

NATIONS FOR MENTAL HEALTH

WHO/MSA/NAM/97.5

Supporting governments and policy-makers



Division of Mental Health
and Prevention of Substance Abuse

World Health Organization
Geneva

Nations for Mental Health:

An Action Programme on Mental Health for Underserved Populations

Objectives of Nations for Mental Health

- To enhance the attention of people and governments of the world to the effects of mental health problems and substance abuse on the social well-being and physical health of the world's underserved populations. A first step is to increase awareness and concern of the importance of mental health through a series of key high profile regional and international events. Secondly, efforts will be devoted to building up the will of the key political authorities to participate. Thirdly, and finally, efforts are to be directed at securing political commitments by decision-makers.
- To establish a number of demonstration projects in each of the six WHO regions of the world. They are meant to illustrate the potential of collaborative efforts at country level, with the view of leading on to projects of a larger scale.
- To encourage technical support between countries for service development, research and training.

The implementation of the programme depends on voluntary contributions from governments, foundations, individuals and others. It receives financial and technical support from the Eli Lilly and Company Foundation, Johnson and Johnson, the Government of the United Kingdom of Great Britain and Northern Ireland, the Institute of Psychiatry at the Maudsley Hospital of London (United Kingdom), the Free and Hanseatic City of Hamburg (Germany), the Villa Pini Foundation (Chieti, Italy), Columbia University (New York, USA), the Laboratoires Servier (Paris, France) and the International Foundation for Mental Health and Neurosciences (Geneva, Switzerland).

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**Supporting
governments
and
policy-makers**

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Division of Mental Health and
Prevention of Substance Abuse

World Health Organization
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Preface

The World Health Organization has established a new Action Programme on Mental Health for Underserved Populations. This programme, called 'Nations for Mental Health', has been created to deal with the increasing burdens of mental health and substance abuse worldwide. The main goal of the programme is to improve the mental health and psychosocial well being of the world's underserved populations.

Solutions to mental health and substance abuse problems entail a joint mobilization of social, economic and political forces as well as substantial changes in governmental policies related to education, health, and economic development in each country. This demands an intense and sustained effort from the nations of the world through joint cooperation between governments, nongovernmental organizations and the organizations within the United Nations system. The programme is of utmost importance to the work of WHO and WHO is willing to lead and coordinate this ambitious task. Several international meetings and launchings have been organized, in collaboration with other international organizations and academic institutions. A number of demonstration projects related to the programme have already been initiated in several countries. These projects are meant to illustrate and/or demonstrate the potential of collaborative efforts at country level, with the view of leading on to projects of a larger scale.

This document is aimed at government ministers, civil servants, government advisors and other policy-makers who are concerned with national health strategy. It summarizes the public health significance of mental health and the main social and economic arguments for tackling mental disorders in a planned strategic way. It sets out the key elements of a strategy, together with a framework for mental health legislation.

This document was written by Rachel Jenkins, Andrew McCulloch and Camilla Parker, WHO Collaborating Centre, Institute of Psychiatry, London, United Kingdom. The authors are grateful for the helpful comments from Dr Benedetto Saraceno, Professor Malik Mubbashar and Professor Srinivasa Murthy.

I am very pleased to present this document as part of the global process of raising awareness and concern about the effects of mental health problems. It is hoped that this document will provide a useful source of ideas and guidelines to support local strategies to improve mental health.

Dr. J. A. Costa e Silva

Director

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World Health Organization

Chapter 1

What do we mean by mental health and mental illness?

Mental health and mental disorders have been defined in many ways. For the purpose of this document the authors have defined these terms as follows.

Mental health is:

- a positive sense of well-being;
- a belief in our own worth and the dignity and worth of others;
- the ability to deal with the inner world of thinking, feeling, managing life and taking risks;
- the ability to initiate, develop and sustain mutually satisfying personal relationships;
- the ability of the mind to heal itself after shock or stress.

Mental disorders include:

- psychoses (disturbances in perception, beliefs, thought processes and mood);
- neuroses (disturbances in mood, concentration, irritability, fatigue);
- substance abuse (excess consumption and dependency on alcohol, drugs, tobacco);
- personality disorders (abnormal personality traits which are handicapping to the individual and/or to others);
- dementias (progressive organic disease of the brain).

Mental disorders have:

- social, psychological and biological causes;
- social, psychological and biological consequences.

It is important to diagnose mental disorders on the basis of disturbances in psychological functioning and not according to disturbances in social functioning. If mental ill-health were to be defined purely by abnormal social functioning, this would allow social deviancy to be labeled as mental illness. Although psychiatric illness often has social consequences and may result in social non-conformity, there are many forms of social deviation that are not illness and many forms of illness that do not result in social deviation.

Chapter 2

The public health significance of mental illness and related disorders

Dramatic changes are taking place in the overall health needs of the world's populations.

