

**Expert Opinion on Barriers and Facilitating  
Factors for the Implementation of Existing Mental  
Health Knowledge in Mental Health Services**

**2007**



**Department of Mental Health and Substance Abuse**

# Acknowledgements

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## Summary

During the past decade, there has been a lack of substantial progress in mental health care in most low- and middle-income (LAMI) countries, despite the publication of a number of high-profile reports.

The authors surveyed a range of international experts in an attempt to understand why change has been lacking and to inform recommendations for how to move forward. Experts included civil society leaders (with and without mental health training), current and former senior government decision-makers on mental health, international consultants, general public health experts and academics. Of the 60 experts approached, 50 (83.3%) responded; in addition, seven experts responded spontaneously. Between them, they provided over 90,000 words of expert opinion. A thematic analysis of their responses was conducted by two independent data analysts to extract key themes.

The respondents identified barriers and corresponding facilitating factors for implementing mental health knowledge in mental health services. They explained the lack of funds for mental health services as being due to a number of factors, including inadequate coordinated, consensus-based national mental health advocacy and plans, the fact that mental health is not included in major donor priorities, the marketing of expensive pharmaceuticals by industry and cost-effectiveness information on mental health services that is unconvincing to senior decision-makers, among others.

In line with longstanding policy recommendations, most respondents suggested that large mental hospitals should be downsized, and that community mental health services should be developed to provide accessible mental health care, including acute inpatient care, in the community.

Most respondents outlined a range of political, financial and workforce- and leadership-related barriers to decentralizing resources from mental hospitals to care in the community. Moreover, they emphasized the existence of substantial challenges in achieving effective mental health care in primary health care settings in the absence of strong training, supervision and referral schemes.

Most respondents suggested developing a system that involves both primary health care and secondary (community-based) mental health services, interacting closely. In addition, many respondents mentioned integrating mental health care into specific disease-related programmes, such as HIV care, as well as linking with and building on resources outside the health sector.

Respondents recommended that the very few available psychiatrists in LAMI countries – encouraged by appropriate incentives – should focus their efforts away from clinical care towards training and supervising formal/non-formal mental/general healthcare providers, thereby facilitating the implementation of a mixed care model through a much-needed expanded workforce for mental health.

To further address the enormous barrier of an understaffed mental health workforce, many respondents suggested the mobilization of families, community members or ex-service users in rehabilitation.

A deficit in public mental health leadership was seen as a major barrier that may be addressed by means of education in public mental health, incentives for public health leadership and international exchange.

Many of the barriers to progress in developing mental health services can be overcome if there is greater political will. To achieve this, advocates for people with mental disorders need to collaborate and to substantially improve on their advocacy. There is a need to overcome resistance to decentralization of resources. It is inferred that mental health investments in primary care are unlikely to be sustained unless they are preceded by, or at least implemented in tandem with, the development of community mental health services, to allow for the training, supervision and support of primary care workers.

There is a need to step up mobilization and recognition of non-formal resources in the community – including community members without formal professional training, people with disorders themselves and their family members – to partake in advocacy and service delivery. Population-wide progress in access to humane mental health care will require substantially more attention to politics, leadership, planning, advocacy and participation.

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## 1. Introduction

The World Health Organization's *World Health Report 2001* raised awareness of the global burden of mental disorders, demonstrated that most mental disorders can be treated effectively, highlighted that (in 2001) very limited resources were dedicated to mental health and made ten broad recommendations to be adapted for action.<sup>2</sup> However, since the appearance of this report and those of a range of other high-profile publications – such as the Institute of Medicine's *Neurological, psychiatric, and developmental disorders: Meeting the challenge in the developing world* (2001)<sup>3</sup> and *World mental health: Problems and priorities in low-income countries* (1995)<sup>4</sup> – very little has changed in mental health care provision in most countries.<sup>5</sup> This document seeks to address the question of why appropriate changes have not been made, despite the evidence.

This document presents an analysis of expert opinions on the barriers and facilitating factors for the implementation of mental health knowledge in mental health services. Throughout, the original words of these leaders in their field have been reproduced so as to serve as a resource for public mental health practitioners, to allow suggestions and reflections to be properly attributed and to facilitate continuation of the discussion beyond these pages. To some extent, this document serves as a thematically organized forum on global mental health.

## 2. Methods

### 2.1 Design

A select group of high-profile, international leaders with experience and knowledge of low- and middle-income (LAMI) countries was asked to complete a qualitative survey (for their affiliations see pages iii–v; for a copy of the letter, see Appendix 1). The survey included seven open-ended questions pertaining to barriers and facilitating factors for mental health financing and service provision (see Appendix 2). Sixty individuals were sent questionnaires, and allowed 22 days to respond. Fifty responded – a response rate of 83.3%. In addition, seven individuals submitted responses to the survey after it was shared with them by an invited colleague. Their comments have been included in the analyses, but not counted in the response rate. One respondent replied and did not complete the survey, because of a lack of familiarity with the field, and has been counted as a non-response. Four survey responses were submitted in Spanish or Portuguese and were translated into English before analysis.

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<sup>2</sup> WHO, *World Health Report 2001; Mental health: new understanding, new hope*, Geneva: World Health Organization, 2001.

<sup>3</sup> Institute of Medicine, *Neurological, Psychiatric, and Developmental Disorders: Meeting the challenge in the developing world*, Washington, DC: National Academy Press, 2001.

<sup>4</sup> Desjarlais R., Eisenberg L., Good B., Kleinman A., *World Mental Health: Problems and priorities in low-income countries*, New York: Oxford University Press, 1995.

<sup>5</sup> Saxena S., Sharan P., Garrido M., Saraceno B., 'World Health Organization's Mental Health Atlas 2005: implications for policy development', *World Psychiatry*, 2006 Oct; 5(3):179-84.

The analyses cover the 57 responses which, accounting for multiple affiliations, include the opinions of 12 current or former senior national government decision-makers on mental health, eight civil society leaders without training in mental health, 13 civil society specialists/leaders in mental health services, three general public health leaders, 20 associate/full professors and 20 current or former international advisers/consultants on mental health services. The latter group included one current and four former WHO Regional Mental Health Advisers. At the time of the survey, respondents were based in 30 countries, including 18 LAMI countries. In total, the responses contained 90,848 words of original text – 200 pages – excluding all appendices, supplementary documents and question stems.

## **2.2 Analysis**

Data analyses were conducted by two qualitative researchers from the University of Oxford (RB and DS). Although RB had previously been involved with WHO in analyzing research papers related to mental health interventions in emergencies, he was not familiar with the study organizers' general vision for mental health in LAMI countries. Neither analyst had (a) previously done work in public mental health, (b) previously formed an opinion about effective organization of mental health services or (c) read policy documents, such as *World Health Report 2001 (WHR 2001)* on mental health. More importantly, the analysts were not familiar with the work of any of the mental health professionals interviewed (except that RB had read some of the work of the few respondents who work in conflict settings). To reduce the risk of bias, the analysts were blind to the identity and affiliation of respondents during the initial stage of analysis, i.e. the extraction of themes from the overall text.

Content analysis was used on the data collected to identify relevant themes and issues, considering them through the text as a whole, without the boundaries of individual survey questions. As mentioned above, during the initial stage of the analysis, the authors were blind to the identity of the respondent and focused on patterns such as recurring issues raised by respondents, as well as areas of dissension; during this phase passages were selected from the surveys and grouped into themes. After the initial blind reading, the authors conferred and identified a handful of issues to consider for further analysis. The surveys were then closely reviewed to identify all data that related to these issue categories. Categories were explored using the voices of the respondents themselves.

The presentation of results by quoting colleagues puts the study authors at risk of bias by selecting quotes from colleagues who are especially eminent in the field. To avoid such bias, one of the independent analysts (RB) was responsible for selecting the quotes cited in the text.

## **2.3 Limitations**

The results should be read with an awareness of the following limitations.

- The analysis focused on broad themes and thus only encompasses a sub-set of all issues raised by respondents. A number of issues that were raised by only a few respondents have been omitted from this report, and likewise many important insights, ideas and experiences shared by individual respondents are not included. Potential future reports on the survey data may give an overview of these important yet still unreported findings.

- The results do not include the reflections of staff from mental health programmes, service users and their families, grassroots community workers or junior-level mental health administrators. Respondents include only persons in prominent positions in government and civil society, senior mental health consultants and academics.
- The respondents were identified and invited to respond by the Director of the World Health Organization Department of Mental Health and Substance Abuse, and some respondents have close affiliations with the WHO; thus it is likely that the WHO's vision for mental health will be shared by many of the experts surveyed. In addition, some respondents gave feedback on what role the WHO could play, and it is likely that responses have been affected by the fact that the WHO was the source of the survey.
- Some issues that are frequently raised are prompted in the question stem, while others arise unprompted. While in this report efforts have been made to identify such prompted issues as they appear, readers should consult the text of the survey (Appendix 2) to best contextualize the responses.
- While the categories themselves provide useful analytical space, many of the responses and quoted passages encompass more than one category or theme. Readers should be aware that the themes discussed here are intertwined, and in many cases interdependent.
- This analysis does not cover barriers or facilitating factors to progress in efforts addressing the determinants of mental health problems (prevention of mental disorders), nor does it deal with issues related to the protection and promotion of well-being in the general population or in specific vulnerable sub-populations.

### 3. Results

The messages of respondents have been broadly organized into four categories, each with sub-headings: (a) funding for mental health, (b) organization of services, (c) strengthening the workforce and (d) public mental health leadership. The following quote from Custodia Mandlhate, writing from Namibia, reflects the interconnected nature of these themes, which we attempt to separate here for thematic analysis:

Mental health care in my country of assignment is still very much centralized. Although a mental policy has been developed under the global policy project, it appears that the implementation of the policy is still a big challenge. No strategic plan has been developed so far. Integration of mental health in general health care has started, but not at the desired pace. The existing competing priorities, compounded by lack of integration and decentralization of mental health services, explain the current situation. The existing opportunities to link mental health to other services are not used.

The respondents to the survey come with varying backgrounds, frameworks for understanding mental health care and concerns. Thus, it is useful to describe some conceptual issues that surround the discussion and recommendations that are not always explicit in the passages cited throughout this paper. There appear to be two major dichotomies in the discussion:

- The division between severe mental disorders (e.g. psychosis, severe depression) and mild/moderate disorders and problems;

- The division between (a) the provision of integrated mental health care vs. (b) the provision of dedicated mental health care. 'Integrated mental health care' refers here predominantly to the delivery of mental health care by non-mental health workers in general healthcare settings (e.g. primary care settings), through vertical physical disease programmes (e.g. HIV clinics) or through general social services, the education system, etc. 'Dedicated mental health care' refers to mental health care by workers concerned exclusively with mental health, usually through specific mental health clinics (e.g. out-patient psychiatry, in-patient care by mental health specialists at general hospitals, care in mental hospitals). This dichotomy is obscured when the delivery of mental health care is performed by full-time mental health staff working in general healthcare settings.

