CHAPTER FOUR

Mental Health Policy and Service Provision

Governments, as the ultimate stewards of mental health, need to set policies – within the context of general health systems and financing arrangements – that will protect and improve the mental health of the population. In terms of financing, people should be protected from catastrophic financial risk; the healthy should subsidize the sick; and the well-off should subsidize the poor. Mental health policy should be reinforced by coherent alcohol and drug policies, as well as social welfare services such as housing. Policies should be drawn up with the involvement of all stakeholders and should be based on reliable information. Policies should ensure the respect of human rights and take account of the needs of vulnerable groups. Care should shift away from large psychiatric hospitals to community services that are integrated into general health services. Psychotropic drugs need to be available, and the required health workers need to be trained. The mass media and public awareness campaigns can be effective in reducing stigma and discrimination. Nongovernmental organizations and consumer groups should also be supported, as they can be instrumental in improving service quality and public attitudes. Further research is needed to improve policy and services, in particular to take account of cultural differences.

4

Mental Health Policy and Service Provision

Developing policy

To protect and improve the mental health of the population is a complex task involving multiple decisions. It requires priorities to be set among mental health needs, conditions, services, treatments, and prevention and promotion strategies, and choices to be made about their funding. Mental health services and strategies must be well coordinated among themselves and with other services, such as social security, education, employment and housing. Mental health outcomes must be monitored and analysed so that decisions can be continually adjusted to meet existing challenges.

Governments, as the ultimate stewards of mental health, need to assume the responsibility for ensuring that these complex activities are carried out. One critical role in stewardship is to develop and implement policy. Policy identifies the major issues and objectives, defines the respective roles of the public and private sectors in financing and provision, identifies policy instruments and organizational arrangements required in the public and possibly in the private sectors to meet mental health objectives, sets the agenda for capacity building and organizational development, and provides guidance for prioritizing expenditure, thus linking analysis of problems to decisions about resource allocation.

The stewardship function for mental health is poorly developed in many countries. The WHO Project Atlas (see Box 4.1) collected basic information on mental health resources from 181 countries. According to these data, which are used to illustrate the main points in this chapter, one-third of countries do not report a specific mental health budget, although they presumably devote some resources to mental health. Half the rest allocate less than 1% of their public health budget to mental health, even though neuropsychiatric problems represent 12% of the total global burden of disease. A non-existent or limited budget for mental health is a significant barrier to providing treatment and care.

Related to this budgetary problem is the fact that approximately four out of ten countries have no explicit mental health policy and approximately one-third have no drug and alcohol policy. The lack of policy related specifically to children and adolescents is even more dramatic (Graham & Orley 1998). It may be argued that a policy is neither necessary nor sufficient for good results, and that for those countries without a mental health policy it would suffice to have a defined mental health programme or plan. But one-third of countries have no programme and a quarter have neither a policy nor a programme. These findings indicate the lack of expressed commitment to address mental health problems and the absence of requirements to undertake national level planning, coordination and evaluation of mental health strategies, services and capacity (see Figure 4.1).

Box 4.1 Project Atlas

The WHO Project Atlas of Mental Health Resources is one of the most recent to examine the current status of mental health systems in countries.[1] It involves 181 of WHO's Member States, thus covering 98.7% of the world population. The information was obtained during the period October 2000 to March 2001 from ministries of health, using a short questionnaire, and was partially validated on the basis of reports from experts and from the published literature. While this information gives an indication of mental health resources in the world, some limitations need to be kept in mind. The first is that the information was based on self-reporting, and not all responses could be validated independently. Second, not all Member States responded, and this, together with other missing data on survey items, is likely to have biased the results. Finally, the results do not provide a comprehensive analysis of all mental health variables of relevance to countries, and therefore leave some questions unanswered.

[1] *Mental health resources in the world. Initial results of Project Atlas* (2001). Geneva, World Health Organization (Fact Sheet No. 260, April 2001).

Health system and financing arrangements

Mental health policy and service provision occur within the context of general health systems and financing arrangements. The implications of these arrangements for the delivery of mental health services need to be considered in policy formulation and implementation.

Over the past thirty years, health systems in developed countries have evolved from a highly centralized system of care to a decentralized system in which responsibility for policy implementation and service provision has been transferred from central to local structures. This process has also influenced the shape of systems in many developing countries. There are typically two main features of decentralization: reforms aimed at cost-containment and efficiency (discussed in this section); and the use of contracts with private and public service providers (discussed below in connection with providing mental health services).

The characteristics of good financing for mental health services are no different from what makes for good financing for health services in general (WHO 2000c, Chapter 5). There are three principal desiderata. First, people should be protected from catastrophic financial risk, which means minimizing out-of-pocket payments and particularly requiring such payments only for small expenses on affordable goods or services. All forms of prepayment, whether via general taxation, mandatory social insurance or voluntary private insurance, are preferable in this respect, because they pool risks and allow the use of services to be at least partly separated from payment for them. Mental problems are often chronic, so what matters is not only the cost of an individual treatment or service but the likelihood of its being repeated over long intervals. What an individual or a household can afford once, in a crisis, may be unaffordable in the long term, just as with certain other chronic noncommunicable problems such as diabetes.

Second, the healthy should subsidize the sick. Any prepayment mechanism will do this in general – as out-of-pocket payment will not – but whether subsidies flow in the right direction for mental health depends on whether prepayment covers the specific needs of the mentally ill. A financing system could be adequate in this respect for many services but still not transfer resources from the healthy to the sick where mental or behavioural problems are concerned, simply because those problems are not covered. The effect of a particular financing arrangement on mental health therefore depends on the choice of interventions to finance.

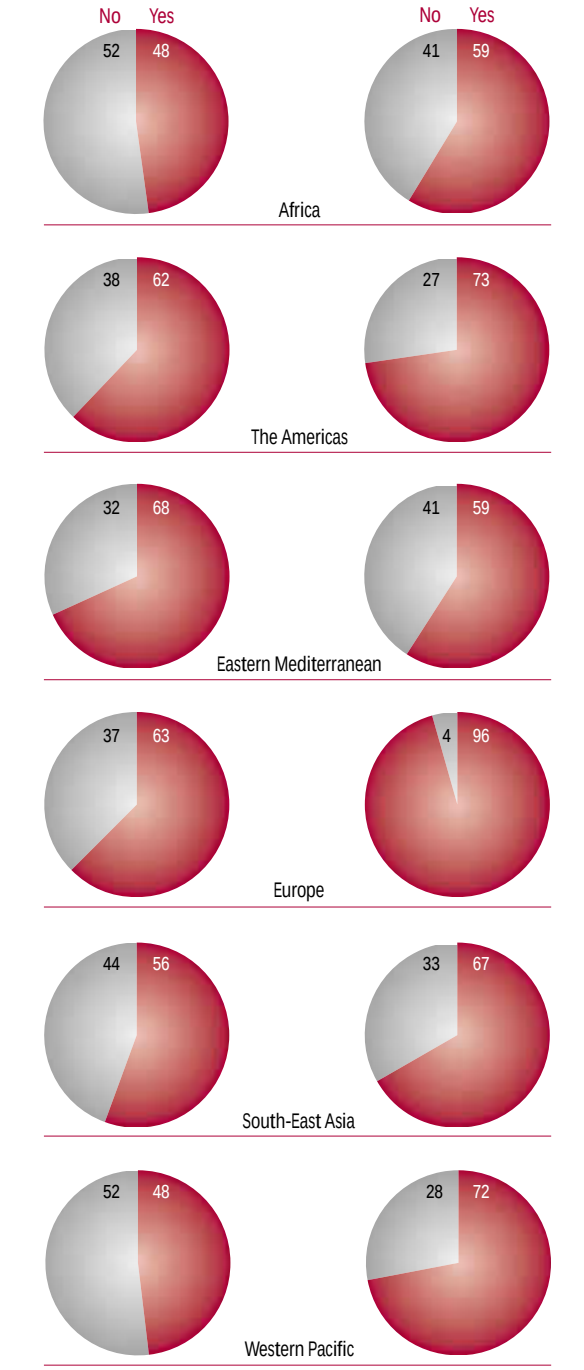
Finally, a good financing system will also mean that the well-off subsidize the poor, at least to some extent. This is the hardest characteristic to assure, because it depends on the coverage and progressivity of the tax system and on who is covered by social or private insurance. Insurance makes the well-off subsidize the worse-off only if both groups are

included, rather than insurance being limited to the well-off; and if contributions are at least partly income-related, rather than uniform or related only to risks. As always, the magnitude and direction of subsidy also depends on what services are covered.

Prepayment typically accounts for a larger share of total health spending in richer countries, and this has consequences for mental health financing. When a government provides 70–80% of all that is spent on health, as occurs in many OECD countries, decisions about the priority to give mental health can be directly implemented through the budget, probably with only minor offsetting effects on private spending. When a government provides only 20–30% of total financing, as in China, Cyprus, India, Lebanon, Myanmar, Nepal, Nigeria, Pakistan and Sudan (WHO 2000c, Annex Table 8), and there is also little insurance coverage, mental health is likely to suffer relative to other health problems because most spending must be out of pocket. Individuals with mental disorders, particularly in developing countries, are commonly poorer than the rest of the population, and often less able or willing to seek care owing to stigma, or previous negative experiences of services, so having to pay out of their or their families' pockets is even more of an obstacle than it is for many acute physical health problems. Finding ways to increase the share of prepayment, particularly for expensive or repeated procedures, as recommended in *The World Health Report 2000*, can therefore benefit mental health spending preferentially, provided enough of the additional prepayment is dedicated to mental and behavioural disorders. Movement in the other direction – from prepayment to more out-of-pocket spending, as has occurred with the economic transition in several countries of the former Soviet Union – is likely to diminish the resources for mental health.

In countries with a low share of prepayment and difficulties in raising tax revenues or extending social insurance because much of the population is rural and has no formal employment, community financing schemes may seem an attractive way to reduce the out-of-pocket burden. The evidence of their success is scanty and mixed so far, but it should be noted that unless such schemes receive substantial subsidies from governments, nongovernmental organizations or external donors, they are not likely to solve the chronic problems of an easily identified part of the beneficiary population. People who are willing to help their neighbours in acute health need will be much less willing to contribute far more perma-

Figure 4.1 Presence of mental health policies and legislation, percentage of Member States in WHO Regions, 2000



[a]Based on information from 181 Member States.
[b]Based on information from 160 Member States.
Source: *Mental health resources in the world. Initial results of Project Atlas* (2001). Geneva, World Health Organization.

nent support. They cannot therefore be counted on as a significant source of financing for mental health: community-based services should not imply or depend on community-based finance.

These same poor countries are sometimes heavily dependent on external donors to pay for health care. This is potentially a valuable source of funds for mental health, just as for other problems, but donors often have their own priorities which need not coincide with those of the government. In particular, currently they seldom give mental health a high priority over communicable diseases. In that case, governments have to decide whether to try to persuade donors to align aid more closely with the priorities of the country, or whether to use their own limited funds in areas neglected by donors, in particular by devoting a greater proportion of domestic resources to mental problems.