- It has been generally assumed that, in the developing regions where four-fifths of the world's people live, the leading causes of the disease burden are communicable agents like viruses and bacteria. In fact noncommunicable diseases such as depression and heart disease are replacing traditional enemies such as infectious diseases and malnutrition as the leading causes of disability and premature death.
- The *World Development Report 1993* (World Bank, 1993), which had the theme "Investing in Health", calculated that the global burden of neuropsychiatric disease was 8.1% (as measured in disability-adjusted life years). This figure has since been revised upwards (see page 3) to 10.5%. However, despite the burden they exert on world health, mental disorders and wider mental health issues have been disproportionately under-represented in the expenditure programmes of governments and international agencies.
- The *Harvard Report* (Desjarlais *et al*, 1995) reviewed the literature on world mental health in low-income countries with the aim of instigating a concerted international response. This report was presented to the United Nations in 1995, and the Secretary-General's response is set out in Box 1.
- In response, WHO has created an Action Programme entitled "Nations for Mental Health". The aim of this programme is to improve the mental health of the world's underserved populations.
- A later study, the *Global burden of disease* (Harvard/World Health Organization/World Bank 1996) has stated that:
 - deaths from noncommunicable diseases predominate over deaths from communicable diseases in every part of the world except India and sub-Saharan Africa (contrary to expectation, premature mortality rates from noncommunicable diseases are higher in populations with high mortality and low income than in the industrialized countries);
 - the global death toll from suicide is immense, and roughly equivalent to that from road traffic accidents;
 - the global burden of psychiatric disorder has been heavily underestimated and is 10.5% of the total burden of disease (five of the 10 leading causes of disability worldwide in 1990, measured in years lived with a disability are psychiatric disorders, namely unipolar depression, alcohol use, bipolar affective disorder, schizophrenia, and obsessive compulsive disorder; depression alone accounts for more than 10% of years of life lived with a disability worldwide; psychiatric and neurological conditions account for an average 28% of years of life lived with disability, in all regions except sub-Saharan Africa where they account for 16% of total disability);

- unsafe sex and alcohol abuse each contribute approximately 3.5% of the total disease burden and tobacco use contributes a further 3% (comparable to the burdens produced by tuberculosis and measles);
- future projections show that psychiatric and neurological conditions could increase their share of the total global burden of disease from 10.5% of the total burden to 15% in 2020 (this is a bigger proportionate increase than that for cardiovascular disease).

Box 1. Remarks at the launch of the Harvard Report at the United Nations, by Secretary-General Boutros Boutros Ghali, May 1995.

“This report puts the issue of mental health and well-being firmly on the international agenda... Psychosocial disorders affect the development – and the peace and security – of many societies. The international community must mobilize to address them... Priorities must change. Mental health must be recognized as a foremost challenge... An international campaign is needed... To secure mental health for the people of the world must be one of the objectives of the United Nations in its second half-century... Our objective is to promote the mental health and well-being of all the inhabitants of the planet. Let us, therefore, respond to this World Mental Health Report not simply by blessing it: let us take its recommendations and act upon them.”

Chapter 3

The social and economic consequences of mental disorder

The costs of not tackling mental disorder efficiently and effectively arise as:

- lost production from *premature deaths* from suicide (generally equivalent to, and in some countries greater than, deaths from road traffic accidents);
- lost production from people with mental illness being *unable to work*, in the short, medium or long term;
- reduced productivity from people being *ill while at work*;
- cost of *accidents* by people who are psychologically disturbed (especially important in people like train drivers, airline pilots, factory workers);
- *supporting dependents* of the mentally ill person;
- *unemployment, alienation, and crime* in young people whose childhood problems (e.g. depression, conduct disorder) were not sufficiently well addressed for them to benefit fully from the education available;
- cost of not properly addressing the consequences of *dyslexia* and other special educational needs in childhood;
- *poor cognitive development* in the children of mentally ill parents;
- higher costs incurred if disorders are not tackled early.

Chapter 4

The main sociodemographic predictors of mental disorder

- **Inner city areas** contain clusters of known risk factors such as poverty, unemployment, poor housing, poor schooling, poor parental mental health and family conflict.
- **Homelessness** is a common problem in the major cities of the world. Conventional psychiatric services often fail to contact or engage homeless mentally ill people so specific services are needed with good interagency coordination to meet the multiple needs of people with physical, psychological and social problems.
- **Poverty in rural areas** (although urban poverty is growing, the rural poor still account for over 80% of the total number of poor people in the world) leads to reduced access to fuel, seasonal unemployment, lack of education and training, isolation and a weak community infrastructure. The rural poor are therefore particularly vulnerable to exploitation, disease, natural calamities, drought, acute regional food shortages and famine.
- **Malnutrition** can result in cognitive impairment, impaired childhood development, stress and demoralization. Malnutrition in pregnancy (e.g. iodine deficiency) can result in congenital abnormalities. Early malnutrition can lead to attention deficits, which can contribute to behaviour problems in later life. Endemic chronic hunger leads to demoralization and may lead to crime, prostitution, forced labour and violence. Women and children are especially vulnerable to poverty.
- **The age structure** of population has a marked influence on *the need for psychiatric services*. For instance, young adults have the greatest need for services for psychosis, eating disorders, disorders of childbirth, drug abuse and personality disorders; and in older persons dementia increases geometrically with age over the age of 60 so that it is 5% in those over 65, and 20% in those over 80. Age structure also affects the *availability of informal carers*. In many parts of the world, the relative availability of informal carers is diminishing as women enter the labour force and as the number of surviving older adults becomes greater than the younger population can sustain.
- **Different ethnic groups** within the same country often have different patterns of prevalence of mental disorders, probably because of the high levels of social disadvantage frequently experienced by ethnic minority groups and their poorer access to general health care services.