As will be described later, the health system solutions suggested by respondents often vary substantially based on which group of disorders the respondent is considering. These distinctions are often implicit in the responses considered for this analysis, and are introduced here by the authors for clarity.

The need to clearly define terms that describe the interaction of mental health services with other aspects of the healthcare system is critical, considering the various meanings that respondents imply when they use words such as 'integration'. Furthermore, some respondents describe the need to simplify the language of mental health, and describe the challenges posed by the heterogeneity of the field:

Mental health professionals have a hermetic discourse, difficult to understand by their colleagues in other sectors of health care, and some effort is needed to 'uncomplicate' this discourse. (Domingos Savio do Nascimento)

The field of mental health problems is quite heterogeneous. It covers at least four types of problems that are: 1) behavioural problems such as violence, substance abuse, suicide; 2) severe and long-term mental illness such as psychosis; 3) problems such as anxiety and depression that can remain unrecognized or unidentified as such; and 4) crisis situations that affect a whole population or some groups of population (wars, population displacements, natural catastrophes). The fact that the field is fragmented into many types of problems can 'distract' the decision-makers from the whole issue of mental health. (Céline Mercier)

Often there is lack of clarity with regard to different types of mental health problems and what problems should be prioritized and treated. People find this confusing. For example, is it correct to lump together illnesses such as schizophrenia with mental health difficulties that may arise as a result of a physical health problem or with relationship or work stress? ... I think that these issues are both a weakness in current debates and an opportunity for mental health. ... I suggested earlier that in most LAMI countries the mental health budget is usually spent on people with severe mental illness ... and that the current budgets need to be spent differently but still on this group or category of people, as they cannot be left without assistance. However, this leaves no room in current mental health budgets for spending on the vast majority of people with mental disorder! Firstly, there needs to be far more attention and lobbying around this issue so that more funds can be acquired. Secondly, and the strategy that is more likely to be effective, is to link mental health into other programmes. ... I think now especially with the attention on HIV/AIDS and the very direct links between mental health and HIV, that there is an enormous opportunity to provide mental health care to people needing it and at the same time to demonstrate the effectiveness of mental health interventions in bringing about better health. I also think that adding mental health into general health care for problems such as depression and anxiety disorders can be done. (Melvyn Freeman)

With respect to achieving integrated care, the challenge of incorporating mental health into other health initiatives and of breaking out of the insulated 'silo' of mental health is described by Florence Baingana:

The final challenge is the silo approach to mental health, consciously or unconsciously advocated for by the 'mental health policy people and technocrats'. Within health, mental health is a part of HIV/AIDS activities, reproductive health, health education, child health, trauma services, and is integral to the care of stroke and cancer patients, as well as being a disorder in and of itself. Outside the health sector, mental health is important in education, social services, support for orphans and vulnerable children, refugees, women in development programmes, among others, yet a mistake that we make as mental health policy-makers is to advocate for a bag of money labelled 'mental health'. We must be more creative in accessing available resources in whatever form they come.

While there appears to be consensus on the need for some form of 'integrated care', it is important to distinguish which group of disorders is being targeted by such efforts. Often, mental health advocates do not make these conceptual distinctions explicit. The lack of clarity on which issues are being targeted causes confusion when talking to donors and decision-makers and can create inconsistent advocacy (see section 3.1.1). Throughout this paper, we emphasize – where relevant – such distinctions, sometimes based on the implicit context of the respondents' suggestions.

### **3.1 The Public Health Agenda and its Implications for Funding**

Respondents concur that resources allocated towards mental health care are insufficient or are ineffectively distributed.<sup>6</sup> This section addresses the question of why there are such low levels of financing in LAMI countries. The respondents give many explanations for the low levels of financing for mental health. None of these reasons are independent of one other; rather, they interact and together form a formidable block to the allocation of appropriate funds, whether by foreign donors, Ministries of Health or Ministries of Finance. In this section we describe five particular reasons for the lack of funding.

#### ***3.1.1 Lack of strong mental health advocacy in countries to increase resources for mental health services***

The most common issue raised by respondents concerning funding was the lack of strong, coordinated and consistent lobbying and political pressure to increase resources for mental health services. Without strong advocacy, mental health will not be high on the public health agenda and political will and funds will remain thin.

This lack of strong advocacy stems from both the intended purpose of advocacy and the differing agents of advocacy. There appear to be two, implicitly stated disagreements regarding the purpose of global mental health advocacy. First, a disagreement on whom to help – some advocates suggest that the goal is to help the severely mentally ill, while others suggest that advocacy serves to help those with, for example, trauma-induced

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<sup>6</sup> For a review on resource scarcity and inequity in mental health systems, see Saxena S., Thornicroft G., Knapp M., Whiteford H., 'Scarcity, inequity and inefficiency of resources: three major obstacles to better mental health', *The Lancet*, in press.

mental disorders or vulnerable groups who lack well-being. Second, among those who agree on which group to focus their advocacy, there is disagreement on what should be done.

Respondents discuss the need and potential for advocacy from service users, families and service providers, including NGOs. Notably, many respondents discuss the need to develop a consensus in advocacy messages among the national mental health community (e.g. service providers, professional associations, senior government leaders in mental health, academics and national policy-makers), as fragmentation at this level has prevented action in many settings.

Respondents discuss advocacy to different levels:

- Senior politicians and Ministry of Health officials, to strengthen the country's legislative and policy framework, support increased funds and/or implement reforms for mental health care;
- International donors, to increase funds for services; and
- The general public, to increase political support for reform of mental health services and to facilitate implementation.

Respondents most often discuss lobbying efforts towards policy and legislation. However, they demonstrate that focusing on legislation and policy alone is insufficient. In reality, advocates must also act to see that these are funded, implemented and translated into services.

Ultimately health system expenditures and budget allocations relate more to power and politics than to knowledge. To this end, there is a need to develop a strong lobby for mental health. (We did this to some extent with disability rehabilitation: the Union of Disabled Palestinians, joining hands with local social action and Palestinian health NGOs, lobbied very powerfully and politically sufficiently to allow for the promulgation of the 1999 disability law, which is the best I know of in the Arab world. Of course, operationalizing this law leaves something to be desired, but it is a start). (Rita Giacaman)

Elizabeth Matare suggests that it is important to encourage “advocacy groups to engage and interface with policy-makers at parliament and implementing ministries and community leadership at grassroots level to drum up support for budgetary allocations [and] policy implementation”. This suggests that coordinated advocacy groups need to continue their work through and beyond the legislative process.

Many respondents believe that people with disorders and their families should become a more powerful constituency, and should press for better mental health care with sufficient funding at local and national levels. The call for service users and families to become involved in advocacy for mental health at both local and national levels appears to be based on the success of such approaches in wealthier countries. The following passages reflect a common sentiment for service user advocacy:

Perhaps the greatest handicap in raising resources is the lack of a strong lobby (users, family or other interested groups in society) that can raise awareness and put pressure on governments and donors to invest in mental health. This is because people with mental health problems and their families are often at the margins of society. (John Mahoney)

Patients and their family members or those who care for them ('consumers and carers') have absolutely no voice or any say at all in matters related to mental health services in most LAMI countries. They are an insignificant group and have no lobbying power of any sort to influence politicians, decision-makers and opinion leaders. They are poorly organized. Politicians often do not have to be concerned about them as they do not form any 'vote bank'. (Mohan Isaac)

The users of mental health services are an extremely invisible and marginalized lot. Their mobilization and organization into associations is a very important step for the mental health sector to take. Participation by users in mental health programme and policy development is negligible in the Indian context. Families of users are better organized and have made an impact on the structural issues plaguing the system. However, this is still third party intervention, as the primary beneficiaries of the mental health system are inaudible in these efforts. (Bhargavi Davar)

One response (from Emran M. Razaghi and A. Rahimi Movaghar) recommends that the international community consider the involvement of users of mental health services in policy-making as an indicator of a country's mental health system.<sup>7</sup>

Service-providing NGOs, with close community connections, can also serve as advocates and coordinating centres for local advocacy, as Mike Davies suggests:

At local level, there is substantial evidence that NGOs can bring about a better sense of responsibility and ownership by local government entities. At national level (in addition to a more structured WHO leverage on national government entities) NGOs should combine to exert pressure. Well-planned and managed advocacy is essential. Up to now, the problem has been one of individualised, fragmented initiatives, all doomed to failure.

Such local advocacy may work in concert with national-level and international advocacy when it is appropriately coordinated.

It is suggested that part of the reason for the political (and thus financial) inaction on mental health can be attributed to the low level of interest from the public in issues of mental health. As Lakshmi Vijaykumar notes, there is no "groundswell of public opinion on mental health issues which will force governments to allocate more funds for mental health". Some respondents note that stigma and discrimination pose a challenge to mobilizing the community to be involved in advocacy, perhaps making it especially important that people who receive mental health care are involved in lobbying. George Alleyne writes:

I believe that the prime reason is that there is no vocal and powerful constituency for mental health. The patients do not die visibly as is the case with children. There is a powerful constituency for children because of sympathy, and because they die needlessly. The same is not the case for mental health. The problem of stigma and discrimination also plays a part.

Public advocacy may make investment in mental health more politically palatable.

In developing coordinated advocacy, the interests of service users and families may diverge from the professional interests of mental health specialists, and the opposing

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<sup>7</sup> WHO AIMS (Assessment Instrument for Mental Health Systems) Version 2.2 (2005) presents this point on the involvement of community in advocacy through 2 of its 156 items.

advocacy may result in inaction on the part of governments. Thus, respondents suggest that it is necessary to develop a clear consensus and plan for action among the national mental health community. The need for unified advocacy is emphasized by Harry Minas:

A problem of great importance in most LAMI countries is that there is no unified voice on what the problems are and what must be done to which governments have to respond. ... The lack of unity among stakeholder groups, and often outright competition between different professional groupings, means that there is generally no political weight behind any demands to improve mental health systems, or that such demands insist that governments move in different, incompatible directions. In the absence of such a unified voice, the easiest response for governments is to do nothing.

The disagreements among a community of mental health specialists may limit funding and abilities for policy change:

The [mental health] field has suffered from a real and perceived lack of consensus among leading experts. This turns donors and policy-makers off. (Peter Salama)

The ministers of health do not know what mental health services to finance. ... Unlike programmes for HIV/AIDS and TB, where there are clear clinical guidelines for treatment, mental health care remains vague, with too many options and competing treatments and value systems. (Richard Mollica)

The internal division among mental health experts and decision-makers is seen as an obstacle to coordinated and effective advocacy. The formation of national plans for mental health, with leadership from service users, families and service providers is discussed below as a potential vehicle for coordinating advocacy.

### **3.1.2 National policies, plans and programmes to facilitate funding**

Respondents suggest that a national mental health strategy is helpful. The point is made that such strategies are needed not only because good planning is necessary for service development,<sup>8</sup> but also because good plans are a helpful vehicle for fund-raising. By functioning as a coherent proposal for services, a national policy or plan, written by the Ministry of Health through a participatory process including all key stakeholders, can facilitate sound financing from different levels of government and can be used as a proposal to international donors.