FORMULATING MENTAL HEALTH POLICY

Within general health policy, special consideration needs to be given to mental health policy, as well as to alcohol and drug policies, not least because of the stigma and human rights violations suffered by many people with these mental and behavioural disorders, and the help a large portion of them need in finding suitable housing or income support.

The formulation of mental health, alcohol and drug policies must be undertaken within the context of a complex body of government health, welfare and general social policies. Social, political and economic realities must be recognized at local, regional and national levels. In drawing up these policies, a number of questions should be asked (see Box 4.2).

Alcohol and drug policies are a special issue as they need to include law enforcement and other controls over the supply of psychoactive substances, and a range of options to deal with the negative consequences of substance use that are a threat to public safety, in addition to covering education, prevention, treatment and rehabilitation (WHO 1998).

An important step in the development of a mental health policy is the identification, by the government, of those responsible for its formulation. The process of policy development must include the views of a wide array of stakeholders: patients (sometimes called consumers), family members, professionals, policy-makers and other interested parties. Some, such as employers and members of the criminal justice system, may not consider themselves to be stakeholders, but they need to be convinced of the importance of their participation. The policy should set priorities and outline approaches, based on identified needs and taking into account available resources.

Box 4.2 Formulating policy: the key questions

The successful formulation of a mental health policy depends on ensuring that it responds affirmatively to the following questions.

- Does the policy promote the development of community-based care?
- Are services comprehensive and integrated into primary health care?
- Does the policy encourage partnerships between individuals, families and health professionals?
- Does the policy promote the empowerment of individuals, families and communities?
- Does the policy create a system that respects, protects and fulfils the human rights of people with mental disorders?
- Are evidence-based practices utilized wherever possible?
- Is there an adequate supply of appropriately trained service providers to ensure that the policy can be implemented?
- Are the special needs of women, children and adolescents recognized?
- Is there parity between mental health services and other health services?
- Does the policy require the continuous monitoring and evaluation of services?
- Does the policy create a system that is responsive to the needs of underserved and vulnerable populations?
- Is adequate attention paid to strategies for prevention and promotion?
- Does the policy foster intersectoral links between the mental health and other sectors?

Box 4.3 Mental health reform in Uganda

Mental health services in Uganda were decentralized in the 1960s, and mental health units were built at regional referral hospitals. These units resembled prisons and were manned by psychiatric clinical officers. Services were plagued by low staff morale, a chronic shortage of drugs and no funds for any community activities. Most people had little understanding of mental disorders or did not know that effective treatments and services were available. Up to 80% of patients went to traditional healers before reporting to the health system.[1]

In 1996, encouraged by WHO, the health ministry began to strengthen mental health services and integrate them into primary health care. Standards and guidelines were developed for the care of epilepsy and for the mental health of children and adults, from community level to tertiary institutions. Health workers were trained to recognize and manage or refer common mental and neurological disorders. A new referral system was established along with a supervisory support network. Linkages were set up with other programmes such as those on AIDS, adolescent and reproductive health, and health education. Efforts were made to raise awareness of mental health in the general population. The Mental Health Act was revised and integrated into a Health Services Bill. Mental and neurological drugs have been included in the essential drugs list.

Mental health has been included as a component of the national minimum health care package. Mental health is now part of the health ministry budget. Mental health units are to be built at 6 of the 10 regional referral hospitals, and the capacity of the 900-bed national psychiatric hospital is to be reduced by half.

[1] Baingana F (1990). Personal communication.

In some countries, mental health is being integrated into primary health care but fundamental reforms to psychiatric hospitals and in relation to community-based options are not being carried out. Major reforms of the health sectors in many countries are opportunities to strengthen the position of mental health in those sectors, and to begin the integration process at policy, health service and community levels. In Uganda (Box 4.3) for example, mental health was until recently given low priority.

Establishing an information base

The formulation of policy must be based upon up-to-date and reliable information concerning the community, mental health indicators, effective treatments, prevention and promotion strategies, and mental health resources. The policy will need to be reviewed periodically to allow for the modification or updating of programmes.

An important task is to collect and analyse epidemiological information to identify the broad psychosocial determinants of mental problems, as well as to provide quantitative information on the extent and type of problems in the community. Another important task is to carry out a comprehensive survey of existing resources and structures within communities and regions, along with a critical analysis of the extent to which they are fulfilling the defined needs. In this respect, it is helpful to use a "mixed economy matrix" to map out different provider sectors, how they are provided with resources, and the ways in which these sectors and resources are linked together. Mental health and associated services, such as social welfare support and housing, could be provided by public (state), private (for-profit), voluntary (non-profit), or informal (family or community) organizations or groups. The reality for most people is that they will receive only a few formal services, alongside informal support from family, friends and community. These services are likely to be funded by a mix of five basic revenue collection modes: out of pocket, private insurance schemes, social insurance, general taxation, and donations by charitable bodies (nongovernmental organizations). After the matrix has been established, a more systematic analysis can be undertaken of the types and quality of services, the main providers, and the questions of access and equity.

Both the formulation and evaluation of policy require the existence of a well-functioning and coordinated information system for measuring a minimum number of mental health indicators. Currently around a third of countries have no system for the annual reporting of

mental health data. Those which have such a system often lack sufficiently detailed information to allow for the evaluation of policy, services and treatment effectiveness. About half the countries have no facilities for the collection of epidemiological or service data at the national level.

Governments need to invest resources in developing information monitoring systems which incorporate indicators for the major demographic and socioeconomic determinants of mental health, the mental health status of the general population and those in treatment (including specific diagnostic categories by age and sex), and health systems. Indicators for the latter might include, for example, the number of psychiatric and general hospital beds, the number of hospital admissions and re-admissions, the length of stay, duration of illness at first contact, treatment utilization patterns, recovery rates, the number of outpatient visits, the frequency of primary care visits, the frequency and dosage of medication, and the number of staff and training facilities.

Methods of measurement could include population surveys, systematic data collection of patients treated at tertiary, secondary and primary levels of care, and the use of mortality data. The system set-up in countries must enable the information collected at local and regional levels to be collated and analysed systematically at the national level.

HIGHLIGHTING VULNERABLE GROUPS AND SPECIAL PROBLEMS

Policy should highlight vulnerable groups which have special mental health needs. Within most countries, these groups would include children, elderly people, and abused women. There are also likely to be vulnerable groups specific to the sociopolitical environment within countries, for example, refugees and displaced persons in regions experiencing civil wars or internal conflicts.

For ***children***, policies should aim to prevent child mental disability through adequate nutrition, prenatal and perinatal care, avoidance of alcohol and drug consumption during pregnancy, immunization, iodization of salt, child safety measures, treatment of common childhood disorders such as epilepsy, early detection through primary care, early identification, and health promotion through schools. The latter is feasible, as shown by experience in Alexandria, Egypt, where child counsellors were trained to work in schools to detect and treat childhood mental and behavioural disorders (El-Din et al. 1996). The United Nations Convention on the Rights of the Child recognizes that children and adolescents have the right to appropriate services (UN 1989). Youth services, which should be coordinated with schools and primary health care, can tackle mental and physical health in an integrated and comprehensive way, covering such problems as early and unwanted pregnancies; tobacco, alcohol and other substance use; violent behaviour; attempted suicide; and the prevention of HIV and sexually transmitted diseases.

For the ***elderly***, policies should support and improve the care already provided to elderly people by their families, incorporate mental health assessment and management into general health services, and provide respite care for family members who often are the principal caregivers.

For ***women***, policies must overcome discrimination in access to mental health services, treatment, and community services. Services need to be created in the community and at primary and secondary care levels to support women who have experienced sexual, domestic or other forms of violence, as well as for those who themselves have problems of alcohol and substance use.

For ***internally displaced groups and refugees***, policies must deal with housing, employment, shelter, clothing and food, as well as the psychological and emotional effects of expe-

riencing war, dislocation and loss of loved ones. Community intervention should be the basis for policy action.

In view of the specificities of ***suicidal behaviour***, policies must reduce environmental factors, particularly access to the means most commonly used to commit suicide in a given place. Policies must ensure care for at-risk individuals, particularly those with mental disorders, and survivors of suicide attempts.

Alcohol-related problems are not limited to alcohol-dependent people. Public health action should be directed at the whole drinking population, rather than to the users who are alcohol-dependent. Political feasibility, the capacity of the country in question to respond, public acceptance and likelihood of impact have to be considered when policies are being determined. The most effective alcohol control policies involve increasing the real price of, and taxes on, alcoholic beverages; restricting their consumption by controlling their availability, including the use of minimum drinking age legislation, and restricting the number, types and opening hours of outlets serving or selling alcohol; drink-drive laws; and server interventions (through policies and training leading to a refusal to serve alcohol to intoxicated persons). Also important are the control of alcohol advertising, particularly that which is targeted to young people; providing public education on the negative consequences of drinking alcohol (for example, through mass media and social marketing campaigns); warning labels; strict controls on product safety; and implementing measures against the illicit production and sale of alcoholic beverages. Finally, the provision of treatment for persons with alcohol-related problems should be part of society's health and social care responsibilities (Jernigan et al. 2000).

Policies concerning ***illicit drug use*** should aim to control the supply of illicit drugs; reduce demand, by prevention and other means; reduce the negative consequences of drug dependence; and provide treatment. These policies should target the general population and various risk groups. The development of effective programmes and services requires an understanding of the extent of drug use and related problems, and how they change over time according to patterns of substance use. Information dissemination needs to be accurate and appropriate for the target group. It should avoid sensationalism, promote psychosocial competence through life skills, and empower individuals to make healthier choices regarding their substance use. As substance use is intertwined with a number of social problems and exclusion, prevention efforts are likely to be more successful if they are integrated with strategies that aim to improve the lives of people and communities, including access to education and health care.

Respecting human rights

Mental health policies and programmes should promote the following rights: equality and non-discrimination; the right to privacy; individual autonomy; physical integrity; the right to information and participation; and freedom of religion, assembly and movement.

Human rights instruments also demand that any planning or development of mental health policies or programmes should involve vulnerable groups (such as indigenous and tribal populations; national, ethnic, religious and linguistic minorities; migrant workers; refugees and stateless persons; children and adolescents; and elderly people) in the planning and development of mental health policies and programmes.

Beyond the legally binding *International Covenant on Civil and Political Rights* and the *International Covenant on Economic, Social and Cultural Rights*, which are applicable to the human rights of those suffering from mental and behavioural disorders, the most significant and serious international effort to protect the rights of the mentally ill is the United

Nations General Assembly Resolution 46/119 on the *Protection of Persons with Mental Illness and the Improvement of Mental Health Care*, adopted in 1991 (UN 1991). Although not legally binding, the resolution brings together a set of basic rights which the international community regards as inviolable either in the community or when mentally ill persons receive treatment from the health care system. There are 25 principles which fall into two general categories: civil rights and procedures, and access to and quality of care. Principles include statements of the fundamental freedoms and basic rights of mentally ill persons, criteria for the determination of mental illness, protection of confidentiality, standards of care and treatment including involuntary admission and consent to treatment, rights of mentally ill persons in mental health facilities, provision of resources for mental health facilities, provision of review mechanisms, providing for protection of the rights of mentally ill offenders, and procedural safeguards to protect the rights of mentally ill persons.