- **Refugees** have experienced multiple losses of family, friends, home and culture. Many have experienced torture, persecution and imprisonment, and their future may be very uncertain. Rates of illness are much higher in the first year or two but may subside with assimilation into the local community unless refugees continue to be subject to racist abuse or attack.
- **Household composition** can also be a predictor. Lone parents and people living alone are at greatest risk of psychiatric disorder and substance abuse.
- **Violence**, such as warfare and internal conflicts, often worsens pre-existing poverty and hunger. It may create influxes of refugees, drug trafficking and post-traumatic stress disorders.
- **Disasters** hit certain groups harder than others. Increased population and urbanization is contributing to more natural disasters (e.g. drought, famine, flood, earthquake) and also to more industrial disasters in poor cities. Of the almost 3 billion people affected by disasters from 1967 to 1991, about 85% lived in Asia, 11% in Africa, and 4% in the Americas. In famine and other disasters, the poor are the most vulnerable. They live in the most precarious environments, have the fewest resources, and have the least access to health services. Roughly one-third of those affected by disasters suffer some form of mental disorder, but few of those living in disaster-prone areas presently receive the kinds of services required. The effects of disasters are much more widespread than the local incident itself because of the effects on relatives living elsewhere, often in ethnic minority groups in developed countries.
- **Low occupational status in developed countries** increases the risk of schizophrenia by a factor of 2 or 3, as well as being associated with longer duration of the illness, greater risk of relapse, poorer treatment response and clinical outcome, disproportionate use of services and differing perceptions of mental illness. It also increases the risk of depression, anxiety and drug and alcohol dependence.
- **Unemployment** in developed countries has a considerable negative effect on mental health, including low self-esteem, depression, anxiety and substance abuse. Unemployment is a strong predictor of admission rates to hospital.

Protective social factors

Social support (information, practical assistance, emotional support) can directly enhance mental and physical health, protect people from stress and reduce exposure to social adversity. A number of strategies can facilitate the development of natural support systems in the community. These include:

- supporting existing social support systems (e.g. families, neighbours and helpers);
- creating new but nonetheless natural support systems (e.g. setting up self-help groups for widows or young mothers);
- educating carers;
- consultation with schools, police, social services and criminal justice system;

- development of community networks to increase the community's involvement in tackling issues that affect mental health (e.g. prostitution, rape, domestic violence, child abuse);
- educating the general public about mental health problems, available treatments and health- promoting resources;
- mental health education to develop important competencies to improve capacity to cope with life transitions and stresses;
- employment, particularly in organizations which adopt good personnel and health policies.

Chapter 5

What are the key elements of a mental health strategy?

First steps toward a strategy

No organization or government starts strategy development with a blank sheet of paper. Each will start from its own information base, from the context of its overall health and social policy, and within its own social history and its own mix of stakeholders and stakeholder views. This is why strategy development is best done nationally by the responsible agencies. However, there are certain principles in mental health strategy development which may be generally applicable.

As an initial step it is worth carrying out a brief analysis of the role and potential role of each relevant agency in relation to mental health. This will vary from country to country. There may, for example, be certain industries with very high rates of mental illness, or a certain product which is favoured for self-harm or suicide. In such a situation the industry or manufacturer concerned needs to be involved in the strategy.

It is unlikely that all the major stakeholders will agree that a strategy is necessary or desirable. A communications exercise will be necessary to involve them. Different stakeholders may require different arguments. Industry and tax-payers may need to be confronted with the economic burdens, and professionals and government may need information on epidemiology and proven effectiveness of the strategy. Historically, human rights and ethical arguments have also been of great importance in moving mental health services forward. It is worth having good quality public affairs and public relations advice on how to prepare the ground for a mental health strategy.

Defining the mission

The next step is to define the overall mission that underpins the mental health strategy. This is not easy as the different stakeholders may have very different ideas about what mental health services should do. However, no strategy will succeed unless a critical mass of stakeholders is satisfied or at least compliant. It is therefore worth carrying out an analysis of what each stakeholder's key interests are, and what stakeholders are likely to want from a mental health strategy. Although there will undoubtedly be a need for leadership, the strategy has to take account of these different interests.

The mission also needs to take account of an assessment of the current situation and of the most pressing issues to be tackled. Possible elements for a mission are listed in Box 2.

