversities such as pollution. It also disrupts established patterns of family life, leading to reduced social support (Desjarlais et al., 1995). In developing countries, urbanization has accompanied economic development, the emergence of formal market economies and rapid industrialization. Government policies do not necessarily promote urbanization but governments can intervene through legislation and policies to improve the housing environment and living conditions of urban populations.

*Urbanization, especially if unplanned, is associated with increased rates of mental disorders.*

**Homelessness** is a risk for and a result of mental disorders. People living in poor housing conditions are more likely to complain of psychological distress and have a higher prevalence of mental disorders than other people (Sullivan et al., 2000; Kamieniecki, 2001). Housing-related legislation and national housing policies which reduce homelessness and raise the quality and availability of housing stock in a country may have a positive effect on the prevalence of mental disorders.

*Homelessness is both a cause and an effect of mental disorders.*

National housing policies and legislation can also ensure that people with mental disorders are not discriminated against in the allocation of housing and that they have the same access to state-provided and/or subsidized housing as the rest of the population. Countries can also promote mental health by providing priority housing for persons with long-standing mental disorders, particularly housing geared towards their special needs, e.g. halfway homes, shared community homes and warden-assisted housing. This is often essential for deinstitutionalization and for long-term community-based care. However, such policies may be contentious if a large proportion of the population lacks housing.

**Unemployment** has a strong two-way association with mental disorders. The unemployed are at increased risk for depression and have increased rates of suicide and self-harming behaviour (Platt, 1984; Preti and Miotto, 1999; Gunnell et al., 1999; Kposowa, 2001). Unemployment can be especially catastrophic for the mental health of older adults who have little prospect of re-entering the job market. Many developing countries have undertaken economic reforms and restructuring in the last decade. These reforms usually

*Unemployment impacts negatively on mental health.*

include legislative changes that are designed to increase the flexibility of the labour market. While this may make economic sense at one level it increases the likelihood of sudden and unexpected rises in unemployment. Finding jobs for people has the potential to dramatically improve a country's mental health status.

**Good employment practices** are essential for promoting and maintaining the mental health of a country's workforce. Although employment can be said to have a protective influence in mental health, in itself it does not guarantee good mental health. Work-related conditions such as the nature of employment and the working environment are crucial factors. Labour laws can promote the development of safe working environments. Occupational and safety legislation should address issues of mental health and substance abuse.

Employment assistance programmes in various forms can provide affordable help to individuals while delivering a cost-effective method for improving the productivity of employees, including management. Depending on the circumstances in the country concerned, this could present excellent opportunities for public/private partnerships. While it might be possible to provide in-house interventions in some situations, in others employees would have to be referred out for assistance.

Many countries have constitutions, laws and codes prohibiting discrimination on the grounds of disability. Even so, people with disabilities, and particularly people with mental disorders, continue to find it difficult to gain access to employment. This is largely because of stigma but also because of the difficulties of employing people with mental disorders, such as the additional support they may need and the possibilities of acute breakdowns. In order to overcome such discrimination, some countries have set disability employment targets for employers, whereby workplaces with a certain number of employees are legally obliged to have a particular percentage of disabled employees. Early indications are that people with mental disorders have not benefited proportionately from such strategies.

Developing countries usually lack comprehensive **social security** systems that would mitigate some of the ill effects of economic restructuring. Mental disorders are associated with significant disability and this must be taken into account when disability benefits are being provided. The families and carers of people with mental disorders play an important role in enabling them to continue living in the community and reducing the care burden on health services. Thus there is a justification for providing social security benefits to families and carers of persons with chronic and severe mental disorders.

*Social security systems should provide adequate coverage for mental disorders attributable to associated disability.*

**Education** is an important determinant of future mental health. Schools provide an opportunity for the early detection of behavioural and emotional problems in children before the emergence of major mental disorders. Through schools it is also possible to conduct promotive and preventive activities in the field of mental health. A lack of secondary education is an important predictor of future mental health problems. Strategies for discouraging 'dropping out' of secondary school can play an important role in the prevention of mental disorders. Other preventive activities include training programmes that promote problem-solving abilities, coping skills, assertiveness and interpersonal skills, and programmes for preventing alcohol and drug abuse among adolescents (World Health Organization, 2001b).