Only a national strategic programme could say how we can [work] with a small budget or with a poor or conflicted administration. Such a programme [presenting a] framework of goals, priorities, first and next steps and [an] evaluation system can fairly well decide where, when and by whom a small amount of money must be spent, for whom. (Jafar Bolhari)

What the LAMI countries especially need to do is to draft a strategy in order to better go through the available resources. (Pirkko Lahti)

The Indian national mental health plan, despite its difficulties in implementation— has received strong support from the government and this, in turn, has led to support for a larger budget:

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<sup>8</sup> See WHO (2003) Policy and Services Package.

The restrategised National Mental Health Programme (NMHP) for the 10th Five-Year Plan (2002–2007) received final approval from the Government of India in early 2002, with a budgetary allocation of INR 1,900 million (US\$42.3 million), a seven-fold increase over the previous plan outlay, and was formally launched by the Health Secretary, Government of India in October 2002 at a national conference attended by the top health administrators representing the various state governments. (DS Goel)

Florence Baingana describes the advocacy and coordination necessary for the realization of a national strategy, and offers insights from experience in Uganda:

In Uganda, it was possible to use evidence to influence the inclusion of mental health as a component of the Essential Health Care Package. Mental health was included as a budget line item and this made it possible for other funders, like the African Development Bank, to provide a US\$17 million loan to the Ministry of Health. A key lesson learned from the Uganda and Afghanistan examples is the importance of creating a mental health coordinating committee that includes representatives of the different stakeholders, including NGOs, clients/consumer representatives and other sectors, other than health.

Based on experiences in Albania, the occupied Palestinian territory and Sri Lanka, John Mahoney suggests also that a national plan, endorsed by government, can facilitate funding from international donors: “It is much easier to approach donors when new national policies are in place.” A unified and coordinated national plan for mental health can be built to facilitate sound financing of mental health and to make the mental health field attractive to international funding agencies.

### **3.1.3 Mental health not formally named as a priority by major international donors**

A prominent explanation for the lack of mental health funding discussed by the respondents concerns the role of donors and the international community as agenda setters. Almost half of the respondents point to this area as one of the reasons that levels of financing for mental health are so low. For example, the Millennium Development Goals (MDGs) and their neglect of mental health is frequently mentioned. (It should be pointed out that the MDGs were mentioned as an example in the question posed to respondents, and thus the frequency of this response is not spontaneous but prompted.)

At the World Bank level, the major challenge was that mental health was not explicitly stated as one of the MDGs. It was thus very difficult, even for those countries that had a need and expressed an interest, to get the World Bank staff to support the investments. (Florence Baingana)

It would probably help a great deal if mental health were explicitly named a priority in the MDGs, in generic World Bank head office and country documents, in WHO generic documents and in speeches of senior staff at key conferences. (Rachel Jenkins)

Unfortunately, mental health was not included explicitly as an MDG or even included as one of the targets. Mental health/mental disorders have a two-way relationship with poverty, and mental disorders are the reason why it is very difficult to get the last 20% of children into school. They are also a leading consequence of violence against women, which is one of the gender targets, and the mental health of women is a major contributor to the overall burden of women’s health – and, as a result, has a role to play in outcomes for children’s health and education outcomes. [Despite all this,] mental health *per se* is never perceived as being integral to the MDGs. The result is that it is impossible to get it included in the Country Development Plans. (Florence Baingana)

Florence Baingana goes on to explain how the exclusion of mental health from the MDGs directly obstructs the financing of mental health services, with a powerful illustration from Rwanda:

Rwanda, recognizing the impact of the 1994 genocide as well as the rising rates of HIV infection, included mental health in the 2002 Poverty Reduction Strategy Paper (PRSP). However, when it came time to determine what would be financed within the Poverty Reduction Strategy Credit, mental health was not included, since it is not explicitly mentioned as an MDG. The result is that the Rwandan Ministry of Health cannot finance mental health services out of the World Bank loan/credit funds, even if mental health is an expressed need, an observed need, and a mental health strategy exists. (Florence Baingana)

In Afghanistan, as in Rwanda, the national authorities made mental health a priority, but funding for it was not delivered by international donors. Peter Ventevogel writes:

As I have observed in Afghanistan from 2002, the new health authorities did not need much 'sensitization' to convince them of the importance of mental health problems. Mental health was included as one of the seven priorities in the Basic Package of Health Services (BPHS). However, pressure from institutional donors (World Bank, USAID) led to the division of the BPHS into a 'first' and a 'second' tier. No surprise: 'mental health' and 'disability' were placed in the second tier, which led in practice to a total neglect of the topic. So we see here that the national health authorities defined mental health as a priority, but the donor community had huge hesitations to fund service delivery. The main reason stated for this reluctance of the donors was the unavailability of clear studies about the cost-effectiveness of public mental health interventions. The institution charged with 'costing' the BPHS (the American institute MSH) said it could not provide the government and donors with data on the estimated costs and benefits.

When international agencies and donors do not prioritize mental health, there is reduced incentive for national policy-makers to address these issues. Respondents note the critical role that international financial institutions can have on setting the donor agenda:

International financial agents can greatly help in building this leadership at the political level by asking for commitment from politicians, using their great influence to allocate public funds in mental health, especially in less developed countries. (C. Sylvester Katontoka)

Various respondents noted that communicable disease, especially HIV/AIDS, has been the funding priority for donors and national leaders, and that this has been a barrier to securing funds for mental health services.

The Global Fund has a major diversionary effect of resources away from mental health. Funds are used to pay for HIV counsellors, for example, who are often recruited at higher salaries from the ranks of mental health nurses, thus further depleting mental health services by an internal brain drain. In Kenya, for example, there are over 3,000 NGOs devoted to HIV (funded by donor money) and only 2,090 state primary care centres. If all the money channelled to these HIV NGOS had in fact been invested in strengthening primary care, the general health, including the mental health, of the population would have been better served. ... Despite the emphasis on HIV counselling, such counselling is usually around testing and diagnosis, and most HIV centres do not aim to recognise and treat depression, do not contain antidepressants and do not liaise with mental health

services. Thus a key opportunity is being missed to address mental health. (Rachel Jenkins)

Mental priorities in the vast majority of LAMI countries are determined by their political stability, HIV/AIDS pandemic, maternal health and environmental factors. As can be seen, 'other' health priorities override mental and psychological interventions e.g. HIV/AIDS, antiretroviral (ARV) therapy, reproductive health child immunization programmes and malaria control, prevention and treatment. (Elizabeth Matare)

Perhaps the most important issue that prevents higher expenditure on mental health in most LAMI countries at present is competing priorities – and particularly HIV/AIDS. In most LAMI countries, especially those in sub-Saharan Africa, the numbers of young, economically productive people infected and dying of AIDS makes any other illnesses fade into insignificance. Any additional resources that may come available either through State or other funding resources are going into fighting and treating this epidemic. Advocating for more resources for mental health in this climate falls on deaf (or perhaps otherwise filled) ears. (Melvyn Freeman)

The focus on HIV/AIDS by donors and governments is a challenge to advocating for more investment in mental health. However, a number of respondents suggest that this challenge can be translated into opportunity, by integrating mental health services into HIV/AIDS programmes. The focus on communicable disease is further reinforced by the relative complexity involved in measuring mental healthcare outcomes. As a result, accountability mechanisms are not in place for mental health, as they are for some communicable diseases. Pau Perez-Sales describes the concerns of a health promotion officer at a rural centre in Peru:

Community mental health is very important. Here the youth do not have anything, the elderly are abandoned, people are in a very bad situation ... But if I go and complain about this to the regional authorities they will reply that the whole country is in the same situation and that it is poverty and that poverty has no treatment. If a grandfather dies of distress or a young person commits suicide, nobody will get to know about it ... But, oh! If a child dies of ARI (acute respiratory infection) or of ADD (acute diarrhoeal disease) ... then I assure you that all inspections and accusations will be made and that I will be transferred from my post to another one 100 kilometres away, as far as possible from my family. ... God forbids it ... This is the way that things are focused here.

It is perceived by many respondents that mental health is stuck in an unbalanced competition for resources with HIV/AIDS and other communicable diseases. Donors and aid agencies often dominate priority-setting amidst a scarcity of resources and the urgent need for health interventions.

In countries where resources are scarce, or where international aid (as sometimes is the case here) dictates the health system agenda, and where various aid agencies *de facto* implement different policies related to the strategies developed in their country, as opposed to a priority listing developed locally, then health system building in itself, let alone mental health system building, is compromised: even with much money spent here, there have been few systemic changes. (Rita Giacaman)

Rather than compete with communicable disease, many respondents suggest integrating mental health care into communicable disease healthcare programmes. Although these respondents typically are not explicit, the authors assume that they see

the integration of mental health care into such programmes as a solution to funding care for the large percentage of people with mostly mild and moderate common mental disorders, but not as a solution to the organization of care for people with chronic, severe mental disorders.

### ***3.1.4 The role of social stigma and the view that mental health is a private responsibility***

Another explanation for the low levels of financing lies in the view that mental disorders involve private issues, and are not an area for governments to invest in. Government neglect of mental health issues may be associated with the belief that mental health care is a private responsibility, and this perception is further reinforced by the stigma of mental disease.

Reflecting on the responsibility of mental care provision, Céline Mercier notes: “Firstly, mental health problems are still seen as private issues that do not have to be taken in charge by the government.” Barbara Stocking describes how stigma may make treatment for mental disorders inaccessible: “Stigma prevents funding, prevents doctors from specializing and prevents service users and families from receiving treatment.” Similarly, Gaston Harnois points out: “One of the main reasons for the lack of investment in mental health services stems from ignorance and stigmatization on the part of decision-makers.” Reflecting on the situation in Sierra Leone, Lynne Jones notes how mental health problems are hidden, or perhaps silenced, by stigma:

The seriously mentally ill are perceived as an unattractive and indeed frightening group of people, who cannot lobby for themselves and have no-one to lobby for them because health workers, families and politicians don't want to be in some senses contaminated by association. The most serious problems are hidden from sight. I had difficulty recruiting health workers to train to work with this group in rural Sierra Leone, in spite of the high incidence and obvious existence of severe disorders because, as some well-trained health workers told me, such patients brought in no income, were still somehow associated with evil-doing and bewitchment which might rub off, were possibly violent, and did not get better. So our first major task was altering these beliefs.

One respondent argues how stigma may obscure evidence in the policy-making process, using the case of epilepsy as an example when cost-effective treatment is not made available, and suggests a causal role for stigma:

At the level of service policies, policy-makers' goals, which may be other than clinical effectiveness, may be negatively influenced by stigma and research evidence may be dismissed as irrelevant. As an example, epilepsy is associated with poor [treatment coverage by] health services, and the disorder is prevalent in the developing world. Research indicates that a primary healthcare worker can make the diagnosis and provide treatment. Treatment of epilepsy has been found to be extremely cost-effective, yet policy makers are often not willing to make this investment. (Florence Baingana)

Robert van Voren notes how in Eastern Europe supporting mental health is politically challenging:

Even those politicians who support our work do not want to go that far and jeopardize their political careers. In other words, some agree to help, but doing this publicly and actively is considered political suicide. A very high percentage of the Lithuanian

population would like to have mental patients locked up in institutions far away.<sup>9</sup> ... The combination of both factors (persons with a disability being considered unproductive and society not being accustomed to having disabled persons around) makes it very difficult to convince authorities to spend time, effort and finances in improving mental healthcare services and, thus, the quality of life of a not unimportant part of the society.