The United Nations *Convention on the Rights of the Child* (1989) provides guidance for policy development specifically relevant to children and adolescents. It covers protection from all forms of physical and mental abuse; non-discrimination; the right to life, survival and development; the best interests of the child; and respect for the views of the child.

There are also a number of regional instruments to protect the rights of the mentally ill, including the *European Convention for Protection of Human Rights and Fundamental Freedoms*, backed by the European Court of Human Rights; *Recommendation 1235 (1994) on Psychiatry and Human Rights* adopted by the Parliamentary Assembly of the Council of Europe; the *American Convention on Human Rights*, 1978; and the *Declaration of Caracas* adopted by the Regional Conference on Restructuring Psychiatric care in Latin America in 1990 (see Box 3.3).

The human rights treaty monitoring bodies represent one example of an underutilized means to enhance the accountability of governments as regards mental health and to shape international law to address mental health matters. Nongovernmental organizations and the medical and public health professions should be encouraged to make use of these existing mechanisms to prompt governments to provide the resources to fulfil their obligations towards the health care of persons with mental disorders, protecting them from discrimination in society, and safeguarding other relevant human rights.

MENTAL HEALTH LEGISLATION

Mental health legislation should codify and consolidate the fundamental principles, values, goals, and objectives of mental health policy. Such legislation is essential to guarantee that the dignity of patients is preserved and that their fundamental human rights are protected.

Of 160 countries providing information on legislation (WHO 2001), nearly a quarter have no legislation on mental health (Figure 4.1). About half of the existing legislation was formulated in the past decade, but nearly one-fifth dates back over 40 years to a period before most of the current treatment methods became available.

Governments need to develop up-to-date national legislation for mental health which is consistent with international human rights obligations and which applies the important principles mentioned above, including those in United Nations General Assembly Resolution 46/119.

PROVIDING SERVICES

Many barriers limit the dissemination of effective interventions for mental and behavioural disorders (Figure 4.2). Specific health system barriers vary across countries but there are some commonalities relating to the sheer lack of mental health services, the poor quality of treatment and services, and issues related to access and equity.

While many countries have undertaken reform or are in the process of reforming their mental health systems, the extent and types of reform also vary tremendously. No country has managed to achieve the full spectrum of reform required to overcome all the barriers. Italy has successfully reformed its psychiatric services, but has left its primary care services untouched (Box 4.4). In Australia, (Box 4.5) health spending on mental health has increased and there has been a shift towards community care. There have also been attempts to integrate mental health into primary care and to increase consumer participation in decision-making. But community care, particularly regarding housing, has been extremely poor in some places.

Although psychiatric institutions with a large number of beds are not recommended for mental health care, a certain number of beds in general hospitals for acute care are essential. There is a wide variation in the number of beds available for mental health care (Figure 4.3). The median number for the world population is 1.5 per 10 000 population, ranging from 0.33 in the WHO South-East Asia Region to 9.3 in the European Region. Nearly two-thirds of the global population has access to fewer than one bed per 10 000 population, and more than half of all the beds are still in psychiatric institutions which often provide custodial care rather than mental health care.

Figure 4.2 Barriers to implementation of effective intervention for mental disorders

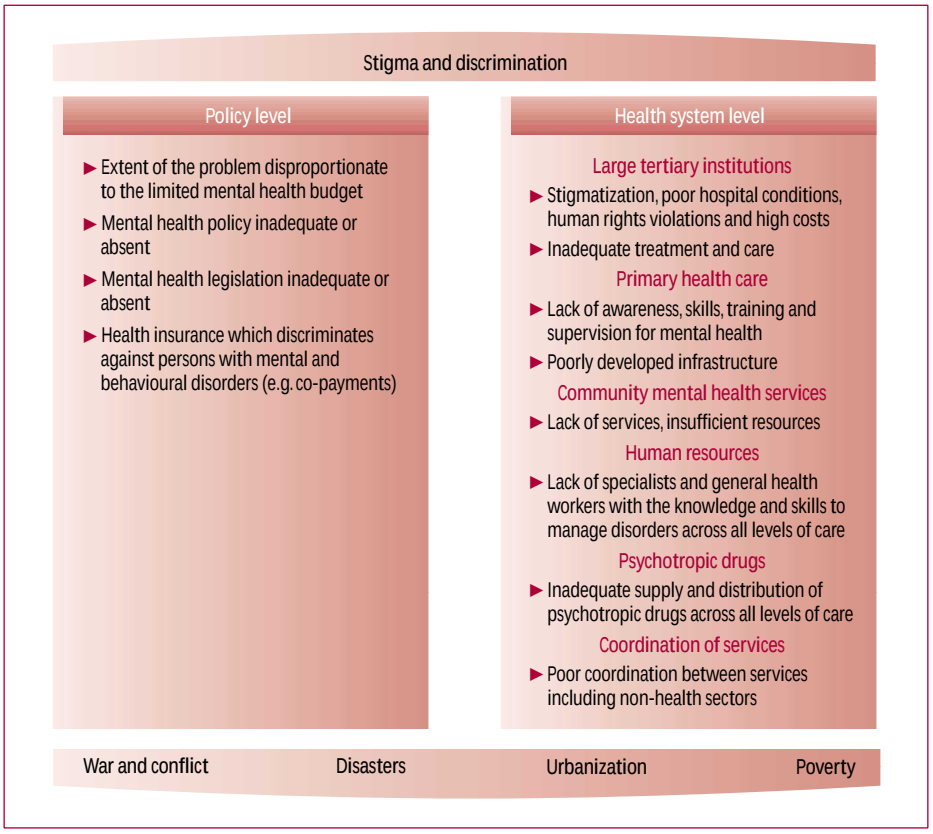
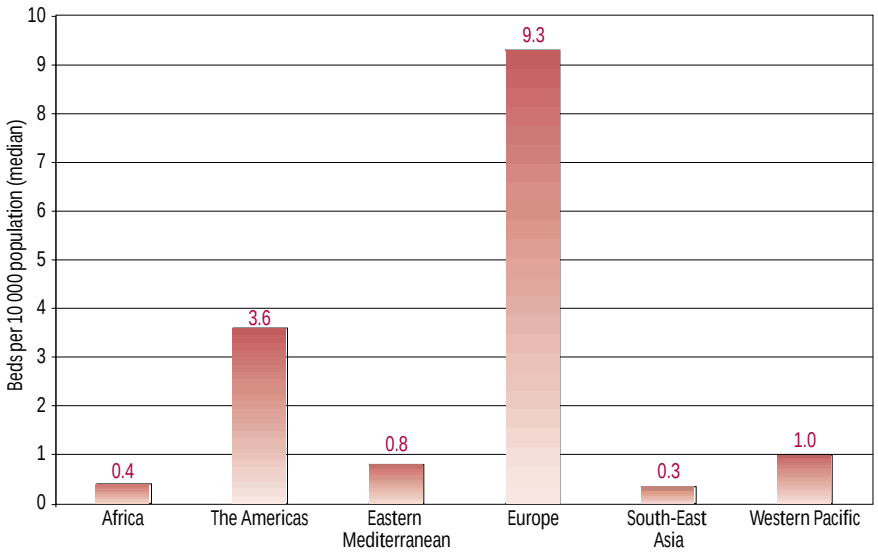


Figure 4.3 Psychiatric beds per 10 000 population by WHO Region, 2000[a]



[a]Based on information from 177 Member States.

Source: *Mental health resources in the world. Initial results of Project Atlas* (2001). Geneva, World Health Organization.

Box 4.4 Mental health reform in Italy

Twenty years ago the Italian Parliament passed "Law 180" which aimed to bring about a radical change in psychiatric care throughout the country. The law comprised framework legislation (*legge quadro*), entrusting regions with the tasks of drafting and implementing detailed norms, methods, and timetables for the translation of the law's general principles into specific action. For the management of psychiatric illness, three alternatives to mental hospitals have been set up: psychiatric beds in general hospitals; residential, non-hospital facilities, with full-time or part-time staff; and non-residential, outpatient facilities, which include day hospitals, day centres, and outpatient clinics.[1]

In the first 10 years following approval of the law, the number of mental hospital residents dropped by 53%. The total number discharged over the past two decades is, however, not known precisely. Compulsory admissions, as a percentage of total psychiatric admissions, have steadily declined from about 50% in 1975 to about 20% in 1984 and 11.8% in 1994. The "revolving door" phenomenon – discharged patients who are readmitted – is evident only in areas that lack well-organized, effective, community-based services.

Even in the context of the new services, recent surveys show that psychiatric patients are unlikely to receive optimum pharmacotherapy, and evidence-based psychosocial modes of treatment are unevenly distributed across mental health services. For example, although psycho-educational intervention is widely regarded as essential in the care of patients suffering from schizophrenia, only 8% of families received some form of such treatment. The scant data available seem to show that families have informally taken on some of the care for the ill relative, which was previously a responsibility of the mental hospital. At least some of the advantages to patients appear to be attributable more to everyday family support than to the services provided.

The following lessons may be drawn. First, the transition from a predominantly hospital-based service to a predominantly community-based service cannot be accomplished simply by closing the psychiatric institutions: appropriate alternative structures must be provided, as was the case in Italy. Second, political and administrative commitment is necessary if community care is to be effective. Investments have to be made in buildings, staff, training, and the provision of backup facilities. Third, monitoring and evaluation are important aspects of change: planning and evaluation should go hand in hand, and evaluation should, wherever possible, have an epidemiological basis. Last, a reform law should not only provide guidelines (as in Italy), but should be prescriptive: minimum standards need to be determined in terms of care, and in establishing reliable monitoring systems; compulsory timetables need to be set for implementing the envisaged facilities; and central mechanisms are required for the verification, control and comparison of the quality of services.

[1]de Girolomo G, Cozza M (2000). The Italian psychiatric reform: a 20-year perspective. *International Journal of Law and Psychiatry*, 23(3–4): 197–214.

The fact remains that, in many countries, large tertiary institutions with both acute and long-term facilities are still the predominant means of providing treatment and care. Such facilities are associated with poor outcomes and human rights violations. The fact that the public mental health budget in many countries is directed towards maintaining institutional care means that few or no resources are available for more effective services in general hospitals and in the community. Data indicate that community-based services are not available in 38% of countries. Even in countries that promote community care, coverage is far from complete. Within countries there are large variations between regions and between rural and urban areas (see Box 4.6).

In most countries, services for mental health need to be assessed, re-evaluated and reformed to provide the best available treatment and care. There are ways of improving how services are organized, even with limited resources, so that those who need them can make full use of them. The first is to shift care away from mental hospitals; the second is to develop community mental health services; and the third is to integrate mental health services into general health care. The degree of collaboration between mental health services and other non-health services, the availability of essential psychotropic drugs, methods for selecting mental health interventions, and the roles of the public and private sectors in delivering interventions are also crucial issues for service reorganization, as discussed below.

Shifting care away from large psychiatric hospitals

The ultimate goal is community-based treatment and care. This implies closing down large psychiatric hospitals (see Table 4.1). It may not be realistic to do this immediately. As a short-term measure, that is, until all patients can be discharged into the community with adequate community support, psychiatric hospitals need to be downsized, the living conditions of patients need to be improved, staff need to be trained, procedures need to be set up to protect patients against unnecessary involuntary admissions and treatments, and independent bodies need to be created to monitor and review hospital conditions. Furthermore, hospitals need to be converted into centres for active treatment and rehabilitation.