*Education provides opportunities for the prevention of mental disorders.*

People with mental disorders are more likely than other people to come into contact with the **criminal justice system**, and people in prison are more likely to have mental disorders than members of the general population. Policies are needed to prevent the inappropriate imprisonment of people with mental disorders and to facilitate the transfer of such people to treatment facilities. The problem of children and youths in prisons should be tackled through legislation, diversion and rehabilitation programmes, and

*People with mental disorders often have significant interactions with the criminal justice system.*

programmes involving families. Treatment and care for mental disorders should be routinely available in prisons as set out in the Standard Minimum Rules for the Treatment of Prisoners (adopted by the First United Nations Congress on the Prevention of Crime and the Treatment of Prisoners in 1955, and approved by the Economic and Social Council in Resolutions 663C (XXIV) of 31 July 1957 and 2076 (LXII) of 13 May 1977).

Many of the above socioeconomic factors are inextricably interlinked. Thus there is a clear connection between poverty, urbanization and homelessness. Policy changes in one area invariably have a cascading effect on other areas, which in turn may impact on the original area. The net effect of this dynamic process on the outcomes for mental health may be either positive or negative. Governments should accept that key macrosocial and macroeconomic policy changes have impacts on the mental health of populations. Mechanisms should be introduced in order to prevent mental disorders and/or to monitor the mental health situation that arises in response to such changes.

**Key points: Government policies outside the health sector**

- Macrosocial and macroeconomic policies have substantial impacts on the mental health of populations through direct and indirect effects.

- The needs of persons with mental disorders transcend traditional sectoral boundaries.

- Poverty is one of the strongest predictors of mental disorders. Both relative poverty and absolute poverty have adverse effects on mental health.

- Many global trends, e.g. urbanization, have negative implications for the mental health of populations.

- Socioeconomic factors are interlinked and policy changes in one sector have cascading effects on other sectors which may influence mental health either positively or negatively.

- Governments should introduce mechanisms for monitoring the effects on mental health of changes in economic and social policies.

# 7. Mental Health Policy and Service Guidance Package: purpose and summary of the modules

This document has so far highlighted the current global burden of mental disorders, the inadequate resources and funding for mental health, and the opportunities for remedying this situation provided by recent developments in the treatment of mental disorders. Furthermore, the implications of recent health sector reforms and the effects of macroeconomic and political issues on mental health have been outlined.

*The current situation demands urgent action.*

Governments have a crucial role to play in ensuring the mental health of their populations. Recent advances in the knowledge and treatment of mental disorders mean that the goal of improving the mental health of populations is attainable. There is now a need for action.

*The guidance package provides practical information to assist countries in developing policy, planning for services, financing those services, improving the quality of existing services, facilitating advocacy for mental health and developing appropriate legislation.*

The Mental Health Policy and Service Guidance Package is intended to help countries to address these issues. The package provides practical information to assist countries in developing policy, planning for services, financing those services, improving the quality of existing services, facilitating advocacy for mental health and developing appropriate legislation.

The package has been developed by experts in the field of mental health policy and service development, in consultation with a wide range of policy-makers and service planners from around the world. The package has been reviewed by ministries of health, nongovernmental organizations, and organizations representing national and international consumers, families, professionals and governments.

The purpose, target group for the modules and their format and use have been described in the preamble to this module. The content of the modules in the Policy and Service Guidance Package is summarized below.

## 7.1 Mental Health Policy, Plans and Programmes

### Introduction

An explicit mental health policy is an essential and powerful tool for a mental health section in a ministry of health. When properly formulated and implemented through plans and programmes, such a policy can have a significant impact on the mental health of a population.

### Developing a policy

A mental health policy is an organized set of values, principles and objectives for improving the mental health and reducing the burden of mental disorders in a population. It defines a vision for the future and helps to establish a model of how action should be taken.

The essential steps for developing a policy include the following.

- Step 1: Assess the population's mental health needs.
- Step 2: Gather evidence for effective policy.
- Step 3: Consult and negotiate.
- Step 4: Exchange information with other countries.
- Step 5: Set out the vision, values, principles and objectives of the policy.
- Step 6: Determine areas for action.
- Step 7: Identify the major roles and responsibilities of the different sectors.
- Step 8: Conduct pilot projects.

### Developing a mental health plan

The strategies of a mental health plan should correspond with the areas for action defined by the policy. They involve activities that have to be carried out in order to ensure the implementation of these areas for action. The development of a mental health plan requires the following activities to be undertaken.