While numerous respondents agree in identifying stigma as a problem, some note the challenges involved in campaigns against stigma:

It would be difficult to demonstrate such an impact of prevention programmes in mental health; evaluation results of campaigns against stigma present contradictory results in European countries where such evaluations have been done. Would it be a good investment to support this type of programme in LAMI countries? It may be safer (and wiser – both politically and clinically!) to invest the few available resources in rehabilitation intervention for persons with severe and persistent disorders in local communities. (Michel Perreault)

Most of the discussion about stigma implicitly focuses on people with severe mental disorders, not on those with common mental disorders. Stigma is often listed by respondents as a barrier to mental health funding, yet few elaborate on the different pathways leading from social stigma in society to poor funding for services. Various respondents note that developing effective services in community settings is likely to be an effective way of reducing stigma.

### **3.1.5 Evidence to inform and complement political pressure**

Another explanation given by respondents for low levels of financing for mental health care is that there is a lack of studies showing what exact gains will be made and at what cost through mental health investments.

The cost of treatment for mental illness is perceived to be high, relative to the treatment for other health conditions. Second, the health gain achieved by mental health interventions is perceived to be less than that achieved by interventions for other health conditions. (Harvey Whiteford)

Another challenge is that countries come to the [World] Bank and express the need for funding for mental health, but are not willing to take a loan for these activities. Policy-makers representing the Ministry of Health or the Ministry of Finance have the mistaken belief that mental health care is a 'charity' issue. They do not believe that there will be a return on the investment, they do not appreciate the fact that not investing in quality mental health services may be draining the scarce resources of the country as well as undermining the productivity of the population. (Florence Baingana)

There seems to be a common belief that mental health interventions are inefficient and too costly. Perceptions of cost-ineffective services need to be addressed with evidence and political pressure. It should be noted that any discussion of cost-effectiveness depends greatly on the mental disorder being considered.<sup>10</sup> Knowledge on the cost-

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<sup>9</sup> The respondent noted that a recent survey suggests that 68% of the Lithuanian population agrees with the statement that 'People with psychological and emotional problems constitute dangers to others.' (Source: European Commission (2006). *Special Eurobarometer 248: Mental Well-being*. Brussels: European Commission)

<sup>10</sup> Hyman S., Chisholm D., Kessler R., Patel V., Whiteford H., 'Mental Disorders', in *Disease Control Priorities in Developing Countries, Second Edition*, ed. Jamison et al., 2006.

efficacy of pharmaceutical treatment may not be applied in many countries; respondents suggest that, due to influence from the pharmaceutical industry, a large proportion of budgets are spent on new drugs, which are not cost-effective.

Peter Salama suggests creating plans for mental health services that consider cost-effectiveness in the context of the environment and of the health system:

A corresponding 'investment case' for mental health services could then be developed that prioritizes the evidence-based interventions according to the type of environment and level of sophistication of the health system. It is important that the cost-effectiveness and feasibility of scaling up the mental health services proposed are also considered.

The treatment of severe mental disorders may not be considered cost-effective but, especially because of the prevalence of human rights violations against people with mental disorders, there is a strong moral case for providing effective and humane mental health care.<sup>11</sup>

Beyond data from health economics, respondents also discuss other forms of evidence. Sylvester Katontoka notes: "Because we have never had research on the prevalence and distribution of mental illness in the country or the living conditions of persons with mental health problems, policy-makers find it difficult to plan for mental health without evidence-based data." However, many respondents suggest that it is not data on the prevalence of mental illness that are needed; in fact, in many cases such data are easily misunderstood. Melvyn Freeman explains that the majority of services are dedicated to the seriously mentally ill and suggests: "We cannot go around using figures like 12% of health burden or 15–20% prevalence if this is not who we want to provide services for." Respondents emphasize the perceived intangibility of the mental health field and call for clear indicators on mental health:

A problem in the mental health field was also the absence of clear indicators. Presumably hard and internationally accepted indicators as exist in mother and child health care, such as 'mortality rate' or 'vaccination coverage', are not available in the field of mental health. ... In Afghanistan the mental health needs were accepted by the national government, but the mental health interventions required to address these needs were not convincing enough to the donors (and in their slipstream the government).' (Peter Ventevogel)

Pau Perez-Sales argues for an international ranking system of mental health systems that could be used to encourage funding, similar to the classification system used by UNDP as a development index. Bhargavi Davar calls for social, rather than psychiatric, research to inform interventions:

The bent of research has been mainly psychiatric. The existing literature even in the last recent decade does not acknowledge the role of social inequity, vulnerability and marginalization in the aetiology of mental illness. While various academic disciplines such as feminist, cultural and legal studies have contributed to a social-political view of mental health, this remains discredited by mainstream teaching and training institutions in mental health.

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<sup>11</sup> Patel V., Saraceno B., Kleinman A., 'Beyond evidence: the moral case for international mental health', *Am J Psychiatry*. 2006 Aug;163(8):1312-5.

As a complement to the existing indicators on disease burden, Gary Belkin calls for community-level measures to take account of the toll that mental illness has on society:

This means re-imagining data collection sources and methods in ways that create platforms for deploying responses at a community level. Most of what can be done at community level will come from giving capability to do something at community level and needs very different surveillance capacities and how they loop to operations.

Evidence from abroad is often ignored. As Srinivasa Murthy notes, there is a need for local evidence to convince health planners to invest in mental health:

The interventions and their effectiveness in low-income countries have not been a priority for researchers. Thus the data/evidence from Western countries do not carry weight with the planners and policy-makers. Most country health planners want either *local evidence* or a *local demand* (often due to a tragedy involving mentally ill persons).

### **3.2 Organization of Services**

Traditionally, health care organization is discussed mostly in terms of (a) primary care (b) secondary care and (c) tertiary care services. Here, however, we will frequently use the terms (a) mental health care in primary care settings, (b) community mental health services (comprising outpatient psychiatry clinics, acute inpatient psychiatry care in general hospitals, community mental health teams, etc.) and (c) mental hospitals, respectively, as these were the terms used in the survey questions and thus are reflected in the respondents' answers.

The integration of mental health care into general health services discussed by respondents occurs mainly in two forms: mental health care delivered by general health workers in primary care settings or through specific programmes addressing physical disease (HIV/AIDS, TB). (Additionally, although not mentioned by respondents, integration into general healthcare services could include, for example, liaison psychiatric services in general hospitals.)

As mentioned earlier, we use the term 'dedicated mental health care' for mental health care delivered by workers performing full-time mental health work through specific mental health services (e.g. out-patient psychiatry, inpatient care by mental health specialists at general hospitals, mental hospitals).

In addition to the above, one could also speak of a hybrid model of general care when a worker's time is fully dedicated to providing mental health care in a primary care clinical setting.

How different types of services are organized/configured/mixed within a mental health system tends to have an impact on the effective treatment coverage of people with diverse mental disorders, and this is the subject of much discussion among respondents. Question 2a in the survey (see Appendix 2) acknowledged that a mixed model of care, in which mental health care is available at multiple levels of care, is the ideal, but encouraged respondents to reflect on which services decision-makers should invest their available, limited resources for mental health care. In response to this question, respondents frequently reflect on the challenges of changing the organization of mental health services.

### **3.2.1 Community mental health services and decentralization**

A broad consensus was re-affirmed that resources and expertise for mental health care need to be geographically decentralized, and a system created that makes treatment for acute and chronic mental illness and the corresponding social and rehabilitation services available at the community level. The need to move staff and financial resources into the community is described by respondents:

The key word usually is decentralization of resources (budget as well as infrastructure and qualified personnel). ... Each area should have its own budget and resources at the different levels of management. ... It will require a personnel policy that makes it obvious where the gaps are in terms of profiles, qualifications, availability. (Pau Perez-Sales)

In Sri Lanka, currently most of the annual finance for mental health goes in supporting the mental health hospitals which are in the southwestern part of country. There should be a better distribution of the funds to cover all the districts and areas, as well as more decentralization of the finance so that peripheral areas can decide how they spend their funds. (Daya Somasundaram)

Writing on Brazil, Pedro Gabriel Delgado expresses the concern that responsibility for mental health provision should be regional, and should consist of general mental health clinics covering a range of disorders, rather than clinics focused on a narrow range of pathologies:

The focus of the investment should be on community services of high effectiveness and defined areas of territorial performance. These are community centres that take charge not only of the service for severe mental disorders ... and are responsible for the demand in mental health in their territory.

Karen Hetherington recognizes community training as essential to decentralization of care:

In Guatemala most of the trained professionals are in the urban areas. There must be a decentralization of these professionals to the semi-rural and rural areas. It is essential that a training programme be established for mental health professionals in order to equip them to export their knowledge in an appropriate fashion.

Basing care in the community allows for improved rehabilitation, which Elizabeth Matare suggests can function more efficiently and effectively when decentralized:

Community mental health care has a better effect than institutional treatment on the outcome and quality of life of individuals with chronic mental disorders. It is also cost-effective and respects human rights. This requires a coordinated effort of health workers and [requires] the rehabilitation services to be extended to the communities/grassroots level, along with the provision of crisis support and community-based rehabilitation centres.

Community-based rehabilitation should lead to shorter stays:

If people are placed in rehab centres far away from home, families find it hard to visit and often lose touch, so patients in residential rehabilitation centres become long-stay. Thus rehabilitation needs to become a local primary care/local community function rather than a specialist function as it is in the West, if people are to be able to access it without running the risk of institutionalisation. (Rachel Jenkins)

The need for formal community mental health services is increasing with demographic trends, as Jafar Bolhari suggests:

In 'modern' times, informal support structures are beginning to break down with increasing urbanization and industrialization (this is particularly true for Iran). However, no substitute has been found for the old support mechanisms.

Parameshvara Deva describes the role that NGOs can play in providing community mental health services:

The progress in mental health in LAMI countries is currently being held back by too much procedural red tape. The professionals inside and outside can help, but their hands are tied by the brick walls of Government agencies, whereas mental health NGOs are outside the red tape and therefore can make big differences to professional services, training, changing attitudes – without ruffling feathers.

However, not all respondents are enthusiastic about NGO collaborations. Harry Minas writes:

These external agencies are frequently more driven by their own agency objectives (and their donors) than they are by the needs of the national population. They frequently compete with each other rather than collaborate, they withhold information (e.g. information derived from endless and often shoddily performed 'needs assessments'), jealously guard their independence rather than put themselves at the service of mental health system development objectives (where these exist) of national governments, and often weaken national mental health systems by attracting away from them (with higher salaries and better international career prospects) the most capable workers in those systems.