Box 4.5 Mental health reform in Australia

In Australia, where depression is ranked as the fourth most common cause of the total disease burden, and is the most common cause of disability,[1] the country's first national mental health strategy was adopted in 1992 by the Federal government and the health ministers of all states. A collaborative framework was established to pursue the agreed priority areas over a five-year period (1993–98).

This five-year programme has demonstrated the changes that can be achieved in national mental health reform. National spending on mental health care increased by 30% in real terms, while spending on community-based services grew by 87%. By 1998, the amount of mental health spending dedicated to caring for people in the community increased from 29% to 46%. Resources released through institutional downsizing funded 48% of the growth in community-based and general hospital services. The number of clinical staff providing community care rose by 68%, in parallel with increased spending.

Stand-alone psychiatric institutions, which had accounted for 49% of total mental health resources, were reduced to 29% of those resources and the number of beds in institutions fell by 42%. At the same time, the number of acute psychiatric beds in general hospitals rose by 34%. Formal mechanisms for consumer and carer participation were established by 61% of public mental health organizations. The nongovernmental sector increased its overall share of mental health funding from 2% to 5%, and funds allocated to nongovernmental organizations to provide community support to people with psychiatric disability grew by 200%.

[1] Whiteford H et al. (2000). The Australian mental health system. *International Journal of Law and Psychiatry*, 23(3–4): 403–417.

Developing community mental health services

Community mental health services need to provide comprehensive and locally based treatment and care which is readily accessible to patients and their families. Services should be comprehensive in that they provide a range of facilities to meet the mental health needs of the population at large as well as of special groups, such as children, adolescents, women and elderly people. Ideally, services should include: nutrition; provision for acute admissions to general hospitals; outpatient care; community centres; outreach services; residential homes; respite for families and carers; occupational, vocational and rehabilitation supports; and basic necessities such as shelter and clothing (see Table 4.1). If de-institutionalization is being pursued, community services must be developed in tandem. All the positive functions of the institution should be reproduced in the community without perpetuating the negative aspects.

Three key financing recommendations should be considered. The first is to release resources for the development of community services through partial hospital closure. The second is to use transitional funding for initial investment in new services, to facilitate movement from hospitals to the community. The third is to maintain parallel funding in order to continue the financing of a certain level of institutional care even after community-based services have been established.

Countries face problems in their attempts to create comprehensive mental health care because of the scarcity of funds. Although, in some countries, funds may be redirected or reinvested in community care as a result of de-institutionalization, this is rarely sufficient on its own. In other countries, it may be difficult to divert funds. For example, in South Africa, where budgets are integrated within the various levels of primary, secondary and

Box 4.6 Mental health services: the urban–rural imbalance

The province of Neuquen in **Argentina** provides mental health care to both urban and remote rural communities, but the balance of specialized human mental health resources is still located in the urban centres. Cities have primary care clinics, secondary level psychiatric units in general hospitals and tertiary mental health centres, whereas resident community health workers, fortnightly visits from general practitioners, and local primary health care clinics serve remote rural communities.[1] Similarly, a community-based rehabilitation programme for severely mentally ill patients in the capital city has no counterpart in the rural areas of the province.[2] In **Nigeria**, urban hospitals have more medical personnel and their support facilities function more efficiently in comparison with government hospitals in the country.[3] In **Costa Rica**, most mental health care workers are still concentrated in towns and cities, and the rural regions remain understaffed.[4] Among **Arab countries**, community mental health care facilities are usually found only in the large cities,[5] although **Saudi Arabia** has psychiatric clinics within some of the general hospitals in rural areas.[6] In **India** too, despite the emphasis on developing rural services, most mental health professionals reside in urban areas.[7] In **China**, community service provision is an urban/suburban model, despite the majority of the population being predominantly rural. Community care services in cities are run by neighbourhood and factory committees.[8] In the countries of the **former USSR,** mental health services are still organized by central planning bureaucracies and are clearly demarcated in terms of local and central administration of services. Authority resides at the centre – meaning the urban centres, whereas remote rural areas are obliged to supply services conceived and financed by the central bureaucracy.[9] In **Turkey**, private and public specialist mental health services are available in town and cities, whereas in rural and semi-rural areas patients have to rely on the primary health centre for local mental health services.[10]

[1] Collins PY et al. (1999a). Using local resources in Patagonia: primary care and mental health in Neuquen, Argentina. *International Journal of Mental Health*, 28: 3–16.
[2] Collins PY et al. (1999b). Using local resources in Patagonia: a model of community-based rehabilitation. *International Journal of Mental Health*, 28: 17–24.
[3] Gureje O et al. (1995). Results from the Ibadan centre. In: Üstün TB, Sartorius N, eds. *Mental illness in general health care: an international study*. Chichester, John Wiley & Sons: 157–173.
[4] Gallegos A, Montero F (1999). Issues in community-based rehabilitation for persons with mental illness in Costa Rica. *International Journal of Mental Health*, 28: 25–30.
[5] Okasha A, Karam E (1998). Mental health services and research in the Arab world. *Acta Psychiatrica Scandinavica*, 98: 406–413.
[6] Al-Subaie AS et al. (1997). Psychiatric emergencies in a university hospital in Riyadh, Saudi Arabia. *International Journal of Mental Health*, 25: 59–68.
[7] Srinivasa Murthy R (2000). Reaching the unreached. *The Lancet Perspective*, 356: 39.
[8] Pearson V (1992). Community and culture: a Chinese model of community care for the mentally ill. *International Journal of Social Psychiatry*, 38: 163–178.
[9] Tomov T (1999). Central and Eastern European countries. In: Thornicroft G, Tansella G, eds. *The mental health matrix: a manual to improve services*. Cambridge, Cambridge University Press: 216–227.
[10] Rezaki MS et al. (1995). Results from the Ankara centre. In: Üstün TB, Sartorius N, eds. *Mental illness in general health care: an international study*. Chichester, John Wiley & Sons: 39–55.

Table 4.1 Effects of transferring functions of the traditional mental hospital to community care

Functions of traditional mental hospital	Effects of transfer to community care
Physical assessment and treatment	May be better transferred to primary care or general health services
Active treatment for short-term and intermediate stays	Treatment maintained or improved, but results may not be generalizable
Long-term custody	Usually improved in residential homes for those who need long-term high support
Protection from exploitation	Some patients continue to be vulnerable to physical, sexual and financial exploitation
Day care and out-patient services	May be improved if local, accessible services are developed or may deteriorate if they are not; renegotiation of responsibilities is often necessary between health and social care agencies
Occupational, vocational and rehabilitation services	Improved in normal settings
Shelter, clothing, nutrition and basic income	At risk, so responsibilities and coordination must be clarified
Respite for family and carers	Usually unchanged: place of treatment at home, offset by potential for increased professional support to family
Research and training	New opportunities arise through decentralization

Source: Thornicroft G, Tansella M (2000). *Balancing community-based and hospital-based mental health care: the new agenda*. Geneva, World Health Organization (unpublished document).

tertiary care, even though a policy of de-institutionalization has been adopted it is difficult to move the money spent on hospital care to the primary care or community care level. Even if the money can be shifted out of the hospital budget, there is little guarantee that it will in fact be utilized for mental health programmes at the community level. Because of budgetary restrictions it is clear that comprehensive community care is unlikely to be a viable option without the support of primary and secondary care services.

Integrating mental health care into general health services

The integration of mental health care into general health services, particularly at the primary health care level, has many advantages. These include: less stigmatization of patients and staff, as mental and behavioural disorders are being seen and managed alongside physical health problems; improved screening and treatment, in particular improved detection rates for patients presenting with vague somatic complaints which are related to mental and behavioural disorders; the potential for improved treatment of the physical problems of those suffering from mental illness, and vice versa; and better treatment of mental aspects associated with "physical" problems. For the administrator, advantages include a shared infrastructure leading to cost-efficiency savings, the potential to provide universal coverage of mental health care, and the use of community resources which can partly offset the limited availability of mental health personnel.

Integration requires a careful analysis of what is and what is not possible for the treatment and care of mental problems at different levels of care. For example, early intervention strategies for alcohol are more effectively implemented at the primary care level, but

acute psychosis might be better managed at a higher level to benefit from the availability of greater expertise, investigatory facilities and specialized drugs. Patients should then be referred back to the primary level for ongoing management, as primary health care workers are best placed to provide continuous support to patients and their families.

The specific ways in which mental health should be integrated into general health care will to a great extent depend on the current function and status of primary, secondary and tertiary care levels within countries' health systems. Box 4.7 summarizes experiences of integration of services in Cambodia, India and the Islamic Republic of Iran. For integration to be successful, policy-makers need to consider the following.

- General health staff must have the knowledge, skills and motivation to treat and manage patients suffering from mental disorders.
- There need to be sufficient numbers of staff with the knowledge and authority to prescribe psychotropic drugs at primary and secondary levels.
- Basic psychotropic drugs must be available at primary and secondary care levels.
- Mental health specialists are required to provide support to and monitor general health care personnel.
- Effective referral links between primary, secondary and tertiary levels of care need to be in place.
- Funds must be redistributed from tertiary to secondary and primary levels of care or new funds must be made available.
- Recording systems need to be set up to allow for continuous monitoring, evaluation and updating of integrated activities.

While it is clear that mental health should be financed from the same sources and with the same objectives for distributing the financial burden as health care in general, it is less clear what is the best way to direct funds to mental and behavioural disorders. Once funds have been raised and pooled, the issue arises of how rigidly to separate mental health from other items to be financed out of the same budget, or whether to provide a global budget for some constellation of institutions or services and allow the share used for mental health

Box 4.7 Integration of mental health into primary health care

Organization of mental health services in developing countries began comparatively recently. WHO supported the movement to dispense mental care within general health services in developing countries,[1] and conducted a seven-year feasibility study of integration with primary health care in Brazil, Colombia, Egypt, India, the Philippines, Senegal and Sudan.

A number of countries have used this approach to organize essential mental health services. In developing countries with limited resources, this has meant a new beginning of care for people with mental disorders. **India** started training primary health care workers in 1975, forming the basis of the National Mental Health Programme formulated in 1982. Currently the government supports 25 district level programmes in 22 states.[2] In **Cambodia**, the ministry of health trained a core group of personnel in community mental health, who in turn trained selected general medical staff at district hospitals.[3] In the **Islamic Republic of Iran**, efforts to integrate mental health care started in the late 1980s and the programme has since been extended to the whole country, with services now covering about 20 million people.[4] Similar approaches have been adopted by countries such as Afghanistan, Malaysia, Morocco, Nepal, Pakistan,[5] Saudi Arabia, South Africa, the United Republic of Tanzania, and Zimbabwe. Some studies have been carried out to evaluate the impact of integration, but more are urgently needed.

[1] World Health Organization (1975). *Organization of mental health services in developing countries. Sixteenth report of the WHO Expert Committee on Mental Health, December 1974.* Geneva, World Health Organization (WHO Technical Report Series, No. 564).