Box 2. Possible elements of a mental health mission

1. To reduce the incidence and prevalence of mental illness.
2. To reduce mortality associated with mental illness.
3. To reduce the extent and severity of problems associated with specific mental disorders, including poor health and social functioning.
4. To develop mental health services.
5. To promote good mental health and reduce stigma, through, for example, public education.
6. To protect the human rights and dignity of mentally ill people.
7. To promote the psychological aspects of general health care.

A common strategic framework for mental health

Once the mission has been determined, the key elements of a national mental health strategy will start to become clear. These need to be rooted in an analysis of the specific mental health needs of the country and its existing health infrastructure. Strategies will therefore vary from country to country. However, the authors have identified 13 common elements of a strategy which many countries will need and all could usefully consider. These elements are presented in Box 3. They are then discussed below, together with an analysis of the benefits of tackling the issue and the consequences of not doing so.

1. Educate, support and resource primary care in its essential role of helping the majority of people with mental health problems.

Primary health care in many countries is often the only health care resource for mental illness. Even in countries that have a relatively sophisticated secondary specialist mental health care system, most people with mental health problems are nevertheless seen and dealt with in primary care because there is a high prevalence of mental disorders relative to the availability of specialists. This means that in all countries it is imperative to educate, support and provide resources to primary care to deal with most if not all people with mental health problems.

In every country, mild to moderate disorders can best be dealt with in primary care where services are close to the patient and are seen as less stigmatizing. If mental disorders are not dealt with adequately at this level, they will either be left untreated or will be unnecessarily referred to secondary care where they will divert these services from their key role of dealing with serious and complex disorders.

A recent WHO multisite study showed that, in both developing and developed countries, around one-third of patients presenting in primary care have a psychosocial problem, and the most common of all chronic disorders (physical or psychological) is depression.

Box 3. A common strategic framework for mental health

1. Educate, support and resource primary care in its essential role of helping the majority of people with mental health problems.
2. Develop effective links between primary and secondary care, with well developed criteria for referral, methods of shared care, adequate information systems and communication etc.
3. Develop comprehensive local specialist health and social services.
4. Develop mental health legislation which protects human rights and controls the circumstances under which patients can be held in hospital or treated without consent.
5. Develop good practice guidelines on effective interventions in primary and secondary care, and on interagency collaboration.
6. Develop a package of public health measures to reduce suicides and homicides by mentally ill people.
7. Develop a research and development strategy for mental health.
8. Develop a mental health promotion strategy embracing generic settings such as the workplace, schools and general health care system..
9. Educate school personnel about the management of mental health problems.
10. Involve users and carers in policy development and in service development and delivery.
11. If resources permit, develop mental health information systems in secondary care, incorporating core clinical minimum data sets and outcome measures which satisfy data protection and confidentiality requirements, in consultation with service users.
12. Develop effective links between the policy makers, the scientific community and the mental health delivery system
13. Develop effective links between the policy makers, the scientific community and the mental health delivery system

Members of the primary care team, especially doctors and nurses, must be trained to assess, diagnose and manage common mental disorders and know when to refer cases to specialists. This means ensuring that adequate attention is given to common mental disorders during the undergraduate, postgraduate and continuing education of doctors, nurses and vocational workers.

Members of the primary care team need to maintain close links with the specialist services so that they can access regular support for their work and can feel confident about being able to refer persons with the more severe and complex disorders. The balance of work within the primary care team needs to ensure that the caseload is tackled in the most efficient way.

In countries where specialist services do not exist, it is also essential to support primary care in dealing with severe psychotic disorders by ensuring the availability of appropriate education, clinical guidelines, ability to prescribe essential drugs etc.

Results: Efficiency. Sensitivity to patient and the community. Cost-effectiveness. Raised morale in primary care. Good outcomes for mild to moderate disorders (which nonetheless impose huge burdens).

Consequences of inaction: Primary care swamped with untreated mental health problems and somatization. Inefficient pattern of onward referrals. Inefficiency. Poor morale. Poor outcomes.

2. Develop effective links between primary and secondary care, with well developed criteria for referral, methods of shared care, adequate information systems and communication etc.

In countries where specialist services exist, it is necessary to ensure the most effective use of those specialist resources and guarantee that those in greatest need receive good care. Thus, specialist services need to be targeted at the more severe and complex disorders. This requires the development of agreed criteria for referral to specialist services – taking into account diagnosis, severity of symptoms, duration and risk of harm to self – and also safe methods of shared care whereby the primary care team can participate where possible (e.g. with medication, physical health care etc).

For specialist services to be able to focus on people with severe disorders, primary care will have to look after the less severe cases. Primary care services will need back-up support from specialist services (e.g. opportunities to agree on clinical guidelines, discuss different cases etc) and will need to learn additional psychological skills.

Results: Similar to 1. In addition, secondary care functions with maximum efficiency.

Consequences of inaction: Poor functioning of secondary care. Inefficiency. Mentally ill, patients are missed, sometimes with serious consequences.