Moreover, respondents note that in some countries NGOs have difficulties in establishing themselves and, even when established, may create their own set of problems. One respondent (who preferred to remain anonymous on this) reports that government agencies in his/her country may discourage the evolution of family groups and of NGOs that could provide services to the mentally ill, due to concern that these organizations are under foreign (or non-government) control, and that in some locations existing NGOs may *decrease* government interest in providing services by grossly inflating reports on the level and quality of social services that they (the NGOs) provide to the mentally ill.

Respondents emphasize that community mental health service models cannot be simply be transferred from one country or region to another. Rangaswami Thara describes the challenges to a day care programme for chronically mentally ill people in rural India:

It was a total failure since families were not keen to send the ill member to the day centre. Reasons for this were many – the cost and trouble of travel, the lack of tangible gains in the ill person working in a sheltered workshop (an essentially urban model) and the relative ease with which they maintained the patient at home. Unlike crowded urban environments, the rural neighbourhood displayed far more understanding and tolerance of the behaviours of the chronic mentally ill.

The process requires linking mental health more closely with other non-health sector services:

Good mental health provision should not be seen as exclusively the province of the health sector or the medical profession. Other UN agencies, NGOs, INGOs and ministries also need to be involved, such as social welfare, home affairs, education, youth and gender. (John Mahoney)

Reflecting on the creation of a programme for social insertion to move people out of hospital, Domingos Savio do Nascimento describes a Brazilian initiative:

Two important measures were taken: in 2000: the authorization of and corresponding funding for protected housing (called Therapeutic Residential Services – SRT) and, in 2003, the creation of a programme called ‘Back Home’, in which funds were reallocated from the psychiatric hospitals where patients had stayed for prolonged periods to their living and care as out-patients. ... Adoption, by the Parliament, under the Government’s proposal, of Federal Law 10,708/2003 created the ‘Back Home’ programme, which facilitated the social reinsertion of more than 2,000 long-term patients in psychiatric hospitals. This programme gives US\$110 per month to the ex-patient and links him/her to a series of community actions and programmes.

It is widely believed that social services are part of, or complementary to, decentralized specialist mental health care, and that this should be reflected in the structure of such services.

Some respondents call for linkages that reach beyond the social services sector to traditional and/or religious healers (Rangaswami Thara, Florence Baingana, Sylvester Katontoka). Florence Baingana writes:

As was done for HIV/AIDS, we may also have to invest into researching this area, since a lot of the out-of pocket payments for mental health services are probably going to the traditional healers. There may be an advantage to collaborating with traditional healers, to minimize the damage that they may do, to improve on patient outcomes, especially for those patients with disorders where a psychotherapeutic approach may be as effective as medication, such as depression and anxiety and the psychosocial disorders.

Much of the discussion of community involvement in mental health focuses on the crucial role of families and community organizations – especially in rehabilitation, and the need to spread resources and expertise beyond mental health hospitals. Respondents, chiefly the civil society mental health experts, repeatedly note the need for the ‘grassroots’ creation and management of mental health programmes, emphasizing collaboration with NGOs (Rangaswami Thara, Lakshmi Vijaykumar, Robert van Voren). Respondents repeatedly note that decentralization and deinstitutionalization – two conceptually distinct but often overlapping processes – open up many opportunities to involve communities and families in mental health care.

Substantial resistance to the decentralization of health resources arises in many countries that have attempted to spread resources to the periphery and to social programmes. Bhargavi Davar describes how the incentives of doctors limit the expansion of mental health care:

So long as the policy decisions are made by the medical professionals, and in their own interest, there will always be a shortage of resources in the mental health sector.

An historical resistance arises in post-Soviet countries, as described by Dainius Puras:

The psychosocial component was eliminated both from explaining pathogenesis of mental health problems/disorders and from investing in the spectrum of therapeutic interventions. Biomedical reductionist theories were dominating research, education and practice of psychiatry, which was fully controlled by Communist ideology. The idea was to support and prove an ideological thesis that in Communist countries psychosocial problems have been solved by the 'socialist' system, so any mental health problem/disorder could be explained as a case of schizophrenia or some other brain disorder.

With such a framework for understanding mental health, as Dainius Puras suggests, resistance to social services is substantial, because it involves an understanding of mental health outside the accepted definitions. Further, integration may be challenged both by the public health branch and by mental health specialists. Diyanath Samarasinghe writes that challenges to integration will come from the "the 'owners' of midwives (the public health branch) and by mental health professionals who want to mystify their specialty".

Some respondents note challenges in financing community-based mental health. For example, Sylvester Katontoka writes:

Although community mental health services were introduced, they could not be sustained due to financial constraints.

To assist with these challenges, Naotaka Shinfuku calls for technical support for LAMI countries to develop financing schemes for community-based approaches: "It is essential for the government to develop financing schemes to favour community-based approaches. Technical support will be needed for LAMI countries to develop such financing schemes." Florence Baingana illustrates the need to understand the separate sectoral costs in attempting to create an integrated, multi-sectoral mental health programme:

A challenge could be that financing of housing for those in community care, or financing of educational services for children with mental disorders, are not easily costed. It may thus appear as if mental health services financing is very low. On the other hand, a majority of LAMI countries do not have social welfare programmes, so that housing and welfare payments are actually non-existent. If we are to make a case for increased financing of mental health services, and if we are also advocating for community-based care, then we must have a better understanding of what all the separate sectoral costs are, and of the best approach to providing effective coordination of financing.

Mental health care finance, perhaps already challenged by the difficulties involved in integration into the health budget, may face additional challenges in integrating with community services outside the health sector.

In addition to divisions between sectors, internal divisions arise when mental health policy created at the national level requires financing at the district level:

In Pakistan the district and provincial governments have the responsibility of health in terms of service delivery and implementation of programmes, while policy is the purview of the federal government. Consequently, even if the policy and legislation is formulated

for mental health services, it is difficult to get the district and provincial governments to buy into it because of limited health allocation, most of which goes towards non-developmental expenditure – unless the federal government provides finances, which obviously is not a sustainable solution. (Khalid Saeed)

Dedicated community mental health services, suggest many respondents, tend to focus on the care of the severely mentally ill. Such an argument is made by Melvyn Freeman, who suggests that this focus should be made more explicit:

We know that by far the highest proportion of the mental health burden is as a result of unipolar depression, but I'm not sure that many mental health advocates would argue that depression should receive a budget proportionate to its burden vis-a vis other mental health problems. I believe that factors such as severity, disruption in the community, ability to treat cheaply etc. do, and must, come into the equation. ... We should say though, and be frank about it, that we are concentrating efforts on around 1–3% of the population and that this is our focus. We must calculate what resources we need to treat this group of people and, where the existing budget is not sufficient, lobby for this.

John Mahoney and Lynne Jones suggest that dedicated community outpatient mental health care, also by non-specialists, can be successfully involved in the treatment of people with severe mental illness:

In [selected parts of] Sri Lanka, a non-professional, community-level workforce has been recruited and trained on short-term funding. They have developed a referral system and brought people for treatment who before would not have received a service. A visiting British psychiatrist in Kalmunai said that, of all the patients brought to the outpatient clinic, all but one was appropriate. If they are to continue, they must focus on people with serious mental illness and receive regular training and supervision. (John Mahoney)

Serious psychiatric disorders can be managed in the community, if staff are adequately trained, supervised and supported. (Lynne Jones)

Dedicated community mental health services play a critical role in the care of the severely mentally ill, and in supporting primary and general health care. The availability of services depends greatly on training and supervision at the community level – which will be discussed in section 3.3 below.

### ***3.2.2 Downsize and improve mental hospitals***

Many respondents suggest that an important – although often difficult – step in decentralizing mental health resources is to downsize existing mental hospitals. While many are critical of mental hospital-based models of care, and the associated risks of human rights violations, respondents also provide concrete suggestions on how to improve hospital care and how to transform hospitals and their staffs into agents of community care. The critics of hospitals most commonly point to the relatively large portion of mental health spending they consume. Lakshmi Vijaykumar, for example, writes: “Investing in tertiary mental hospitals caters only to the needs of the urban elite rather than the majority of the rural poor.” Pedro Gabriel Delgado expresses a view that large hospitals “produce exclusion, a vicious circle, abandonment and disrespect to human rights”. Gaston Harnois offers a view of the discrepancy in spending: “Close to 90% of the mental health budgets (themselves representing only 1% of the total health

budget) of Guatemala, Salvador and Nicaragua go to pay for their respective national psychiatric hospitals.”

As the above quotes demonstrate, respondents suggest that large mental hospitals have poor coverage, tend to put people at elevated risk of human rights violations and absorb a disproportionate amount of resources. The numerous statements criticizing large, central psychiatric hospitals appear to reaffirm a consensus among mental health experts (Bhargavi Davar, Domingos Savio do Nascimento, Pedro Gabriel Delgado, Mohan Isaac, John Mahoney, Joe Mbatia, Daya Somasundaram).

The suggestions of respondents, many of whom have themselves reformed mental health programmes, are broadly to gradually downsize mental hospitals and to make use of staff and the physical space in community mental health programmes. However, respondents indicate that some of the most persistent barriers to the implementation of such community programmes are the vested interests of psychiatrists and hospital workers. These interests are an obstacle to funding, deinstitutionalization and the expansion of a mental health workforce. Concerns about job security have delayed moves to community-based care, as described by John Mahoney:

There are huge barriers to change and not least from staff, trade unions and vested interests. All staff's personal futures need to be addressed, however, in moving to community-level provision.

The staff and leadership of psychiatric institutions are able to exert influence that opposes the political will to reform mental health services. Alberto Minoletti suggests, based on the Chilean experience:

The main barrier for downsizing psychiatric hospitals is the high political cost that this entails, due to the pressure from the trade unions of hospital workers and organizations of mental health professionals (who should learn new skills for community care but who may also lose some of their present privileges). In relation to the above, there are no professionals appropriately trained to be leaders in the process of downsizing psychiatric hospitals or to face its technical challenges and social and political barriers.

In pursuit of mental health service reform, psychiatrists should be seen as stakeholders, not just as providers (Harry Minas). Dainius Puras describes his experience in Eastern Europe, where stakeholders in many psychiatric institutions appear to have exerted control to promote their own interests:

An ineffective, self-feeding system of centralized psychiatric institutions has through many decades developed sophisticated skills of survival and resistance. ... The system is controlled by a powerful lobby of administrators of psychiatric institutions, who have good relations with the political and academic establishment. Ideologically, the system is supported by the still prevailing culture of paternalism and dependence, which is based on a presumption that mentally ill people are not capable of making independent decisions, so psychiatrists and other staff need to take care of them in a very paternalistic way. ... Even service users and family organizations are often on the side of the traditional system, because they do not know about alternatives or they become financially dependent on organizations/institutions lobbying for institutional care and the biomedical paradigm.