- Step 1: Set priorities for the major strategies.
- Step 2: Establish the time frame and resources.

### Developing a mental health programme

A programme defines the concrete mental health interventions that the population will receive. This means organizing a number of interrelated technical activities in effective schemes so as to address a mental health issue, using the best available evidence. The formulation of a programme should involve the following steps.

- Step 1: Identify the issue or problem to be addressed.
- Step 2: Set out the objectives of the programme.
- Step 3: Choose appropriate programme interventions.
- Step 4: Describe programme activities.
- Step 5: Identify responsible agents.
- Step 6: Set out a time frame.
- Step 7: Draw up a budget.
- Step 8: Evaluate the programme.

### Implementation issues for policy, plans and programmes

A mental health policy can be implemented through the priority strategies identified by the plan and the priority interventions identified by the programme. Several actions are necessary for the implementation of these strategies and interventions.

- Step 1: Disseminate the policy.
- Step 2: Generate political support and funding.
- Step 3: Develop supportive organization.
- Step 4: Set up a demonstration area.
- Step 5: Empower mental health providers.
- Step 6: Reinforce intersectoral coordination.
- Step 7: Promote interaction among stakeholders.

Specific examples from countries are used to illustrate the process of developing policy, plans and programmes throughout the module.

## 7.2 Mental Health Financing

Financing is a critical factor in the realization of a viable mental health system. It is the mechanism by which plans and policies are translated into action through the allocation of resources.

Policy-makers and mental health planners should address the following key questions.

- How can sufficient funds be mobilized to finance mental health services and the required infrastructure?
- How can those funds be allocated and how can the delivery of mental health care be organized so that defined needs and priorities are addressed?
- How can the cost of care be controlled?

It is important to note that the financing of mental health care is not an isolated activity but occurs in widely disparate political and economic contexts. In many countries it is subsumed under more general health financing and is often not distinct. It is often shaped, if not determined, by the objectives of such financing.

The steps in mental health financing are as follows.

- Step 1: Understand the broad health care financing context.
- Step 2: Map the mental health system in order to understand the level of current resources and how they are used.
- Step 3: Develop the resource base for mental health services.
- Step 4: Allocate funds to address planning priorities.
- Step 5: Build budgets for management and accountability.
- Step 6: Purchase mental health services so as to optimize effectiveness and efficiency.
- Step 7: Develop the infrastructure for the financing of mental health.
- Step 8: Use financing as a tool to change the delivery of mental health services.

## 7.3 Mental Health Legislation and Human Rights

### Context of mental health legislation

Mental health legislation is necessary for protecting the rights of persons with mental disorders, who comprise a vulnerable section of society. They face stigma, discrimination and marginalization in most societies. This implies a heightened probability of violation of their human rights. Legislation should strike a fine balance between the individual's rights to liberty and dignity on the one hand and society's need for protection on the other.

There is no national mental health legislation in 25% of the world's countries, accounting for nearly 31% of the global population, although countries with a federal system of governance may have state mental health laws. It should be noted that the existence of mental health legislation does not necessarily guarantee the protection of the human rights of persons with mental disorders. In some countries, indeed, mental health legislation contains provisions that lead to the violation of human rights.

### Activities preceding the formulation of legislation

A country that has decided to draft and enact new mental health legislation should conduct certain preliminary activities that can inform this process, among them the following.

- Identify the principal mental health problems and barriers to the implementation of mental health policies and plans.

- Critically review existing legislation in order to identify gaps and difficulties.
- Study international human rights conventions and standards.
- Critically review existing mental health legislation in other countries, especially ones with similar social and cultural backgrounds.
- Engage all stakeholders in consultation and negotiation about possible components of mental health legislation.

### Content of mental health legislation

Some of the more important issues to be addressed in legislation are indicated below.

*(I) Substantive provisions for mental health legislation*

These include:

- the principle of the least restrictive alternative;
- confidentiality;
- informed consent;
- voluntary and involuntary admission;
- voluntary and involuntary treatment;
- independent review body;
- competency and guardianship.

*(II) Substantive provisions for other legislation impacting on mental health*

These include legislative provisions for protecting the rights of persons with mental disorders in the following sectors:

- housing;
- employment;
- social security.