[2] Srinivasa Murthy R (2000). Reaching the unreached. *The Lancet Perspective*, 356: 39.

[3] Somasundaram DJ et al. (1999). Starting mental health services in Cambodia. *Social Science and Medicine*, 48(8): 1029–1046.

[4] Mohit A et al. (1999). Mental health manpower development in Afghanistan: a report on a training course for primary health care physicians. *Eastern Mediterranean Health Journal*, 5: 231–240.

[5] Mubbashar MH (1999). Mental health services in rural Pakistan. In: Tansella M, Thornicroft G, eds. *Common mental disorders in primary care*. London, Routledge.

to be determined by demand, local decisions or other factors (bearing in mind that out-of-pocket spending is not pooled and is directed only by the consumer). At one extreme, line-item budgets which specify expenditure on every input for every service or programme are overly rigid and leave no discretion to administrators, so they almost guarantee inefficiency. They cannot readily be used to contract with private providers. Even within public facilities, they can lead to imbalance among inputs and make it hard to respond to changes in demand or need.

In spite of the lack of evidence, it is fair to say that these problems could probably be minimized by assigning global budgets, either to purchasing agencies which can contract out or to individual facilities. The advantages of such budgets include administrative simplicity, the encouragement of multi-agency decision-making, the encouragement of innovation via financial flexibility, and incentives for primary health care providers to collaborate with mental health care providers and to provide care at the primary care level.

However, if there is no budgeting according to end-use and no specific protection for particular services, the share going to mental health may continue to be very low, because of low apparent priority and the false impression that mental health is not important. This is a particular risk when the intention is to reform and expand mental health services relative to more established or better-funded services. To reduce that risk, a specific amount may be allocated to mental health, which cannot easily be diverted to other uses, while still allowing the managers of health facilities some flexibility in setting priorities among problems and treatments. "Ring-fencing" mental health resources in this way may be used to ensure their protection and stability over time. In particular, for countries with minimal current investment in mental health services, ring-fencing may be pertinent for indicating the priority accorded to mental health and for kick-starting a mental health programme. This need not imply a retreat from service organization, nor should it prevent mental health departments sharing in any additional funds that become available for health.

Ensuring the availability of psychotropic drugs

WHO recommends a limited set of essential drugs for the treatment and management of mental and behavioural disorders through its essential drugs list. However, it is common to find that many of these drugs are not available in developing countries. Data from the Atlas project suggest that about 25% of countries do not have commonly prescribed antipsychotic, antidepressant and antiepileptic drugs available at the primary care level.

Governments need to ensure that sufficient funds are allocated to purchase the basic essential psychotropic drugs and distribute them amongst the different levels of care, in accordance with the policy adopted. Where there is a policy of community care and integration into general health services, then not only must essential drugs be available at these levels, but also health workers need to be authorized to administer the drugs at these levels. Even where a primary care approach is adopted for the management of mental problems, a quarter of countries do not have the three essential drugs for the treatment of epilepsy, depression and schizophrenia available at the primary level. Drugs may be purchased under generic names from non-profit organizations, such as ECHO (Equipment for Charitable Hospitals Overseas) and the UNICEF Supply Division in Copenhagen, which supply drugs of good quality at low prices. In addition, WHO and Management Sciences for Health (2001) issue an annual drug price indicator guide of essential drugs, which includes addresses and prices of several reputable suppliers of different psychotropic drugs, at non-profit world-market wholesale prices.

Creating intersectoral links

Many mental disorders require psychosocial solutions. Thus links need to be established between mental health services and various community agencies at the local level so that appropriate housing, income support, disability benefits, employment, and other social service supports are mobilized on behalf of patients and in order that prevention and rehabilitation strategies can be more effectively implemented. In many poor countries, cooperation between sectors is often visible at the primary care level. In Zimbabwe, coordination between academics, public service providers and local community representatives at the primary care level led to the development of a culturally relevant community-based programme to detect, counsel and treat women suffering from depression. In the United Republic of Tanzania, an intersectoral strategy resulted in an innovative agricultural programme to rehabilitate persons suffering from mental and behavioural disorders (see Box 4.8).

Choosing mental health strategies

Regardless of a country's economic situation, there will always seem to be too few resources to fund activities, services and treatments. For mental health, as for health generally, choices must be made among a large number of services and a wide range of prevention and promotion strategies. These choices will, of course, have different effects on different mental health conditions and different population groups in need. But it is important to recognize that choices have ultimately to be made among key strategies, rather than among specific disorders.

What is known about the costs and results of different interventions, particularly in poor countries, is still quite limited. Where evidence does exist, great care must be taken in applying conclusions to settings other than the one that generated the evidence: costs can differ greatly, and so may outcomes, depending on the capacity of the health system to deliver the intervention. Even if more were known, there is no simple formula for deciding which interventions to emphasize, much less for determining how much to spend on each of them. Private out-of-pocket spending is under no one's control but that of the consumers, and private prepayment for mental health care is quite low in all but a few countries.

The crucial decision for governments is how to use public funds. Cost-effectiveness is an important consideration in several circumstances, but is never the only criterion that matters. Public funding also should take account of whether an intervention is a public or partly public good, meaning that it confers costs or benefits on people other than those receiving the service. Although maximizing efficiency in the allocation of resources is desir-

Box 4.8 Intersectoral links for mental health

In the United Republic of Tanzania, psychiatric agricultural rehabilitation villages encapsulate an intersectoral response by local communities, the mental health sector, and the traditional healing sector to the treatment and rehabilitation of people with severe mental illness in rural areas.[1] Patients and relatives live within an existing village population of farmers, fishermen and craftsmen, and are treated by both the medical and traditional healing sectors. Mental health nurses, nursing assistants, and local artisans supervise therapeutic activities; a psychiatrist and a medical social worker provide weekly assistance and consultation; and the involvement of traditional healers depends on the expressed needs of individual patients and relatives. There are also plans for a more formal collaboration between traditional and mental health sectors, including regular meetings and seminars. Traditional healers have participated in community mental health training programmes and shared their knowledge and skills in treating patients; they could play an increased role in managing stress-related disorders in the community.

[1] Kilonzo GP, Simmons N (1998). Development of mental health services in Tanzania: a reappraisal for the future. *Social Science and Medicine*, 47: 419–428.

able, governments will need to trade some efficiency gains to reallocate resources in the pursuit of equity.

While, in general, mental health services should be evaluated and decisions made about public spending on the same basis as for other health services, there appear to be certain significant features that distinguish at least some of the possible interventions. One is that there can be large benefits to controlling some mental disorders. In contrast to the benefits that arise from control of communicable diseases, where treating one case may prevent others and immunization of most of the susceptible population also protects the non-immunized, the benefits arising from mental health care often appear in non-health forms, such as reduced accidents and injuries in the case of alcohol use or lower cost of some social services. These cannot be captured in a cost-effectiveness analysis but require some judgement of the overall social benefit from both health and non-health gains.

Another possibly significant difference derives from the chronic nature of some mental disorders. This makes them – like some chronic physical conditions and unlike acute, unpredictable medical needs – difficult to cover via private insurance and therefore especially appropriate for public insurance, whether explicit (as in social security) or implicit (via general taxation). Finally, while many health problems contribute to poverty, long-term mental disorders are particularly associated with inability to work and therefore with poverty, so that attention to the poor should be emphasized in budgets for mental health services.

Difficult as it may be to work out priorities from the variety of relevant criteria, any rational consideration of the issues just mentioned offers the opportunity to improve on arbitrary or merely historical allocation of resources. This is especially true if mental health care is to get substantially more public resources: expansion in equal proportions of whatever is currently financed is unlikely to be either efficient or equitable. Needs-based allocation is a more equitable means for distributing resources, but it presupposes agreement on a definition of "need". Moreover, needs by themselves are not priorities, because not every need corresponds to an effective intervention – apart from the fact that what people need, and what they want or demand, may not coincide. This is a problem even for physical health problems when the consumer is competent to express his or her demand; it becomes more complicated when some mental disorder limits that competence.

As emphasized above, financing intended for mental health has actually to be devoted to services, and whether this occurs may depend on how funds are organized through budgets or purchasing agreements. One technique for making that connection is to specify some mental health services, chosen on the basis of the criteria just described, as part of an overall package of basic or essential interventions which the public sector in effect promises to finance, whether or not the budget specifies the amount to be devoted to each such service. The same approach can in principle be used in the regulation of private insurance, requiring insurers to include certain mental health services in the basic package that all clients' policies will cover. Because insurers have a strong incentive to select clients on the basis of risk (and potential clients have a strong incentive to hide their known risks and purchase insurance against them), it is much harder to enforce such a package in the private than in the public sector. Nonetheless some countries – Brazil and Chile are examples among middle-income countries – require private insurers to offer the same services that are guaranteed by public finance. Whether such a course is feasible in much poorer countries is doubtful because of the much lower coverage of private insurance and the lower regulatory capacity of governments. Deciding how far to try to impose public priorities on private payers or providers is always a complex question, perhaps more so for mental health

than for physical problems. Data from Atlas show that insurance as a primary source of funding for mental health care is present only in about one-fifth of countries.

Purchasing versus providing: public and private roles

The foregoing discussion emphasizes the financial role of the public sector, even when it accounts for only a small share of total health spending, because that is where the desirable reforms in mental health seem easiest to undertake and because some features of mental health services are particularly suited to public funding. But there is no necessary connection between public money and public provision, although traditionally most governments have spent most or all of their health funds on their own providing institutions. Both because of the move towards decentralization and because giving public facilities a monopoly on public resources removes any competitive stimulus to efficiency or more responsive service, there is an increasing split in some countries between purchasing and provision of services, (WHO 2000c, Chapter 3).

While the theoretical benefits of introducing more competition and regulation as substitutes for direct public provision are clear, evidence on the success of such arrangements is still scanty. Developing countries often lack the resources and experience to regulate contractual arrangements between health care purchasers and providers, and to enforce the delivery of the services agreed upon in the contract when these services are perceived to be a low priority by the provider. Without such controls there is great potential for waste and even fraud. If this is the case for contracts with service providers for general health services, mental health services may be still more difficult to contract effectively because of the greater difficulty of measuring outcomes. In countries where mental health services have been previously unavailable or were only provided directly by the health department, a separate detailed contract for mental health services may be necessary. For all these reasons, separating funding from providing should be approached cautiously where mental health services are concerned. Nonetheless it is worth considering whenever there are nongovernmental or local government providers able to take over provision and there is enough capacity to supervise them. In many countries, public health outpatient facilities offer no mental health services because of a funding emphasis on hospital inpatient care. Separation of funding and provision may therefore be especially valuable as a way to promote the desirable shift from public psychiatric hospitals to care provided in the community. Shifting the public budget priority without involving nongovernmental providers may even be essentially impossible because of internal resistance to innovation and lack of the required skills and experience.