3. Develop comprehensive local specialist health and social services.

Countries will vary in their capacity to provide resources to a comprehensive range of specialist local health and social services, and even the richest countries will not be able to afford sufficient psychiatric specialists to deal with all mental health problems. There must be an appropriate balance of specialist and primary care services to allow specialist services to be targeted on those with greatest need.

Now that research has demonstrated that prolonged institutionalization can cause long-term damage to health and social functioning, most countries are attempting to care for people with severe mental illness in their own homes or in home-like environments that are as close to the home as is compatible with the health and safety of the patient and the public.

In many developing countries, the principal resource is often a large psychiatric hospital, which may be remote from many of the people it serves. In this situation, efforts need to be made to start outreach community clinics and to use the hospital resource as imaginatively as possible. For instance, half-way houses can be created for people with long-term severe mental illness. Existing buildings on the site can be used for this if they are not presently being used to best effect.

The functional needs which should be met in people with severe mental illness are food, housing, health care, leisure activities, occupation, family relationships and social networks. The structures which are put in place to satisfy those needs will depend on the resources available in each country. The involvement of the local community will be essential in all countries, and is often the only possible resource though its ready availability to people with mental illness depends on the extent to which stigma is attached to them and to those who care for them.

More developed countries tend to provide more local comprehensive services, including:

- acute beds for episodes of acute and severe illness;
- 24-hour nursed long-stay accommodation, in home-like units, for people with enduring severe mental illness who need regular supervision of medication and daily monitoring of their mental state but who do not require the continuous presence of medical staff;
- supported housing;
- domiciliary services;
- opportunities for daytime activities;
- occupational rehabilitation services.

Multidisciplinary teams are needed to care for clients in hospital, residential and home settings. The term “community care” should therefore be taken to

refer to a range of local services, including inpatient care as well as support at home. Round-the-clock medical and nursing care will always be required for some people during acute episodes of very severe illness, and a small group of people need continuing nursing care over many years.

Health professionals (doctors, nurses, psychologists, occupational therapists) will have to work closely with social workers, voluntary workers, advice and housing workers, probation officers, the police and other relevant agencies to ensure that care is properly coordinated.

Results: Good outcomes. Sensitivity to need. Patients can occupy least restrictive and most cost-effective slots in the system.

Consequences of inaction: Patients may “block” inpatient facilities as they have nowhere to move to. Others will receive inadequate care. Poor outcomes. Poor sensitivity to need. Inefficiency.

4. Develop mental health legislation which protects human rights and controls the circumstances under which patients can be held in hospital or treated without consent.

Each country requires a legal framework which balances the need and desire of professionals to treat people when they are unable to consent with legal protection for the individual’s rights and regulation of the circumstances under which detention and involuntary treatment in a mental illness hospital can take place. This is dealt with in detail below.

Results: An appropriate balance of individual rights with the need to allow involuntary treatment under certain circumstances. Clarity on the part of all concerned about their rights and duties. The creation of appropriate appeals and regulatory bodies. Improved standards.

Consequences of inaction: Ad hoc practice coupled with frequent judicial challenge. Noncompliance with international declarations and charters. Poor relations between individuals, user liberties and civil liberties bodies and professionals. Possible abuse of human rights.

5. Develop good practice guidelines on effective interventions in primary and secondary care, and on interagency collaboration.

It is vital to ensure adequate quantity and quality in the processes of care both in primary and specialist services, and to work towards raising standards of care generally. Where possible, good practice guidelines should be developed in collaboration with the relevant professional bodies. These guidelines should address all elements of care including physical and psychological health care needs, social care, housing, employment and income support/welfare benefits.

Good interagency collaboration and the coordination of care are essential if health care for people with more complex needs is to work well.

Results: Efficiency. Good communications. Development of inconsistent local practices avoided. Stops patients dropping out of the system.

Consequences of inaction: Use of ineffective interventions. Poor communications. Patients are lost to the system.

6. Develop a package of public health measures to reduce suicides and homicides by mentally ill people.

A number of governments, including those of Australia, Finland, New Zealand, Norway, Sweden, and the United Kingdom have now begun to construct national strategies, with specialized national targets to be met in a specified time frame, to tackle suicide. Suicide rates vary from country to country but, even in countries with relatively low-to-average rates, the total numbers of deaths are very high and often exceed deaths from road traffic accidents.

Suicide reduction strategies need to be multifaceted in approach and should include several core elements, namely:

- educating primary and secondary health and social care professionals about the assessment and management of suicide risk;
- supporting high-risk occupational groups (these will vary but may include groups such as doctors, nurses, farmers, veterinary surgeons and pharmacists);
- reducing access to the means of suicide (e.g. by safety measures relating to weapons, medicines, vehicle exhausts etc);
- auditing all suicides to learn the lessons for prevention;
- carrying out research into causes and effective prevention;
- working with the media to ensure more responsible reporting of suicides.

Suicide strategies need to be inter-departmental or pan-governmental since a range of sectors are involved, and not just health agencies.