Legislation can also be used in order to promote mental health and prevent mental disorders. It should contain specific provisions for protecting the rights of vulnerable groups such as women, children, the elderly and indigenous ethnic populations. Other examples include measures to promote mother-and-child bonding through the provision of maternal leave, legislation for the early detection and prevention of child abuse, laws restricting access to alcohol and drugs, and legislative provisions for setting up school mental health programmes.

### Process issues in mental health legislation

The task of drafting legislation should be delegated to a specially constituted committee. A draft of proposed legislation should be presented for consultation to all the key stakeholders in the mental health field. Consultation plays a key part in identifying weaknesses in proposed legislation, potential conflicts with existing laws, vital issues inadvertently omitted from the draft legislation, and possible practical difficulties in implementation.

Difficulties in implementation can be anticipated as from the drafting stage and corrective measures can adopted. Such difficulties may arise because of a lack of finances, a shortage of human resources, a lack of awareness among professionals, carers, families and the general public about mental health legislation, a lack of coordinated action, and, occasionally, procedural problems.

Funding is required for the activities connected with the implementation of new mental health legislation. Adequate budgetary provision should be made for this purpose.

A coordinating agency can help with the time-bound implementation of various sections of mental health legislation. Implementation is also helped by wide dissemination of the provisions of new mental health legislation to mental health professionals and users, carers, families and advocacy organizations. A sustained programme of public education and of increasing public awareness can also play an important role in implementation.

## 7.4 Advocacy for Mental Health

### Concept of mental health advocacy

Mental health advocacy is a relatively new concept. It was developed with a view to reducing stigma and discrimination and promoting the human rights of people with mental disorders. It consists of a variety of actions aimed at changing the major structural and attitudinal barriers in the way of achieving positive mental health outcomes in populations.

### Importance of mental health advocacy

The emergence of mental health advocacy movements in several countries has helped to change the way in which people with mental disorders are perceived. Consumers have begun to articulate their own vision of the services they need and want, and are increasingly making informed decisions on treatment and other matters of their daily lives. In itself the participation of consumers and families in advocacy organizations may have several positive impacts.

### The roles of different groups in advocacy

*(I) Roles of consumers and families*

The roles of consumer groups in advocacy have ranged from influencing policies and legislation to providing concrete help for persons with mental disorders. These groups have helped to sensitize the general public to their cause and have helped to educate and support people with mental disorders. They have denounced some forms of treatments believed to be negative, poor service delivery, inaccessible care and involuntary treatment.

Families have a distinctive key role in caring for persons with mental disorders, particularly in developing countries. In many places they are the primary care providers and their organizations are fundamental as support networks. In addition to providing mutual support and services, many family groups have become advocates, educating the community, increasing support from policy-makers, denouncing stigma and discrimination, and fighting for improved services.

*(II) Roles of nongovernmental organizations*

These organizations may be professional, i.e. including only mental health professionals, or interdisciplinary, i.e. with members from diverse areas. Nongovernmental organizations may carry out many of the advocacy roles described for consumers and families. Their main contribution to the advocacy movement involves supporting and empowering people with mental disorders and their families.

*(III) Roles of general health workers and mental health workers*

Mental health workers can play an important part in protecting consumer rights and raising awareness of the need for better services. However, there may be conflicts of interest between health workers and consumers.

*(IV) Roles of policy-makers and planners*

Ministries of health, and specifically their mental health sections, can and should play an important part in advocacy. They may implement advocacy actions directly, in order to have an impact on the level of mental health in populations and on consumers' civil and health rights. Ministries of health may achieve similar or complementary impacts on populations indirectly by supporting advocacy organizations (consumers, families, non-governmental organizations, mental health workers). It is necessary for each ministry of health to convince other policy-makers, including the executive branch of government, the ministry of finance and other ministries, the judiciary, the legislature and political parties, to focus on and invest in mental health. Furthermore, ministries of health can develop many advocacy activities by working with the media.

There may be some contradictions in the advocacy activities of ministries of health. Some of the issues that can be advocated may also be responsibilities, at least partially, of health ministries. If ministries of health are service providers and also advocate for accessibility and for services of satisfactory quality, for example, they can become vulnerable to criticism from political oppositions.

### How ministries of health can support advocacy

Ministries of health can support advocacy activities with:

- consumer groups, family groups and nongovernmental organizations;
- general health workers and mental health workers;
- policy-makers and planners;
- the general population.