Where substantial private provision exists and is paid for privately without public funding or regulation, several problems arise that call for the exercise of stewardship. There is likely to be inadequate referral between unregulated mental health service providers such as traditional healers and outpatient mental health services located in primary care and district hospitals. The poor may consume large amounts of low-quality mental health care from unregulated private mental health care providers such as drug sellers, traditional healers, and unqualified therapists. The inability of government health departments to enforce the regulation of private outpatient services leaves users vulnerable to financial exploitation and ineffective treatment procedures for mental ailments that are not addressed by the public health system. Contracts for primary and secondary providers, guidelines for mental health service items and costs, and accreditation of the different ambulatory mental health care providers are potential responses to these problems that do not require governments to expand spending massively or take on all the responsibility for provision.

Governments should also consider regulating specific provider groups within the informal health sector, such as traditional healers. Such regulation might include the introduction of practice registration to protect patients from harmful interventions and to prevent fraud and financial exploitation. Considerable progress in integrating traditional medicine into general health policy is being made in China, Viet Nam and Malaysia (Bodekar 2001).

Managed care, an important health care delivery system in the United States, combines the role of purchasing and financing health care for a defined population. A major concern is that managed care concentrates more on cost reduction than on service quality, and that it shifts the costs of care, for those who cannot afford insurance, from the public health system to families or charitable institutions (Hoge et al. 1998; Gittelman 1998). For mental and behavioural disorders, managed care efforts to date have often failed to provide an adequate response to the need for medical treatment combined with a long-term social support and rehabilitation strategy, although there have been some notable exceptions. Furthermore, the expertise, skills, and comprehensiveness of services required by a managed care system are beyond the current capabilities of most developing countries (Talbott 1999).

Developing human resources

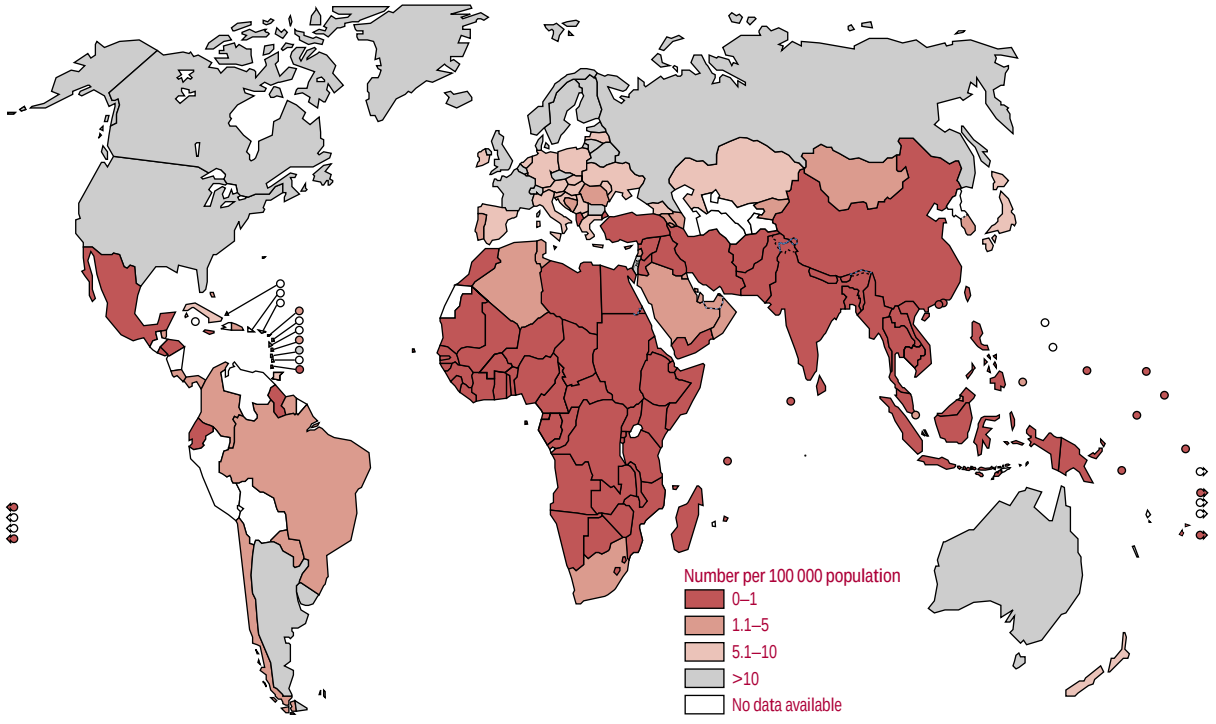
In developing countries, the lack of specialists and health workers with the knowledge and skills to manage mental and behavioural disorders is an important barrier to providing treatment and care.

If health systems are to advance, time and energy need to be invested in assessing the numbers and types of professionals and workers required in the years to come. The ratio of mental health specialists to general health workers will vary according to existing resources and approaches to care. With the integration of mental health care into the general health system, the demand for generalists with training in mental health will increase and that for specialists will decrease, although a critical mass of mental health specialists will always be required to effectively treat and prevent these disorders.

There is a wide disparity in the type and numbers of the mental health workforce throughout the world. The median number of psychiatrists varies from 0.06 per 100 000 population in low income countries to 9 per 100 000 in high income countries (Figure 4.4). For psychiatric nurses, the median ranges from 0.1 per 100 000 in low income countries to 33.5 per 100 000 in high income countries (Figure 4.5). In almost half the world, there is fewer than one neurologist per million people. The situation for providers of care for children and adolescents is far worse.

The health workforce likely to be involved with mental health consists of general physicians, neurologists and psychiatrists, community and primary health care workers, allied mental health professionals (such as nurses, occupational therapists, psychologists and social workers), as well as other groups such as the clergy and traditional healers. Traditional healers are the main source of assistance for at least 80% of rural inhabitants in developing countries. They can be active case finders, and can facilitate referral and provide counselling, monitoring and follow-up care. The adoption of a system of integrated community-based care will require a redefinition of the roles of many health providers. A general health care worker may now have the additional responsibility of identifying and managing mental and behavioural disorders in the community, including screening and early intervention for tobacco, alcohol and other drug use, and a psychiatrist previously working in an institution may need to provide more training and supervision when moved to a community setting.

Figure 4.4 Number of psychiatrists per 100 000 population, 2000[a]

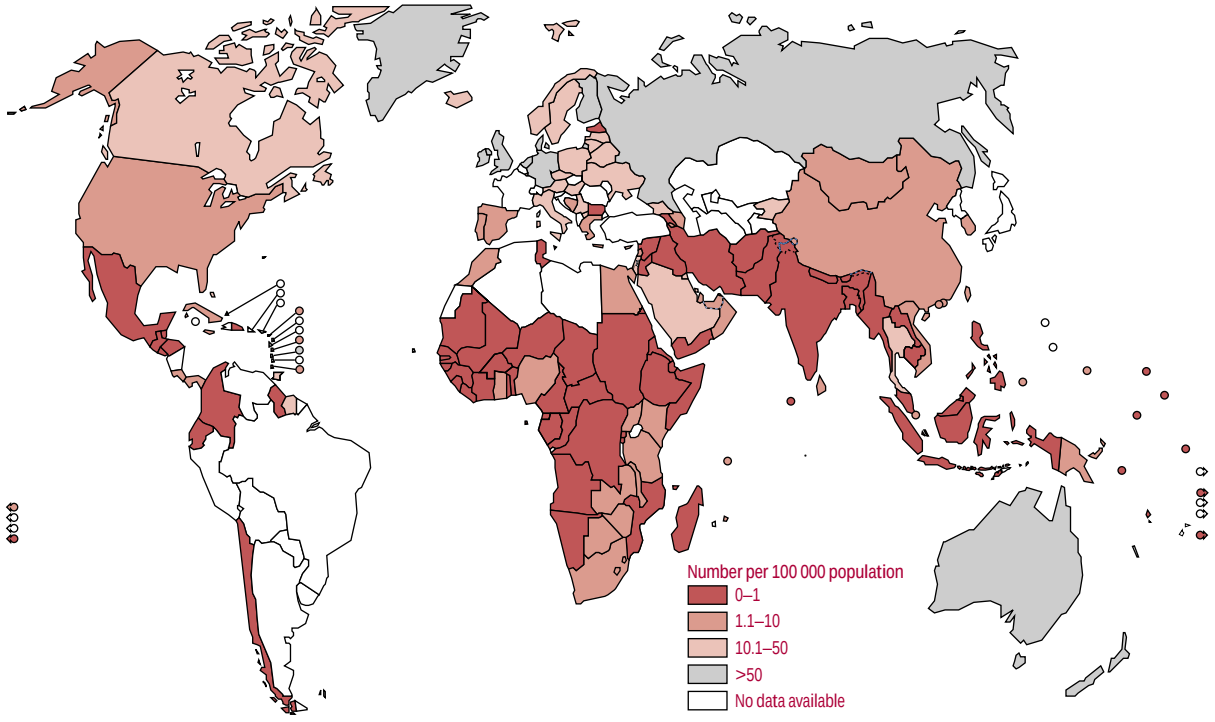


[a] Based on information from 177 Member States.
Source: *Mental health resources in the world. Initial results of Project Atlas* (2001). Geneva, World Health Organization.

Decentralization of mental health services is also likely to have an impact on roles and responsibilities through the transfer of management and administration responsibilities to the local level. Redefinition of roles needs to be explicit, in order to ensure that new responsibilities are adopted more readily. Training is also required to provide the skills necessary to carry out new roles and responsibilities. Undoubtedly, the changing of roles will bring issues of power and control to the forefront, and these will act as barriers to change. For example, psychiatrists perceive and resist their own loss of power when other less experienced health workers are given the authority to manage mental disorders.

In developed and developing countries alike, undergraduate medical curricula need to be updated to ensure that graduating physicians are skilled in diagnosing and treating persons suffering from mental disorders. Recently Sri Lanka expanded the duration of training in psychiatry and included it as an examination subject in undergraduate medical education. Allied health professionals, such as nurses and social workers, require training to understand mental and behavioural disorders and the range of treatment options available, focusing on those areas most relevant to their work in the field. All courses should incorporate the application of evidence-based psychosocial strategies, and skill-building in the areas of administration and management, policy development and research methods. In developing countries, higher level educational opportunities are not always available; instead training is often undertaken in other countries. This has not always led to satisfactory outcomes: many trainees sent abroad do not return to their own countries and consequently their expertise is lost to the developing society. This needs to be addressed in the long term, through the setting up of centres of excellence for training and education within countries.

Figure 4.5 Number of psychiatric nurses per 100 000 population, 2000[a]



[a] Based on information from 157 Member States.
Source: *Mental health resources in the world. Initial results of Project Atlas* (2001). Geneva, World Health Organization.

One promising approach is the use of the Internet to provide training and quick feedback by specialists on clinical diagnosis and management matters. Internet access is increasing rapidly in developing countries. Three years ago, only 12 countries in Africa had Internet access; now it is available in all African capital cities. Training must now include the use of information technology (Fraser et al. 2000).

PROMOTING MENTAL HEALTH

A wide range of strategies is available to improve mental health and prevent mental disorders. These strategies can also contribute to the reduction of other problems such as youth delinquency, child abuse, school dropout and work days lost to illness.

The most appropriate entry point for mental health promotion will depend both on needs and on the social and cultural context. The scope and level of activities will vary from local through to national levels as will the specific types of public health action taken (development of services, policy, dissemination of information, advocacy and so on). Examples are provided below of different entry points for intervention.