Financial incentives and professional self-interest lead psychiatrists and mental health staff to resist deinstitutionalization and any restructuring of care to the community level,

and to oppose expansion of the workforce and public health models of care. Florence Baingana states these interests simply:

The interest of the Director of the Hospital is to increase funding for the hospital. He/she would thus be biased against integration into primary health care, since this moves funds away from his/her institution.

Similarly, Pedro Gabriel Delgado describes the “strong resistance that shouts for the return of the beds” from the Regional Council of Medicine of Brazil. Downsizing hospitals is a threat to the economic and professional interests of those who work in hospitals. Thus, Gaston Harnois suggests that financial and professional guarantees be put in place for hospital staff during the period of transformation:

To make the above changes possible, every worker (including psychiatrists) should be offered the guarantee of a job and their representative should participate in the elaboration of a new mental health programme. The emphasis should be on strengthening the mental health component of primary health care, the development of psychosocial rehabilitation services in the community, the provision of different types of housing modalities and fostering the development of community-based support groups.

Respondents suggest that the opposition to downsizing hospitals in favour of community-based care most often comes from directors of national mental hospitals, trade unions and hospital staff. Some respondents make useful suggestions regarding a reform process that incorporates these groups, in which they would be offered roles in the community-based secondary mental health system. While this report makes suggestions for expanding the mental health workforce, it should be recognized that this may be resisted by psychiatric interests, as Diyanath Samarasinghe suggests: “Where there are private practice interests, they [psychiatrists] are not keen to make their few skills generally available through other professionals.” Such resistance to changing mental health services is often taken up by professional associations which represent psychiatrists as stakeholders and make it difficult for leaders to cultivate the political will to pursue reforms. The challenges posed by the vested interests of psychiatrists are substantial, but Domingos Savio do Nascimento offers a message of hope based on a generational change of mental health professionals:

I believe that the key for the motivation of new professionals lies in the recognition that a clinical practice guided by more contemporary technical and ethical foundations might compensate for eventual economic losses.

The recommendations of this report could inform the technical and ethical foundations for care that can, as Domingos Savio do Nascimento suggests, perhaps supplant narrow economic interest.

Despite much agreement among international mental health experts regarding deinstitutionalization, there often exist some controversy and debate in society. One respondent notes that deinstitutionalization has led to many mentally ill persons living on the streets in North America and is thus not sure whether deinstitutionalization has improved the well-being of the mentally ill.<sup>12</sup>

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<sup>12</sup> This indeed has occurred in settings where deinstitutionalization is poorly executed, without the creation of community-based services.

Sometimes deinstitutionalization is stopped due to stigma. Pau Perez-Sales describes the concerns expressed by a Minister of Health about closing large mental hospitals:

Society prefers to have patients in a secluded area and turn away its head instead of having to deal with them in the community. ... The director of mental health of a Latin American country made this comment to me ... The Minister refused any attempt of psychiatric reform because she said: "The yellow press and the opposition will destroy us. The headlines in the press the following day would be: 'Health officers have released mad men to wander free in the streets'. Let's have someone else make this decision..."

Stigma in society concerning the seriously mentally ill can pose a challenge to deinstitutionalization, especially if picked up on by politicians. In parallel, the treatment of severely mentally ill people in mental hospitals reinforces stigma, as pointed out by Harry Minas:

Among the consequences of this lack of attention to human rights is the perpetuation of neglect and abuse at community levels (such as the use of restraints – chains, stocks, locked outhouses – by families) and extremely poor conditions in mental hospitals. Such conditions in communities and in families perpetuate stigma and discrimination and the common view that there is no effective treatment for people with serious mental illness.

Rita Giacaman describes the potentially broad resistance to the suggestion of closing a mental hospital in the occupied Palestinian territory, noting the (realistic) fears of the impact of closing a hospital without first having the appropriate community services in place:

The inevitable result would have been adding huge burdens on families, and women as a matter of fact, in a situation where already poverty was high, and rising, and where there is very little medical or other forms of support, not even the trained staff that could man a secondary care centre, let alone a first.

Melvyn Freeman similarly stresses that downsizing or closing mental hospitals is likely to result in failure if not accompanied with secondary care and community services:

Importantly, however, if a country is embarking on a deinstitutionalization programme, it may need, as a short-term strategy, to reallocate the budget spent on individuals in the institution to things like housing, employment programmes, etc. If this redistribution does not occur the programme could easily fail.

It is critical to note that the consensus among mental health experts to downsize mental hospitals co-exists with the consensus to develop community mental health services. Challenges to develop community mental health services may translate into challenges to downsizing mental hospitals. Respondents seem to agree that the primary responsibility for mental health care should not be at the mental hospital level, and that resources from hospitals should be translated into resources for community mental health services. However, decision-makers are sometimes unwilling to downsize and/or close mental hospitals – due to the political risk of facing vested interests. Deinstitutionalization is technically complex and cannot occur without adequate community mental health services in place. Thus, any downsizing of mental hospitals should be concurrent with improving community-based inpatient care for the mentally ill.

### **3.2.3 Integration within primary health care**

#### **3.2.3.1 The case for a primary care model**

Most respondents argue for a mixed model of services that prominently includes primary health care (PHC):

Investment should go to a mixed model of (a) primary health care setting system (b) linked up to a 'pyramidal' system of psychiatric experts (mental health nurse practitioner as first choice, psychologist, MD, etc.). (André Delorme)

In my opinion there has to be equal emphasis on decentralized and integrated outpatient services at all levels of health care clinics and inpatient psychiatric care in general hospitals with few designated beds for the mentally ill. The reason why I say this is that, on one hand, unless the service is made available at lower levels, it would be only very few people who could access the service; on the other hand, if we emphasize only lower-level outpatient services without inpatient care, those who need inpatient care will suffer from lack of appropriate care, plus the carers/families will be overburdened. This in turn will lead the community to lose confidence in the lower-level care being able to solve such problems or lead them to a place where better care can be obtained. (Atalay Alem)

I would argue for both an upskilling of the primary health care workforce in mental health and the expansion of specialist community mental health services. There will never be sufficient community mental health services to treat all people with mental illness so there cannot be a sole emphasis on these services. However, primary care services cannot adequately diagnose and treat patients with serious mental illness without the support of specialised services. I believe the mutual interaction and support that each of these service components gives to the other produces an outcome which justifies the resource implications of expanding both. (Harvey Whiteford)

I have little doubt that the budget for serious mental disorder should be allocated at all levels of the health system i.e. integrated primary health care (early diagnosis, ongoing therapy maintenance, dealing with uncomplicated cases, referral), secondary health care (integrated into general hospitals, community outreach programmes, life skills, day care, etc.) and more specialized services (tertiary services for treatment-resistant or highly complex cases and some long-stay care for patients needing ongoing nursing care). This way of providing mental health is a system that needs each component to work, otherwise it breaks down. By prioritizing any one area at the expense of any other will mean that the system will break down. (Melvyn Freeman)

I am for a mix of different services which should include essential mental health services at primary health level, outpatient clinic and acute psychiatric services in general hospitals and, preferably, special mental health institutions to provide technical support and specialized services. (Xiangdong Wang)

Primary care workers should be trained to assess and treat mental disorders, should be equipped with essential medicines, good practice guidelines and health management information systems that enable them to record the common disorders, and should receive support, supervision and dialogue from district-level specialist services. District services should contain mental health specialists: in low-income countries, these will often be mental health nurses and clinical officers, while some middle-income countries may also be able to place psychiatrists at district level. (Rachel Jenkins)

The need for expertise to recognize, treat and refer patients with psychiatric problems in primary care is clear. A mix of services is needed, including inpatient and outpatient

psychiatric services for the most seriously mentally ill, and building a capacity for responding to common mental disorders in primary care and general medical services. (Mitchell Weiss)

Some respondents consider PHC the starting point for developing services:

Mental health in primary health care should be the starting point because it is the only existing point of access in most of the countries in which I have worked (e.g. Sierra Leone, Chad, Aceh, Pakistan). It is also non-stigmatizing and accessible. (Lynne Jones)

Lynne Jones goes on to describe how community health workers, including psychiatric nurses, midwives, public health officers and other primary healthcare workers, could be trained to dedicate time to mental health, just as primary care workers have routinely done for antenatal care. However, others argue that the availability of community mental health services is perhaps a prerequisite for a primary care model:

As an approach, I think primary health care systems in low-income countries are usually poorly paid, little recognized and overloaded with multiple tasks and hardly can go, if we are realistic, farther than a certain attempt at case management of psychotic disorders, in coordination with some reference centres. ... Primary health care can take action when there is at least a minimum of resources of community mental health [workers] that can be used as a support network. (Robert van Voren)

Support for broadening the mental health workforce by integrating mental health into PHC is based on practical realities: "Given the very low availability of trained psychiatrists and psychologists, it is probably health workers and community-level workers who will form the core of MHS." (Rangaswami Thara). Based on experience in previous integrations with primary care, respondents offer the following valuable reflections:

There are model examples of integrating mental health care into primary care. In Chile they have successfully implemented a national programme for the detection, diagnosis and treatment of depression within primary clinics throughout the country. (Thom Bornemann)

Based on the Tanzanian experience, it pays to invest in integration of mental health into primary care with sustained funding for both pre-service and in-service training. Community mental health [care] has to be part of the equation, otherwise you end up with no referral system. This means we also need policy initiatives that can influence government at all levels and mobilize the necessary resources for an effective mental health service in primary care. (Joe Mbatia)

### **3.2.3.2 Challenges in integration within primary care services**

While some respondents note model examples for integrating mental health into general health care, there is substantial discussion about the failures of attempted integration with primary care systems,<sup>13</sup> and some discussion of the challenges of integration with disease-specific programmes. Critics of integration of mental health into a primary care system note that past attempts at integration have frequently failed. A key question is, in

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<sup>13</sup> See also WHO (2001) *The Effectiveness of Mental Health Services in Primary Care: View from the Developing World*. Geneva: WHO. [http://www.who.int/mental\\_health/media/en/50.pdf](http://www.who.int/mental_health/media/en/50.pdf)

the words of Thom Bornemann, “whether the integration of mental health into primary care is a bad idea, or if the idea has been poorly executed”.

Critics of integration with primary care suggest that the evidence base and methods for integration have not been appropriately developed. While some respondents describe a failure of integration in terms of workforce deficits (described in section 3.3), others suggest that integration has failed at a system level. Lakshmi Vijaykumar points out that integration can create a referral system, rather than provide care at the primary level:

Many LAMI countries have integrated mental health care in primary health services. This has provided only a partial success, as rather than offering the service at the primary health level it has turned into a referral mechanism.