Homicide reduction strategies include:

- the provision of 24-hour nursed care for people with such severe and enduring mental illness that lesser degrees of support are insufficient to reduce risk to themselves and the public; and generally ensuring that people are at the right level of support and security;
- listening to the fears of family members if they perceive themselves to be at risk;
- educating health workers in appropriate risk assessment techniques;
- maintaining continuity of care, and being aware of the warning signals;
- encouraging users' participation in their care programmes.

Results: Reduced mortality. Increased public confidence. Efficiency (public health measures are often more cost-effective than secondary care interventions).

Consequences of inaction: Health care services may be overwhelmed. Loss of public confidence. Unnecessary deaths.

7. Develop a research and development strategy for mental health.

Investment in research and development, and the wide dissemination of research findings, are important for extending knowledge both about the causes of mental illness, the possibilities for prevention, improved treatments and services, and about the prevention of suicide and other causes of death in people with mental illness. Multisite and multidisciplinary collaboration in research are helpful.

Results: Improved efficiency and effectiveness. Better informed staff. Better services.

Consequences of inaction: Decay in the quality and effectiveness of services. Services unable to keep pace with global research findings. Lack of innovation. Services frozen into outdated models.

8. Develop a mental health promotion strategy embracing generic settings such as the workplace.

The economic burden of mental health problems in the workplace (reduced performance, poor staff relations, sickness absence, labour turnover, accidents) is so great (for example, mental ill-health is one of the top three causes of sickness absence in the United Kingdom) that it is very much in the employers' interests to address employees' mental as well as physical health.

A workplace mental health policy is a systematic statement of action on mental health agreed by staff, management and trade unions. Its core components include:

- commitment to a healthy workforce, placing a high value on both mental and physical health;
- acknowledging that mental health problems have many causes, including stress in the workplace and the outside world as well as domestic factors;
- listing factors which lead to increased stress in the organization;
- stating that the organization is committed to action.

Action in the workplace may include:

- information and education;
- action to reduce workplace stress and to ensure;

- early recognition of problems;
- access to counselling and support,
- helping people to return to work after mental health problems.

Results: Increased understanding. Early presentation. Reduced morbidity. Reduced economic burden. Reduced prejudice.

Consequences of inaction: Continued stigma. Lack of presentation. Steady or increasing economic burden.

9. Educate school personnel about mental health promotion, prevention and management of mental health problems.

Like the workplace, schools are an important environment for the prevention of mental ill-health. They need to be committed to improving or sustaining the mental and physical health of children. Mental health promotion in schools includes teaching about coping skills, improving self-esteem, and learning to say no to involvement in risk behaviours, education about parenting and child rearing skills.

Examples of prevention activity in schools may include:

- mobilizing support for those at risk from recent life events (e.g. bereavement) or vulnerability factors (e.g. poverty);
- reducing risk factors (e.g. by introducing anti-bullying strategies);
- prompt detection of mental health problems, including eating disorders and helping children to return to school after absences.

Results: Lower prevalence/better detection. Improved school environment. Better educational, social and health outcomes.

Consequences of inaction: Teachers unable to cope with difficult or disturbed children. Exclusion of vulnerable children. Disrupted education. Poor outcomes.

10. Involve users and carers in policy development and in service development and delivery.

Service users and carers are the immediate “customers” of the service. They are aware of the consequences of mental health problems on their lives and the need for services to be sensitive. Their involvement can greatly improve the planning and delivery of services as they can spot gaps and failings as well as commenting on what is working well. User-led services are proving highly acceptable to users and are a valuable part of comprehensive services.

Results: Improved sensitivity of services. Greater commitment and engagement from users and carers.

Consequences of inaction: Insensitive services. Lower engagement. Unmet need.

11. Develop mental health information systems in secondary care, incorporating core clinical minimum data sets and outcome measures which satisfy data protection and confidentiality requirements, in consultation with service users.

Mental health information systems are of great value in planning the delivery of specialist services, assisting the coordination of care between a variety of professionals, and helping to ensure that clients do not miss the care they need. At their simplest, mental health information systems comprise names and addresses of patients, their age and sex, and date of referral to specialist services. However, many countries and districts are now developing minimum data sets that include measures of health and social functioning.

Such information systems must be developed in consultation with users and carers in order to meet concerns about confidentiality and to develop sensible procedures for accessing information. Common standards in information technology will allow local information systems to communicate across agency and geographical boundaries, and as clients move around.

Results: Supports planning and the measurement of effectiveness, leading to more effective services. Supports good care planning and communication, leading to continuity of care. Supports research.

Consequences of inaction: Planning, monitoring, research and evaluation are held back. Care is difficult to coordinate and patients can be lost to care. Inefficiency.

Finalizing the strategy

The strategy should consist of a statement of the key objectives and the major actions that which will take place to achieve those objectives. In addition, most strategies include information about time scale, costs, milestones, targets, evaluation and action leads – either in the strategic plan or, more commonly, in an associated operational plan. But all this material is subordinate to the description of the objectives and the actions that will be taken to achieve the desired outcomes.