Interventions targeting factors determining or maintaining ill-health. Psychosocial and cognitive development of babies and infants depend upon their interaction with their parents. Programmes that enhance the quality of these relations can substantially improve the emotional, social, cognitive and physical development of children. For example, the USA programme Steps Towards Effective Enjoyable Parenting (STEEP) targeted first-time mothers and others with parenting problems, particularly in families with a low educational level (Erickson 1989). There was evidence of reductions in anxiety and depression in mothers,

better-organized family life, and the creation of more stimulating environments for children.

Interventions targeting population groups. By 2025, there will be 1.2 billion people in the world who are over 60 years of age, close to three-quarters of them in the developing world. But if ageing is to be a positive experience it must be accompanied by improvements in the quality of life of those who have reached old age.

Interventions targeting particular settings. Schools are crucial in preparing children for life, but they need to be more involved in fostering healthy social and emotional development. Teaching life-skills such as problem-solving, critical thinking, communication, interpersonal relations, empathy, and methods to cope with emotions will enable children and adolescents to develop sound and positive mental health (Mishara & Ystgaard 2000).

A child-friendly school policy which encourages tolerance and equality between boys and girls and different ethnic, religious and social groups will promote a sound psychosocial environment (WHO 1990). It promotes active involvement and cooperation, avoids the use of physical punishment, and does not tolerate bullying. It helps to establish connections between school and family life, encourages creativity as well as academic abilities, and promotes the self-esteem and self-confidence of children.

Raising public awareness

The single most important barrier to overcome in the community is the stigma and associated discrimination towards persons suffering from mental and behavioural disorders.

Tackling stigma and discrimination requires a multilevel approach involving education of health professionals and workers, the closing down of psychiatric institutions which serve to maintain and reinforce stigma, the provision of mental health services in the community, and the implementation of legislation to protect the rights of the mentally ill. Fighting stigma also requires public information campaigns to educate and inform the community about the nature, extent and impact of mental disorders in order to dispel common myths and encourage more positive attitudes and behaviours.

Role of the mass media

The various forms of the mass media can be used to foster more positive community attitudes and behaviours towards people with mental disorders. Action can be taken to monitor, remove or prevent the use of images, messages or stories in the media that potentially would have negative consequences for persons suffering from mental and behavioural disorders. The media can also be used to inform the public, to persuade or motivate individual attitude and behaviour change, and to advocate for change in social, structural and economic factors that influence mental and behavioural disorders. Advertising, although expensive, is useful for increasing awareness of issues and events and for neutralizing misperceptions. Publicity is a relatively cheaper way to create news to attract the attention of the public and to frame issues and actions to achieve advocacy. The placement of educational health or social messages in the entertainment media (so-called "edutainment"), is useful for promoting change in attitudes, beliefs and behaviours.

Examples of public information campaigns which have used the media to overcome stigma include "Changing minds – every family in the land" by the Royal College of Psychiatrists in the UK and the World Psychiatric Association's campaign "Open the doors" (see Box 4.9).

The Internet is a powerful tool for communication and accessing mental health information. It is increasingly being used as a means to inform and educate patients, students, health professionals, consumer groups, nongovernmental organizations and the population at large about mental health; to host self-help and discussion groups; and to provide clinical care. With the Internet as source of information, the community will be more knowledgeable and as a consequence will have greater expectations regarding the treatment and care they receive from providers. On the negative side, they will have to analyse and understand a vast amount of complex literature, of varying degrees of accuracy (Griffiths & Christensen 2000). Increasingly, Internet users will expect to receive easy access to treatment and consultation from health professionals, including mental health care providers, ranging from simple inquiries to more sophisticated video-based consultations or telemedicine.

Major challenges are to use this information technology to benefit mental health in developing countries. This requires improved access to the Internet (fewer than one million people of a total of 700 million have access to it in Africa) and the availability of mental health information in a variety of languages.

Using community resources to stimulate change

Although stigma and discrimination have their origin in the community, it should not be forgotten that the community can also be an important resource and setting for tackling their causes and effects and, more generally, for improving the treatment and care provided to persons suffering from mental and behavioural disorders.

The role of the community can range from the provision of self-help and mutual aid to lobbying for changes in mental health care and resources, carrying out educational activities, participating in the monitoring and evaluation of care, and advocacy to change attitudes and reduce stigma.

Nongovernmental organizations are also a valuable community resource for mental health. They are often more sensitive to local realities than are centrally driven programmes,

Box 4.9 Fighting stigma

"Open the doors" is the first-ever global programme against stigma and discrimination associated with schizophrenia. Launched by the World Psychiatric Association in 1999,[1,2] the goals are to increase awareness and knowledge about the nature of schizophrenia and treatment options; to improve public attitudes to people who have or have had schizophrenia and their families; and to generate action to eliminate stigma, discrimination and prejudice.

The Association has produced a step-by-step guide to developing an anti-stigma programme, and reports on the experience of countries that have undertaken the programme, as well as collecting information from around the world on other anti-stigma efforts. The materials have been put to trial use in Austria, Canada, China, Egypt, Germany, Greece, India, Italy and Spain, and other sites are starting to work on the programme as well. In each of the sites, a programme group has been established involving representatives of government and nongovernmental organizations, journalists, health care professionals, members of patient and family organizations, and others committed to fighting stigma and discrimination. The results of programmes from different countries are added to the global database, so that future efforts benefit from previous experience. In addition, the Association has produced a compendium of the latest information available on the diagnosis and treatment of schizophrenia, and strategies for reintegration of affected individuals into the community.

The stigma attached to schizophrenia creates a vicious cycle of alienation and discrimination – leading to social isolation, inability to work, alcohol or drug abuse, homelessness, or excessive institutionalization – which decreases the chance of recovery and normal life. "Open the doors" will allow people with schizophrenia to return to their families and to school or the workplace, and to face the future with hope.

[1] Sartorius N (1997). Fighting schizophrenia and its stigma. A new World Psychiatric Association educational programme. *British Journal of Psychiatry*, 170: 297.
[2] Sartorius N (1998a). Stigma: what can psychiatrists do about it? *The Lancet*, 352(9133): 1058–1059.

and are usually strongly committed to innovation and change. International nongovernmental organizations help in the exchange of experiences and function as pressure groups, while nongovernmental organizations in countries are responsible for many of the innovative programmes and solutions at the local level. They often play an extremely important role in the absence of a formal or well-functioning mental health system, filling the gap between community needs and available community services and strategies (see Box 4.10).

Consumer groups have emerged as a powerful, vocal and active force, often dissatisfied with the established provision of care and treatment. These groups have been instrumental in reforming mental health (WHO 1989). There now exist in many parts of the world a large number of consumer associations with interests, commitments and involvement in the mental health area. They range from informal loose groupings to fully fledged constitutionally and legally created organizations. Although they have differing aims and objectives, they all strongly advocate the consumer's viewpoint.

Authorities responsible for delivering services, treatment and care are accountable to the consumers of the system. One important step towards achieving accountability is to involve consumers in the creation of services, in reviewing hospital standards, and in the development and implementation of policy and legislation.

In many developing countries, families play a key role in caring for the mentally ill and in many ways they are the primary care providers. With the gradual closure of mental hospitals in countries with developed systems of care, responsibilities are also shifting to families. Families can have a positive or negative impact by virtue of their understanding, knowledge, skills and ability to care for the person affected by mental disorders. For these reasons, an important community-based strategy is to help families to understand the illness, encourage medication compliance, recognize early signs of relapse, and ensure swift

Box 4.10 The Geneva Initiative

The Geneva Initiative on Psychiatry was founded in 1980 to combat the political abuse of psychiatry as a tool of repression. Despite its name, the international Initiative is based in the Netherlands.

The All-Union Society of Psychiatrists and Neuropathologists (AUSPN) of the former USSR withdrew from the World Psychiatric Association (WPA) in early 1983 in response to pressure from campaigns by the Geneva Initiative, and in 1989 the WPA Congress set strict conditions for its return. The Russian Federation acknowledged that psychiatry had been abused for political purposes and invited the WPA to send a team of observers to Russia. At the same time, increasing numbers of psychiatrists contacted the Geneva Initiative to assist them in reforming mental health care. By then, the situation was changing dramatically: in the preceding two years, virtually all political prisoners had been released from prisons, camps, exile and psychiatric hospitals.

Between 1989 and 1993 the Initiative concentrated on a few Eastern European countries, particularly Romania and Ukraine. It became clear that a new approach to the mental health reform movement was needed. Though many reforms had been undertaken throughout the region and many people had acquired new skills and knowledge, no links existed among the reformers, and there was a lack of trust and unity. With financial support from the Soros Foundation, the first meeting of Reformers in Psychiatry was organized in Bratislava, Slovakia, in September 1993. Since then, over 20 similar network meetings have taken place.

Today, the Network of Reformers unites some 500 mental health reformers in 29 countries of Central and Eastern Europe and the newly independent states, and has links with over 100 nongovernmental mental health organizations. Its members are psychiatrists, psychologists, psychiatric nurses, social workers, sociologists, lawyers, relatives of people with mental disorders, and a growing number of consumers of mental health services. Mostly through this Network, the Geneva Initiative now operates in over 20 countries, where it manages about 150 projects.

The Geneva Initiative strives for structural improvement, and thus concentrates on programmes concerned with reform of policy, institutional care and education. It aims to combat inertia and to achieve sustainability and maintain funding. Last year, the Initiative was awarded the Geneva Prize for Human Rights in Psychiatry.

More information about the Initiative can be found on the web site http://www.geneva-initiative.org/geneva/index.htm

resolution of crisis. This will lead to better recovery, and reduce social and personal disability. Visiting community nurses and other health workers can provide an important supportive role, as can networks of self-help groups for families and direct financial support.

A couple of cautionary notes are warranted. First, the erosion of the extended family in developing countries, coupled with migration to cities, presents a challenge to planners to utilize this resource for the care of patients. Second, when the family environment is not conducive to good quality care and support, and in fact may be damaging, a family solution may not be a viable option.

Involving other sectors

War, conflict, disasters, unplanned urbanization, and poverty are not only important determinants of mental ill-health but are also significant barriers to reducing the treatment gap. For example, war and conflict can destroy national economies and health and welfare systems, and can traumatize entire populations. With poverty comes an increased need for health and community services but a limited budget to develop comprehensive mental health services at the national level and a reduced ability to pay for these services at the individual level.

Mental health policy can partially address the effects of environmental determinants by meeting the special needs of vulnerable groups and ensuring that strategies are in place to prevent exclusion. But because many of the macro-determinants of mental health cut across almost all government departments, the extent of improvement in mental health of a population is also in part determined by the policies of other government departments. In other words, other government departments are responsible for some of the factors involved in mental and behavioural disorders, and should take responsibility for some of the solutions.

Intersectoral collaboration between government departments is fundamental in order for mental health policies to benefit from mainstream government programmes (see Table 4.2). In addition, mental health input is required to ensure that all government activities and policies contribute to and do not detract from mental health. Policies should be analysed for their mental health implications before being implemented, and all government policies should address the specific needs and issues of persons suffering from mental disorders. Some examples are provided below.