In Lithuania, when mental health care was made available at the primary health level, according to one respondent, the system may actually have led to a reduction in care for the severely mentally ill:

In Lithuania mental health teams, including psychiatrists, function at the level of primary care, are funded by the capitation system and may be accessed without a ‘gatekeeper’. Initially this was regarded as a big achievement. However, it appears now that such a system creates many problems: GPs are not involved in mental health care, many ‘mild’ or ‘common’ cases go directly to a mental health team that works mostly with mild cases, and no resources are left for proper management of severe cases – those who are in biggest need of services. (Dainius Puras)

Rangaswami Thara describes the lack of impact achieved by a policy of integration in India, and suggests that community-based methods, which can function with less reliance on psychiatrists, may be more promising:

In India, the National Mental Health Programme (NMHP) envisaged the integration of mental health with primary care – a laudable programme indeed. But after almost three decades, the NMHP is yet to take off in many states, and even in those where it has been implemented, the impact was nothing to talk about. No formal, scientific evaluation has been carried out in the states where the NMHP has been taken more seriously. Lack of interest and motivation on the part of doctors and health professionals in the primary care settings is probably the most important reason for the partial failure of this programme. ... It appears that community-based mental health services will be the ideal intervention model to support in a country like India. These services should have a bottom-up approach with minimal reliance on psychiatrists, whose numbers are anyway dwindling in the country.

Florence Baingana suggests that where successful integration with primary care has taken place, it has not been properly documented:

Documentation of effective models for the integration of mental health into primary health care is also not as widely available and often not very comprehensively done. The model of Australia, the model of Uganda, the model of Romania, among others, all need to be written in a form that is accessible to policy-makers and disseminated as widely as possible.

Srinivasa Murthy criticizes the lack of effort to refine and develop the proposed integration:

In spite of the importance of the integration of mental health with primary health care, in spite of the early start of WHO in this area in the 1970s (Strategies for Extending Mental Health Care project in seven developing countries, there has not been a focus on *refining* the process of integration of mental health with primary health care. The development of training materials, evaluation of integration efforts in countries like Iran, India, Tanzania, etc. have not been the subject of serious effort by professionals and WHO. ... Ironically, if you look at the world literature of the last few years, there is more mental health in PHC research from developed countries than from developing countries. It should be the other way around.

The calls to better develop a method and evidence base for integrating mental health and primary care reinforce the need to improve strategies in training and supervising a mental health workforce, and to refine the systems-level interaction with community mental health services.

Respondents discussing the integration of mental health into primary care frequently describe under-trained, unsupervised primary care workers who are not sufficiently competent in the care (identification and treatment and/or referral) they are supposed to provide. For example, Norman Sartorius notes: "Training of general health care staff about mental health has often had disappointing results." Harry Minas describes the shortcomings in training and supervision of staff:

In most LAMI countries community treatment will usually mean treatment in primary care settings. Enhancing the capability of primary health workers to recognize, treat and when appropriate refer people with mental illness is a continuing key strategy. However, it is clear that short-term training of primary health workers is an ineffective strategy. Investment is required that will enable the provision of clinical supervision to primary health workers by specialist mental health workers to enable effective mental health services in primary care, and that will continuously improve the capacity of the primary care system. This will usually mean a shift in the role of mental health specialists from primary responsibility for assessment and treatment to a primary responsibility for teaching, supervision and support for primary care workers, as well as a direct clinical role in more complex and difficult cases.

Without appropriate training and supervision, it is suggested that primary care staff tend to increase their reliance on pharmaceuticals:

Without stiff regulations and the presence of an efficient judiciary, without the separations of powers (all in the domain of politics, of course) and without training and rigorous supervision of PHC staff, transferring management to the primary health care level is very problematic, as we are witnessing here with the distress problems people face, being given medications with side effects and being sent home instead of alternative methods of management. (Rita Giacaman)

Similarly, Peter Ventevogel notes the relative ease of prescribing medications in primary care:

Many primary care physicians and nurses are already overburdened and are not very keen to invest much extra time in mental health interventions; relatively easy to do is medication provision to patients with psychotic disorders, epilepsy and severe depression.

For common mental disorders the treatment will typically consist of prescription of antidepressant drugs. This implies a risk of medicalisation for social problems, while much of the distress of Afghan patients, women in particular, is related to their actual life circumstances.

Paradoxically, a few respondents highlight the fact that in many LAMI countries essential psychotropic medicines are often not continuously available at the PHC level – a barrier that hinders appropriate care for those people whose disorders can be effectively treated through medication.

Lynne Jones suggests that training and supervision of existing healthcare providers can successfully expand the base of providers:

We have found that a paramedic with training in general health can function as an independent mental health provider, after six months of intensive training and supervision in mental health.

A challenge to this approach may exist in recruiting mental health specialists to provide six months of training and supervision. A thorough discussion of methods and challenges in training a mental health workforce will follow later in this paper (see section 3.3.1). It is important to note that challenges in developing a mental health workforce translate into challenges in integrating with primary care.

Running through the discussion on integration with primary care there is perhaps agreement that investment in community mental health services and supervision of PHC workers by mental health specialists is critical to the success of the primary care model. It should be noted that this observation is in line with the 1978 Alma Ata Declaration, which promoted a primary care model “sustained by integrated, functional and mutually supportive referral systems” as an integral part of a country’s health system. Thom Bornemann may be right in concluding that the integration of mental health into primary care is not a bad idea, but one that has often been poorly executed.

The overall success of mental health in PHC thus appears to depend on sufficient worker time, sustained supervision and supports and continuously available medicines. The message is that all three barriers need to be overcome to successfully integrate mental health care into PHC. One feasible and sustainable development strategy is to start by first making available dedicated community mental health services, so that ongoing training, supervision and referral can more easily be made available to primary healthcare workers .

### **3.3 Strengthening the Workforce**

The interests of many national and international agencies and donors in constructing buildings rather than building services through strengthening the workforce is a key concern, as expressed by Istvan Patkai:

I observed in Africa and in Southeast Asia that decision-makers invest more in buildings and centres, probably due to political motivations and lack of knowledge about priorities. Human resource development for mental health is seldom targeted.

A commitment to strengthening the mental health workforce by training staff in the community and by expanding the base of providers will require a new role for mental health professionals, one focused on training and supervision, and one that involves the mobilization of families and communities in care and rehabilitation.

### ***3.3.1 Train and supervise staff hands on, in the community and continually***

The respondents' recommendations for improving the structure of the mental health system in LAMI countries depend fundamentally on the availability of an adequate mental health workforce. Respondents, with experiences in diverse settings, deliver a clear consensus that mental health training needs to move beyond hospitals and universities and beyond theoretical sessions, to a continual process of supervision and mentorship in the community they serve. This call for more community-based training may be applied to the training of psychiatrists, medical officers and primary care providers, as well as paraprofessionals in mental health. Many respondents describe the need to foster international collaboration for training, or to have international assistance in fostering collaborations with other LAMI countries. Rita Giacaman describes the need for training through hands-on supervised clinical work:

Our experience here is that the best form of training is in the form of ongoing, hands-on supervision, problem-solving and managing the sometimes huge structural constraints that can turn the training into practice.

A similar notion is expressed by Itzhak Levav with regard to undergraduate medical students, psychiatrists and nurses in training:

First, training has to take place where people go for services. Often, medical students and psychiatric residents are trained in mental hospitals. Same goes for nursing students.

Critical of the less clinically relevant, but dominant, training in psychiatric hospitals for undergraduate medical students, John Mahoney writes:

Many young staff have told me the only training they received was in the large psychiatric hospitals and it has "put them off for life". Most patients were admitted while acutely ill and the majority were readmissions.

Reflecting on a successful experience, Lynne Jones highlights the benefit of experiential learning for community health officers:

We suggested a model training course integrated into the training of community health officers in Bo in Sierra Leone where field work would be done with PHC clinics in the field. This would shift experiential learning to the relevant context and a problem-solving approach could be used

It is suggested that training should take place regularly, in community clinical settings and under the dedicated supervision of mental health specialists, rather than through one-off workshops, as the quotes below demonstrate:

One-time training, even intensive training, is not adequate; in retrospect, it would have been more effective if the training had been periodic and ongoing with access by phone or e-mail to consultants with specialized skills. (Thom Bornemann)

As for the training process, I am becoming less and less enthusiastic for the workshops, especially with 'training of trainers' notions. Often a lot of money is spent on workshops and not much output comes and there is seldom any follow-up. Therefore I am concentrating on supervision, home visits, follow-up and referral issues in community-based clinical settings. (Istvan Patkai)

Theoretical training without continuous on-the-job supervision is a very poor investment. In-and-out short courses, even with excellent trainers and on vital topics, tend to be a waste of time without some form of follow-up. (Lynne Jones)

Joe Mbatia emphasizes the supervisory role that mental health experts must take in order to focus on planning and training:

The few mental health experts available in LAMI countries should be mobilized towards a community-oriented approach that integrates mental health into primary care. Mental health will have to be facilitated so that they focus mainly on training workers from lower levels in the diagnosis and management of common conditions. The experts' role should be that of training, supervision, monitoring and evaluation. They should take the lead in strategically planning services based on available resources.

Mental health support in the community may depend on a shift in the role of mental health experts to one of supervision as discussed above.

### ***3.3.2 Increase and diversify the workforce: using all available formal and non-formal resources***

While some respondents suggest that providers in the primary care system should be further trained in mental health, others suggest finding new groups altogether, given the lack of available primary care workers. Lakshmi Vijaykumar writes:

Primary health care workers are often overburdened with infectious diseases, maternal and child health issues. A new cadre of primary health workers who are trained for non-communicable diseases, which includes mental health, can be considered for LAMI countries which are going through a demographic transition.

Many respondents call for the community-based training of dedicated mental health workers. Respondents suggest that those trained in the community must be recognized by governments, and allowed to qualify as professionals, in order to allow community-based care and training. Joe Mbatia suggests that countries should accept people with more modest training:

In Tanzania, mental health nurses form the backbone of services in the regions, districts and primary care. A highly-trained mental health workforce would be good to have, but it is hard to train and retain. I am increasingly convinced that countries have to accept more modest levels of training, preferably in-country trained and adapted to local demands. Short courses of not more than a year are adequate for diagnosis and management of common mental disorders, rehabilitation, prevention and promotion of community mental health.

Other, more provocative, suggestions include training lay individuals in the community to appropriately refer persons for further care:

I am a firm believer in expanding the category of mental health care givers. ... I was enthusiastic about the training of hairdressers, barbers and priests to recognize the simple mental health disturbances and refer them for further therapy if necessary. In some cases, simple counselling can be given by this cadre of person. (George Alleyne)

One hundred lay counsellors may be a better response to enhancing community mental health rather than a highly biomedically-oriented psychiatrist/specialist, who may be good for a few patients with serious disorders but not professionally competent or emotionally prepared to decentralize responsibility to a group of supervised lay volunteers. (Ravi Narayan)

Training of lay counsellors – like training of PHC workers or any other community resources – requires adequate post-training supervision from professionals. John Mahoney illustrates the popular sentiment that mental health providers can be drawn from a broader base, with less formal training. He notes:

Mental health care has in the past relied far too heavily on professional staff, when good community-level workers have been shown to perform the task of community mental health professionals. Importing Western models is not necessarily the answer. The approach should be to recruit for attitudes and train for skills.