The strategy must flow naturally from the preceding analysis and should be realistic with regard to its starting point. For example, general practitioner/primary care triage may be a weak model if primary care is poorly developed. In such a situation, triage may need to take place immediately upon referral or

presentation to secondary care. Again, a capital-led strategy to build large numbers of inpatient facilities may be beyond many nations' means while a community-based strategy, perhaps with supervised unqualified workers overseen by professionals, or with adult fostering of very disabled people, might be a way forward. There is usually little merit in completely overthrowing existing systems; usually an evolutionary approach is most cost-effective and feasible. Sometimes, however, elements of the existing system may be so poor that it is easiest to start again. For example, hospitals with totally inadequate premises and institutionalized staff might have to be closed and the money reinvested in a more locally based and comprehensive spectrum of services. Care is needed to ensure that money released from hospital closures and sale of the hospital site is directly reinvested in mental health services and not used for other purposes. In many cases, the strategy will need to concentrate more on creating a framework for investment and development rather than on detailing exactly who the providers will be – this may come later.

The time scale will also be an important part of the strategy. Five to ten years is probably a realistic period for achieving significant change. Any shorter time scale is likely to be unrealistic, while a time horizon that is too long may not satisfy the stakeholders. Different elements of the strategy may require different time scales. A few examples are as follows:

- Reconfigure an old long-stay hospital service into a comprehensive locally based service (20-30 years).
- Close a single hospital (5 years).
- Reform professional training and establish national accreditation procedures (5 years).
- Establish basic training for unqualified workers (3 years).
- Reform mental health legislation (3 years).
- Establish a strategy for research and development (2 years, 5 years for first results).
- Establish an information system (3 years).
- Start a national health promotion programme (2 years).
- Roll out good practice protocols (2 years).
- Restrict access to a means of suicide (1-2 years).

Adopting the strategy

This process is likely to require strong advocacy and strong arguments. It is important to stress not only the benefits of action, such as improved national mental health, lower economic burdens and improved human rights, but also the possible negative consequences. Wherever possible, hard epidemiological and economic data should be used to support the argument.

It is worth considering developing a separate communications strategy to support the principal strategy. Communications underpins all work in mental health. There is great value, for example, in placing both negative media stories about the inadequacies of current policy and services and positive ones about what could be achieved if change proceeded. This can often be done without conflict of interest by nongovernmental organizations. It is also essential to have some well-placed persons to advocate the strategy at the highest levels within government and other key agencies. The ideal strategy from the point of view of business, medicine and science will not succeed unless mental health is pushed up the government agenda. This rarely happens by chance.

In establishing the vision, it is also vitally important to communicate the strategy to all the partner agencies and, within those agencies, to individuals. Many strategies fail simply because they are poorly communicated. Sometimes they are not communicated at all, and sometimes the essence of the strategy is missed and people focus on contentious details that are not essential to the overall vision.

Linking the strategy across government departments.

As already stated, the mental health strategy needs to be linked with overall health policy and with other government policies. Box 4 shows the main policy links for the mental health strategy.

It is particularly important that any general public health strategy should address mental health as well as physical health so that:

- mortality indicators include suicides;
- morbidity indicators include, or plan to include, relevant measures of morbidity due to mental illness;
- public health interventions in areas such as housing and social welfare should outline the impact on mental health;
- any statements of health impact should explicitly include mental health.

Box 4 Policy links for the mental health strategy

1. Ministry of Health:
 - primary care policy;
 - professional education and human resources;
 - finance;
 - commissioning and providing models;
 - public health strategy ;
 - client group policies;
 - occupational health of the health care workforce.
2. Ministry of social welfare:
 - access to social welfare benefits for mentally ill people.
3. Ministry of Employment/Labour:
 - access to employment, including sheltered employment;
 - employment rehabilitation;
 - workplace mental health policies;
 - occupational health.
4. Ministry of Education:
 - including education on mental health as part of the health and social skills elements of school curricula;
 - developing higher education, including generic courses, vocational qualifications, distance learning, and occupational standards relevant to mental health.
5. Ministry of Home affairs and criminal justice:
 - diversion of mentally ill offenders from the criminal justice system;
 - public security and the welfare of mentally ill people coming into contact with the criminal justice system.
6. Ministry of Environment/Housing:
 - ensuring an adequate supply of ordinary and special needs/sheltered housing for mentally ill people.
7. Ministry of Trade and Industry:
 - maintaining communications with insurance companies and others;
 - preventing discrimination (relevant generally).
8. Ministry of Finance
9. Medical Research Councils and other research doners
10. Professional bodies

Chapter 6

A framework for mental health legislation and accompanying guides of good practice

A key element of a mental health strategy will be the development of mental health legislation. The first step in this process will be to establish agreed principles on which the legislation should be based. Such general principles may then be used as a guide for the legislators when defining the scope of the powers, duties and rights set out in the statute. Examples of some general principles are in Box 5.

Agreeing on general principles will assist in determining the aims and objectives of the legislation. This can be demonstrated by looking at the five suggested general principles in further detail.