Labour and employment

The work environment should be free from all forms of discrimination as well as sexual harassment. Acceptable working conditions have to be defined and mental health services provided, either directly or indirectly through employee assistance programmes. Policies should maximize employment opportunities for the population as a whole, and retain people in the workforce, particularly because of the association between job loss and the increased risk of mental disorders and suicide. Work should be used as a mechanism to reintegrate persons with mental disorders into the community. People with severe mental disorders have higher unemployment rates than people with physical disabilities. Government policy can be instrumental in providing incentives for employers to employ persons with severe mental disorders and enforcing anti-discrimination policy. In some countries, employers are obliged to hire a certain percentage of disabled persons as part of their workforce. If they fail to do so, a fine can be imposed.

Table 4.2 Intersectoral collaboration for mental health

Government sector	Opportunities for improving mental health
Labour and employment	• Create a positive work environment free from discrimination, with acceptable working conditions and employee assistance programmes • Integrate people with severe mental illness into the workforce • Adopt policies that encourage high levels of employment, maintain people within the workforce, and assist the unemployed
Commerce	• Adopt policies of economic reform which reduce relative poverty as well as absolute poverty • Analyse and correct any potentially negative impact of economic reform on unemployment rates
Education	• Implement policies to prevent attrition before completion of secondary school education • Introduce anti-discrimination policies in schools • Incorporate life skills into the curriculum, to ensure child-friendly schools • Address the requirements of children with special needs, e.g. those with learning disabilities
Housing	• Give priority to housing people with mental disorders • Establish housing facilities (such as halfway houses) • Prevent discrimination in location of housing • Prevent geographical segregation
Social welfare services	• Consider the presence and severity of mental illness as priority factors for the receipt of social welfare benefits • Make benefits available to family members when they are the main carers • Train the staff of social welfare services
Criminal justice system	• Prevent the inappropriate imprisonment of people with mental disorders • Make treatment for mental and behavioural disorders available within prisons • Reduce the mental health consequences of confinement • Train staff throughout the criminal justice system

COMMERCE AND ECONOMICS

Some economic policies may negatively affect the poor, or lead to increased rates of mental disorders and suicide. Many of the economic reforms under way in countries have as a major goal the reduction of poverty. Given the association between poverty and mental health, it might be expected that these reforms would reduce mental problems. However, mental disorders are not only related to absolute poverty levels but also to relative poverty. The mental health imperatives are clear: inequalities must be reduced as part of strategies to increase absolute levels of income.

A second challenge is the potential adverse consequences of economic reform on unemployment rates. In many countries undergoing major economic restructuring, for example, Hungary (Kopp et al. 2000) and Thailand (Tangchararoensathien et al. 2000), reform has led to high job losses and an associated increase in the rates of mental disorders and suicides. Any economic policy involving restructuring must be evaluated in terms of its potential impact on employment rates. If there are potentially adverse consequences, then these policies need to be reconsidered or strategies need to be put in place to minimize the impact.

Education

An important determinant of mental health is education. While current efforts focus on increasing the numbers of children attending and completing primary school, the main risk for mental health is more likely to result from a lack of secondary-school education (10–12 years of schooling) (Patel 2001). Strategies for education therefore need to prevent attrition prior to the completion of secondary school. The relevance of the type of education offered, freedom from discrimination at school, and the needs of special groups, for example children with learning disabilities, also need to be considered.

Housing

Housing policy can support mental health policy by giving priority to mentally ill people in state housing schemes, providing subsidized housing schemes and, where practical, mandating local authorities to establish a range of housing facilities such as halfway homes and long-stay supported homes. Most importantly, housing legislation must include provisions to prevent the geographical segregation of mentally ill people. This requires specific provisions to prevent discrimination in siting and allocation of housing as well as health facilities for persons with mental disorders.

Other social welfare services

The type, range and extent of other social welfare services varies across and within countries and is partly dependent on levels of income and the general attitude of the community towards groups in need.

Policies for social welfare benefits and services should incorporate a number of strategies. First, the disability resulting from mental illness should be one of the factors taken into account in setting priorities among groups receiving social welfare benefits and services. Second, under some circumstances, social welfare benefits should also be available to families that provide the care and support to family members suffering from mental and behavioural disorders. Third, staff working in the various social services need to be equipped with the knowledge and skills to recognize and assist people with mental disorders as part of their daily work. In particular they should be able to evaluate when and how to refer the more severe problems to specialized services. Fourth, welfare benefits and services need to be mobilized for groups likely to be adversely affected by the implementation of economic policy.

Criminal justice system

People with mental disorders often come into contact with the criminal justice system. In general, there is an over-representation of people with mental disorders and vulnerable groups in prisons, in a number of cases because of lack of services, because their behaviour is seen as disorderly and because of other factors such as drug-related crime and driving under the influence of alcohol. Policies should be put in place to prevent the inappropriate imprisonment of the mentally ill and to facilitate their referral or transfer to treatment centres instead. Furthermore, treatment and care for mental and behavioural disorders should be routinely available within prisons, even when imprisonment is appropriate. International standards with regard to the treatment of prisoners are set out in the Standard Minimum Rules for the Treatment of Prisoners which provide that the services of at least one qualified medical officer “who should have some knowledge of psychiatry” shall be avail-

able at every institution (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 1957 and 1977).

Policy concerning the confinement of vulnerable groups needs to be examined in relation to the increased risk of suicide, and there needs to be a training strategy to improve the knowledge and skills of staff in the criminal justice system to enable them to manage mental and behavioural disorders.

PROMOTING RESEARCH

Although knowledge of mental and behavioural disorders has increased over the years, there still remain many unknown variables which contribute to the development of mental disorders, their course and their effective treatment. Alliances between public health agencies and research institutions in different countries will facilitate the generation of knowledge to help in understanding better the epidemiology of mental disorders, and the efficacy, effectiveness and cost-effectiveness of treatments, services and policies.

EPIDEMIOLOGICAL RESEARCH

Epidemiological data are essential for setting priorities within health and within mental health, and for designing and evaluating public health interventions. Yet there is a paucity of information on prevalence and the burden of major mental and behavioural disorders in all countries, particularly in developing countries. Similarly, longitudinal studies examining the course of major mental and behavioural disorders and their relationship with psychosocial, genetic, economic and other environmental determinants are lacking. Epidemiology, amongst other things, is also an important tool for advocacy, but the fact remains that many countries lack data to support advocacy for mental health.

TREATMENT, PREVENTION AND PROMOTION OUTCOME RESEARCH

The burden of mental and behavioural disorders will only be reduced if effective interventions are developed and disseminated. Research is needed to develop more effective drugs which are specific in their action and which have fewer adverse side-effects, more effective psychological and behavioural treatments, and more effective prevention and promotion programmes. Research is also needed on their cost-effectiveness. More knowledge is required to understand what treatment, either singly or in combination, works best and for whom. Adherence to a treatment, prevention or promotion programme can directly affect outcomes, and research is also needed to help understand those factors affecting adherence. This would include examination of factors related to: the beliefs, attitudes and behaviours of patients and providers; the mental and behavioural disorder itself; the complexity of the treatment regime; the service delivery system, including access and treatment affordability; and some of the broad determinants of mental health and ill-health, for example, poverty.

There remains a knowledge gap concerning the efficacy and effectiveness of a range of pharmacological, psychological and psychosocial interventions. While ***efficacy research*** refers to the examination of an intervention's effect under highly controlled experimental conditions, ***effectiveness research*** examines the effects of interventions in those settings or

conditions in which the intervention will ultimately be delivered. Where there is an established knowledge base concerning the efficacy of treatments, as is the case for a number of psychotropic drugs, there needs to be a shift in research emphasis towards the conduct of effectiveness research. In addition, there is an urgent need to carry out ***implementation or dissemination research*** into those factors likely to enhance the uptake and utilization of effective interventions in the community.

Policy and service research

Mental health systems are undergoing major reforms in many countries, including de-institutionalization, the development of community-based services, and integration into the overall health system. Interestingly, these reforms were initially stimulated by ideology, the development of new pharmacological and psychotherapeutic treatment models, and the belief that alternative forms of community treatment would be more cost-effective. Fortunately there is now an evidence base, derived from a number of controlled studies, demonstrating the effectiveness of these policy objectives. Most of the research to date has, however, been generated in industrialized countries and it is questionable whether results can be generalized to developing countries. Research is therefore needed to guide reform activities in developing countries.

Given the critical importance of human resources for administering treatments and delivering services, research needs to examine the training requirements for mental health providers. In particular, there is a need for controlled research on the longer term impact of training strategies, and the differential effectiveness of training strategies for different health providers working at different levels of the health system.

Research is also needed to understand better the important role played by the informal sector and if, how and in what ways the involvement of the traditional healers can either enhance or adversely affect treatment outcomes. For example, how can primary health care staff better collaborate with traditional healers in order to improve access, identification and successful treatment of persons suffering from mental and behavioural disorders? More research is required to understand better the effects of different types of policy decisions on access, equity and treatment outcomes, both overall and for the most disadvantaged groups. Examples of research areas include the type of contracting arrangement between purchasers and providers that would lead to better mental health service delivery and patient outcomes, the impact of different methods of provider reimbursement schemes on access and use of mental health services, and the impact of integrating budgets for mental health into general health financing systems.

Economic research

Economic evaluations of treatment, prevention and promotion strategies will provide useful information to support rational planning and choice of interventions. Although there have been some economic evaluations of interventions for mental and behavioural disorders (for example, schizophrenia, depressive disorders and dementia), economic evaluations of interventions in general tend to be scarce. Again the overwhelming majority come from industrialized countries.

In all countries, there is a need for more research on the costs of mental illness and for economic evaluations of treatment, prevention and promotion programmes.

Research in developing countries and cross-cultural comparisons

In many developing countries there is a notable lack of scientific research on mental health epidemiology, services, treatment, prevention and promotion, and policy. Without such research, there is no rational basis to guide advocacy, planning and intervention (Sartorius 1998b, Okasha & Karam 1998).

Despite many similarities of mental problems and services across countries, the cultural context in which they occur can differ substantially. Just as programmes need to be culturally informed, so does research. Research tools and methods should not be imported from one country to another without careful analysis of the influence and effect of cultural factors on their reliability and validity.

WHO has developed a number of transcultural research tools and methods including the Present State Examination (PSE), Schedule for Comprehensive Assessment in Neuropsychiatry (SCAN), Composite International Diagnostic Interview (CIDI), Self Reporting Questionnaire (SRQ), International Personality Disorder Examination (IPDE), Diagnostic Criteria for Research (ICD-10DCR), World Health Organization Quality of Life Instrument (WHOQOL), and World Health Organization Disability Assessment Schedule (WHODAS) (Sartorius & Janca 1996). These and other scientific tools need to be further developed to allow valid international comparisons that will help in understanding the commonalities and differences in the nature of mental disorders and their management across different cultures.

One lesson of the past 50 years is that tackling mental disorders involves not only public health but also science and politics. What can be achieved by good public health policy and science can be destroyed by politics. If the political environment is supportive of mental health, science is still needed to advance understanding of the complex causes of mental disorders, and to improve their treatment.