## 7.5 Quality Improvement for Mental Health

There should be access to basic mental health care for everyone who needs it. This means that mental health care should be affordable, equitable, geographically accessible, available on a voluntary basis and of adequate quality. In many countries, services for people with mental disorders remain minimal and do not measure up to these principles. In a context where resources are inadequate and mental health is emerging as a new priority, concern for quality may seem premature. Quality may seem more of an issue for well-established, well-resourced systems than for ones that are just becoming established.

### Why is quality important for mental health care?

Quality is important in all mental health systems for various reasons. From the perspective of persons with mental disorders, good quality means that they receive the care they require and that their symptoms and quality of life improve. From the perspective of family members it means that support is provided and that help is given for the preservation of family integrity. From the perspective of service providers or programme managers it means that effectiveness and efficiency are ensured. From the perspective of policy-makers it is the key to improving the mental health of populations and ensuring accountability and value for money.

## What is quality?

In mental health care, quality is a measure of whether services increase the likelihood of desired mental health outcomes and whether they are consistent with current evidence-based practice. For people with mental disorders, their families and populations as a whole, this definition emphasizes that services should produce positive outcomes. For practitioners, service planners and policy-makers, it emphasizes the best use of current knowledge and technology.

## Steps for quality improvement

The steps for improving quality are cyclical. Once policy, standards and accreditation procedures are established the continual improvement of the quality of care requires the ongoing monitoring of services, the integration of quality improvement strategies into management and the improvement of services.

### Step 1: Align policy for quality improvement.

Policy-makers have a key role in the quest for quality. They are in a position to establish the broad parameters of quality through consultation, partnerships, legislation, funding and planning.

**Consultation** is necessary with all mental health stakeholders, in both the development of policy and all subsequent steps of quality improvement. Active steps should be taken by policy-makers to develop **partnerships** with professional groups, academic institutions, advocacy groups and other health and social service sectors. Such partnerships form the backbone of the quality improvement process and make it possible to achieve long-term sustainability. They build consensus and consistency in messages related to the need for quality, and can also be a mobilizing force for obtaining the resources and other necessary supports. Policy-makers should promote **legislation** that reflects concern for and emphasizes quality. **Financial** systems for mental health care should be aligned so that they maximize quality and do not hinder quality improvement. Improved efficiency is an essential goal in relation to both quality improvement and cost containment.

### Step 2: Design a standards document in consultation with all mental health stakeholders.

An essential step towards improving the quality of mental health services involves developing a set of standards against which services can be measured. This requires planners and managers to establish a working group, consult with relevant stakeholders and draft a standards document covering all aspects of the mental health service identified as belonging in particular domains.

### Step 3: Establish accreditation procedures in accordance with the criteria of the standards document.

Accreditation provides the opportunity to assess the quality of care delivered by mental health services and to provide them with appropriate legal recognition. It is essential because it makes quality a cornerstone of the official licensing of mental health services or facilities.

### Step 4: Monitor the mental health service by means of the standards document and accreditation procedures.

It is necessary to monitor mental health services in order to assess the quality of care. This monitoring can take several forms: the use of standards for assessing services

annually; the use of accreditation procedures to assess and accredit new service developments and to review the functioning of services; routine information-gathering through existing information systems; and consultation with independent organizations of people with mental disorders, carers and advocacy groups.

### Step 5: Integrate quality improvement into service management and delivery.

Apart from the use of standards and accreditation procedures for the monitoring of services it is essential that services continue to improve the quality of care. Continuous quality improvement is a perpetual process of striving for optimal quality.

This can be achieved by:

- conducting annual reviews of service quality;
- including quality checks in service planning targets;
- building quality improvement into clinical practice through evidence-based practice, clinical practice guidelines, teamwork and continuing professional development;
- improving quality when services are commissioned;
- auditing.

### Step 6: Reform or improve services where appropriate.

Assessment of the quality of mental health services may highlight requirements for their systematic reform or improvement. This step may require concerted planning and coordination involving various sectors.

### Step 7: Review quality mechanisms.

Once quality mechanisms are in place they should be reviewed at the same time as reviews of service targets at the local level, i.e. approximately every 5 to 8 years. This is necessary so that the mechanisms can be updated on the basis of evidence relating to the most effective methods of quality improvement.

## 7.6 Organization of Services for Mental Health

Mental health services are the means by which interventions for mental health are delivered. The way in which these services are organized has an important bearing on their effectiveness and on whether the objectives of national mental health policies are ultimately met.