1. Respect for individuals and their social, cultural, ethnic, religious and philosophical values.

This embraces the other general principles and may be the most difficult to frame within legislation (except for anti-discrimination legislation). Its implementation may require:

- adequate training for staff;
- effective monitoring;
- interpreters;
- an accessible complaints procedure;
- advocacy services.

Box 5 General principles for mental health legislation

1. Respect for individuals and their social, cultural, ethnic, religious and philosophical values.
2. Individuals' needs taken fully into account.
3. Care and treatment provided in the least restrictive environment compatible with the care and safety of the individual and the safety of the family and the public.
4. Provision of care and treatment aimed at promoting each individual's self-determination and personal responsibility.
5. Provision of care and treatment aimed at achieving the individual's own highest attainable level of health and well-being.

2. Individuals' needs taken fully into account.

The agencies concerned must be able to carry out proper assessment of an individual's need for health and social care. In particular, it is important to ensure that the views of an individual (and his or her carers) are considered. For this to happen, there must be close liaison between health, housing and social care services, and individuals' views must be obtained and taken into account.

3. Care and treatment provided in the least restrictive environment.

In order to uphold this principle, legislation should be framed so that involuntary (formal) hospital admission is a last resort. This can be achieved through:

- clearly defined grounds for detention;
- procedural safeguards when the power to detain is used;
- an obligation to discharge when grounds for detention are no longer met;
- an independent review of the decision to detain.

4. Provision of care and treatment aimed at promoting each individual's self-determination and personal responsibility.

It is vital that individuals are given the opportunity to exercise choice and make decisions about their own care and treatment. Legislation should aim to ensure that:

- treatment can be imposed only in strictly limited and clearly defined circumstances and must be the least restrictive alternative;
- where individuals are unable to make decisions for themselves, steps are taken to find out their wishes and feelings;
- clear information on treatment and detention is readily available;
- appropriate provisions for confidentiality are in force.

5. Provision of care and treatment aimed at achieving the individual's own highest attainable level of health and well-being.

In addition to issues of quality and continuity of care, this principle could address the question of a "right" to treatment. It can also cover more general issues such as the requirement that the individual should be cared for properly in a safe environment and subject only to restrictions for reasons of his or her health or safety, or the safety of others. In this regard:

- there should be no restrictions on an individual's contact with friends and family, save for exceptional and clearly defined circumstances;
- stringent safeguards from abuse, exploitation and neglect should be in place.

Human rights and mental health law

In addition to general principles, legislators will wish to comply with their obligations under international human rights treaties such as the International Covenant of Civil and Political Rights and the regional human rights declarations. Issues raised in such treaties and declarations are directly relevant to the compulsory detention of individuals and the imposition of treatment without consent. Such treaties cover issues such as liberty, inhuman treatment and privacy.

A right to liberty

Liberty may be restricted only in prescribed circumstances. In the event of a person being detained under mental health legislation, the following requirements should apply:

- there is objective medical opinion to establish a true mental disorder;
- the mental disorder is of a kind or degree that warrants detention;
- the continued validity of detention depends on the persistence of the mental disorder;
- the lawfulness of detention must be open to a speedy review by a court or independent tribunal;
- there must be regular review of the decision to detain.

Freedom from inhuman or degrading treatment

Provisions for good practice in areas such as the general hospital environment, seclusion and compulsory treatment would need to be considered.

A right to privacy

Again, provisions for good practice need to be addressed in areas such as compulsory treatment, visiting, withholding of mail and personal searches.

Putting principles and rights into practice – issues and questions

Governments need to address their obligations under human rights treaties in consultation with users, carers, professionals and other stakeholders. Box 6 lists the major issues which are likely to arise in such discussions and which need to be covered in mental health legislation.

Box 6 Issues to be covered in mental health legislation

1. The balance between protecting the public and protection of the individual.
2. Definition of mental disorder and mental illness.
3. Whether psychopathic disorder should be included.
4. Whether a mental disorder that affects only the person's health be considered as warranting detention.
5. Whether there should be an immediate independent review of the decision to detain.
6. What treatment may be given for mental disorder.
7. When treatment can be given without consent.
8. Whether compulsory treatment decisions should take account of previous wishes of the individual.
9. How to ensure that treatment is appropriate and beneficial to the individual.
10. Whether individuals should have rights to care and treatment.
11. Resource implications of providing rights to treatment and/or the least restrictive alternative.
12. Ways of involving users and carers.
13. The need for an independent inspection agency.
14. Dealing with emergencies.
15. Consider legislation to facilitate prevention of mental illness and promotion of mental health

Documents produced by Nations for Mental Health

Gender differences in the epidemiology of affective disorders and schizophrenia.
WHO/MSA/NAM/97.1.

Meeting of a Consultative Group, Geneva, 2-3 December 1996, Report.
WHO/MSA/NAM/97.2.

Nations for Mental Health: An overview of a strategy to improve the mental health of underserved populations.
WHO/MSA/NAM/97.3.

Nations for Mental Health: A focus on women.
WHO/MSA/NAM/97.4

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