### Description and analysis of mental health services

Different components of mental health services can be identified. The following classification is not a recommendation as to how services should be organized but an attempt to broadly map the variety of services found across the world.

(I) Mental health services integrated into general health systems can be broadly grouped as being in primary care or in general hospitals.

(II) Community mental health services can be categorized as formal or informal.

(III) Mental hospital institutional services include specialist institutional mental health services and dedicated mental hospitals.

### Current status of service organization

From the standpoint of proportionality very few countries have an optimal mixture of services. In this connection two main conclusions can be drawn from experiences across the world. Firstly, mental health services pose a challenge for both developing and developed countries, although the nature of the challenges differs. Secondly, more expensive specialist services are not the answer to these problems. Even within the resource constraints of health services in nearly all countries, significant improvements in the delivery of mental health services can be achieved by redirecting resources towards services that are less expensive, have reasonably good outcomes and benefit larger proportions of populations.

### Recommendations for organizing services

A key issue for service planners is to determine the exact mixture of different types of mental health services and the levels of provision of particular service delivery channels. The absolute requirements for various services differ greatly between countries but the relative needs for different services is probably the same in all countries.

It is clear that the most numerous services should be informal community mental health services and mental health services provided by primary care staff, followed by psychiatric services based in general hospitals, formal community mental health services and, lastly, specialist mental health services.

The main recommendations are as follows,

(I) Integrate mental health services into the general health system.
(II) Develop formal and informal community mental health services.
(III) Promote and implement deinstitutionalization.

### Key issues in organizing mental health services

The above principles for organizing mental health services should take into account the evidence base for mental health interventions, the unique needs of persons with mental disorders, the ways in which communities and patients have access to services, and other important structural issues, e.g. the need for intersectoral collaboration.

Health care systems should also be oriented towards the needs of many persons with severe and long-term mental disorders. These people are poorly served by a throughput model of care which emphasizes the importance of vigorous treatment of acute episodes in the expectation that most patients will make a reasonably complete recovery without requiring further care until the next such episode occurs, if there is one. A continuing care approach is more appropriate, emphasizing the need to address the totality of people's needs, including their social, occupational and psychological requirements.

The pathways to care are the routes whereby people with mental disorders access mental health service providers. These pathways are different in developed and developing countries with different levels of health system development. They can occasionally hinder access to mental health services, resulting in delays in seeking help and thus in an increased likelihood of poor long-term outcomes.

Service planners should also pay attention to eliminating geographical disparities between rural and urban settings in the provision of mental health services.

A service-led approach, as opposed to a needs-led approach, is characteristic of many mental health services and imposes significant barriers to access, especially for people

with severe mental disorders whose needs go beyond purely medical and therapeutic interventions. There is a move towards needs-led models of service provision involving, for example, case management, assertive treatment programmes and the creation of psychiatric rehabilitation villages in rural areas. These models represent an acknowledgement that the needs of patients should be placed centrally and that the organization of services should be adapted to meet these needs.

The complex needs of many people with mental disorders cannot be met by the health sector alone. Intersectoral collaboration is therefore essential. Collaboration is needed both within the health sector (intra-sectoral) and between the health sector and other sectors (inter-sectoral).

### 7.7 Planning and Budgeting to Deliver Services for Mental Health

The purpose of this module is to present a model for assessing the mental health care requirements of local populations and for planning services accordingly. The intention is to provide countries with a set of planning and budgeting tools that can assist with the delivery of mental health services in local areas.

The steps in planning and budgeting, which are presented in cyclical form, include the following.

#### Step A: Situation analysis.

This includes identifying the population to be served, reviewing the local context of mental health care, consulting with all relevant stakeholders, identifying who is responsible for mental health budgeting and planning, and reviewing current mental health resources and service utilization.

#### Step B: Needs assessment.

The needs of the local population for mental health care are established. This includes establishing the prevalence, incidence and severity of priority conditions, estimating the service resources for the identified needs, and costing the resources for the estimated services.

#### Step C: Target-setting.

The above information is collated and targets are set for future planning. Target-setting includes identifying and setting priorities for local mental health services, appraising options for the most urgent service priorities and setting medium-term targets for service delivery.

#### Step D: Implementation.

The budgeting and financial management systems should now fall into place. The services have to be monitored and evaluated in order to establish whether the targets are being achieved. This leads to the completion of the cycle of planning and budgeting as new service information becomes applicable to the next situation analysis.

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