Recognizing locally-trained persons as professionals or paraprofessionals who can be included as staff in a government programme will make care more accessible. In addition to recognizing staff trained specifically for mental health, Pedro Gabriel Delgado suggests that investing to attract psychiatrists to public health and qualifying the general practitioner's role in mental health, as has been done in small municipal districts under a Brazilian programme, would also make care more locally available. By creating a system that recognizes community-trained persons, or general practitioners qualified in mental health, the decentralization of mental health provision can continue, and services can expand to the communities in need.

Mitchell Weiss also notes the disparity in financial incentives, commenting that the “lack of incentives to stay in LAMI countries and appealing incentives to leave promote brain drain and loss of the best qualified professionals”. As noted by various respondents, the magnitude of the brain drain is substantial in certain countries (e.g. India, Sri Lanka, Nigeria). Elizabeth Matare devotes substantial discussion to the need to create incentives to recruit and retain mental health professionals.

Custodia Mandlhate suggests that improving working conditions may attract more health professionals:

The main barrier in attracting nurses for mental health is still the stigma related to mental health and the very difficult working conditions that mental health professionals are exposed to. There has been an attempt to renovate the facilities where mental health patients are treated; however, the environment is still not what we could call conducive.

Respondents call for investment in the training, salaries and working conditions of mental health personnel, so that incentives remain in place to encourage mental health leaders to work in LAMI countries, and particularly in the public health system.

The suggestion to more formally involve families in providing care, and to empower them as advocates, receives substantial support among respondents. Céline Mercier writes:

In my view, the first principle to guide every development of services would be to build on what already exists. It looks as if, up to now, extended families and neighbours are doing a lot. In that sense, support to families and communities should be the first move. Any plan should be implemented with a view to examining, in the first place, how the local communities can contribute to this plan. This means that actions should not be so much orientated towards more services but towards more 'resources', including informal resources as well as formal services.

Similarly, Sylvester Katontoka stresses that family members are a valuable resource that should be seen as part of the mental health system:

Family members in community mental health care must be recognized as a *key* resource to the community mental health system. Psychosocial education can be promoted to impart some skills/knowledge on how to manage the burden of mental illness and increase their effectiveness as care providers.

Likewise, John Mahoney suggests involving service users in care, describing a potential role for users as staff in supported housing programmes. To best involve families in care, Elizabeth Matare suggests that they need the support of trained personnel, who can provide support and guide the use of medications; she writes: "The provision of psychotropic drugs at that level will prevent families from discarding their ill relatives." She further suggests that family care may be especially useful in rural areas, if families are given appropriate support by trained mental health staff:

The families/carers need extensive support in the absence of qualified personnel. The minimal resources will go a long way in strengthening the positive aspects of rural life. In the majority of LAMI countries 60% of the total population is ordinarily rural-based. Families have been seen as a substitute for professional care and not as an essential component of mental health.

After family support systems have been welcomed into the mental health system, Florence Baingana suggests possible methods for coordinating and financing their involvement:

Some other middle-income countries have a strong family support system and a well-established community mental health care system well integrated into primary health care. The emphasis for these countries would be streamlining the coordination of the financing between the different sectors, as well as piloting innovative approaches to social insurance mechanisms, if the social welfare system is weak. An example would be India, which piloted the provision of a stipend to families.

Involving families makes them stakeholders in mental health; the resulting advocacy was productive in Zambia, as Sylvester Katontoka recounts:

According to my experience, the formation of a consumer movement in 2000 and some involvement of family members played a very important part in mental health reforms. With clients and family members as stakeholders in mental health, there was demand that medical treatment should be a basic right for persons with mental health problems.

While overall respondents are supportive of including families in care systems, it should be noted that there is some concern about the effect such involvement may have on public services:

A more prevalent family model – extended family – means that much of the patients' care is provided by families, so their needs are partially met and the public services tend to ignore them. (respondent who preferred to be quoted anonymously)

Many respondents suggest that family responsibilities should be incorporated into public services, rather than having only one or the other. Family members are an active resource, and a number of respondents recommend a formal involvement of families in the mental health system to sustain and further their role. In addition to involving families, it was suggested earlier that the involvement of service users in advocacy may lead to increased funding for mental health services; at the community level, user involvement may facilitate deinstitutionalization and greater community integration.

The involvement of families is complemented by the involvement of the community, and is consistent with using participatory action approaches, which have been common in rural development and which are now also used by some mental health NGOs (e.g. BasicNeeds). Such approaches are also increasingly common in psychosocial programmes in emergencies.

In India, framing mental health in the realm of community and economic development has assisted in advocacy to increase funding for mental health, and may hold promise as a strategy:

Advocacy for additional resources for the National Mental Health Programme was conceptualized around the basic principles underpinning the MDGs: rights-based approach to mental health, mental health as a development issue, mental health as a prudent economic investment. (D.S. Goel)

### **3.3.3 A changing role for mental health specialists**

As touched upon earlier, many respondents note that making mental health care broadly available necessitates a supervisory role for mental health specialists. John Mahoney writes:

If developing mental health provision in primary care is ever to be successful, however, psychiatrists have to change their role from providing services to continuous training and supervision at various locations in the community, and only take on clinical responsibility for those patients who present with complex needs.

Harry Minas describes the need for psychiatrists to focus efforts on training other health workers:

A key change that is required is that psychiatrists must stop ... taking primary responsibility for the clinical care of patients. They must transfer their knowledge and skills to large numbers of other health workers – particularly primary care physicians and nurses. Their key responsibility is to build capacity in the mental health system by building a skilled workforce.

Redefining the role of mental health specialists will be costly, given the existing compensation schemes for the provision of care. Gaston Harnois describes the challenge in shifting the role of psychiatrists to that of trainers in the public health sector:

In many LAMI countries, a majority of psychiatrists work in the private sector; efforts (and modalities) should be worked out to involve some of them for part of their time in working for the public health sector, mostly as trainers in primary health care, in rehabilitation and in community support.

Developing a broader base of mental health care providers, in general health services and in community-based mental services, depends on mentorship and community-based training. To restructure care as respondents recommend requires that the specialist must frequently switch to a training and supervisory role.

### **3.4 Public mental health leadership**

Mental health leaders in LAMI countries – such as directors of mental health in Ministries of Health – have responsibility for the complex tasks of increasing funding, making mental health care more broadly available, developing a system for secondary and community care and reforming hospitals, among other challenges. Such tasks require not only a familiarity with the needs and possible supports for diverse people with mental disorders, but also population-based, public health vision and skills. Harry Minas offers a description of what a mental health leader needs to do:

The tasks of leadership in this context include the articulation of a compelling and commonly accepted vision of what the mental health system should be, the development of strategies for achieving agreed goals and the engagement of all of the key stakeholders in the common pursuit of agreed mental health system development objectives.

The skills for such leadership need to be developed, or sought from outside the mental health field, according to Itzhak Levav:

Leadership cannot be expected from clinicians turned by default into administrators/planners. Their views, experience and training are not compatible with a population-oriented mental health action. Perhaps, and this until cadres of public mental health leaders become available, we should rely on public health leaders or other stakeholders (e.g. family members) who have the capacity to lead programmes (the former) or to e.g. advocate/negotiate/inspire (the latter). In many cases I would look for leadership outside of the classical mental health field.

Many respondents note the need to employ public health models and strategies. Gary Belkin notes the urgent need to use public health principles in mental health:

Yes, stigma is an issue. Yes our 'evidence base' needs deepening – ability to better economically model impact, impact of behavioural outcomes on social categories and vice versa, morbidity effects. But the real next steps are plain and simple strategic institution-building through an embracing of public health vehicles, which has been a blind spot for our profession.

Dainius Puras similarly notes the need for public health models, and the need for leadership that can develop and employ such a model where it has previously been absent:

Keeping in mind that post-Communist countries suffer from epidemics of suicide, violence and alcohol abuse, it should be clearly decided that such epidemics cannot be solved by training more psychiatrists and investing in more psychiatric services. This is firstly a public health problem, and it should be solved in a population-based way, through modern public health approaches. These are very underdeveloped in post-Communist countries, because the concept of public health (sanitary hygiene) has never involved mental health, which was left to psychiatry.

The absence of public health-minded approaches in mental health care may be due in part to the nature of existing interventions, and also to the training of mental health leaders:

An important barrier is the lack of population models and public health considerations in the training institutions and practices of mental health. Unlike our colleagues concerned with infectious diseases, injury prevention, nutrition and so forth, mental health has no historical traditions of sanitary commissions, seatbelts or vitamin A, and we need to innovate and develop analogues. Leaders representing mental health in government and policy groups may lack sufficient experience beyond clinical practice that is relevant for mental health systems. (Mitchell Weiss)

The lack of public mental health leadership may be due to a lack of incentives for psychiatrists to take a public health view, and also to a lack of authority for non-psychiatrists attempting to engage such a view.

There are few economic, social, psychological or policy incentives to be an effective mental health leader. First, the state health care sector pays a salary that is so low that only a fool or an idealist feels attracted to such a position. In order to survive, the mental health focal person – if it is a psychiatrist – has to do other chores such as a private clinic in order to survive. That implies that he or she often will not have the time to develop a public health view on mental health and will often limit himself/herself to e.g. running a psychiatric hospital with some community initiatives. If the mental health leader/focal point of the country is not a psychiatrist, he/she often will not have the authority to convince the psychiatrists to engage in a public mental health model. (Joop de Jong)

As noted by Joop de Jong, in most LAMI countries – as in most high-income countries – “training in public mental health does not exist”. Melvyn Freeman suggests training courses for public mental health leaders:

There is often the belief that good clinicians or good academics make good leaders. People who excel in these areas are then promoted into leadership and policy positions without management experience, without personal leadership qualities, with no understanding of advocacy and lobbying and little or no knowledge of public health. Many people do not have the available public mental health ‘evidence’, or personal drive to promote and lead mental health. There needs to both training in ‘public mental health’ for people already in such positions and career paths for people interested in the policy and management side of mental health.

Similarly, Emran Razaghi and Rahimi Movaghar call for a closer affiliation and integration of mental health with public health, and recommend that countries:

... encourage and promote curricula on mental health, at all levels, to be enriched by public health science; and ... initiate mutual dialogue with public health professionals to recognize the capacity and necessity of implementation of mental health as an integral part of health.

There is a consensus that training leaders in public mental health may greatly improve mental health strategies in LAMI countries, and that such leaders can be supported with training, incentives and collaborations.

Respondents suggest that international assistance and incentives are crucial to developing public mental health leadership. Two trends emerge from respondents' discussion of collaborations in the training of mental health leaders: respondents suggest the importance of lateral collaborations – with other LAMI countries, or regionally – and of collaborations with international organizations. Discussing the potential for an international network, Elizabeth Matare recommends establishing:

... lateral exchange programmes amongst mental health professional in the LAMI countries, with the specific challenge of what can be learnt from best practices in mental health delivery programmes that can be emulated elsewhere. The sharing of information from established pilot programmes may have a different perception on the mental health workforce e.g. Asia, Africa, South America.

Similarly, others describe how high-income countries may help in the training of leaders:

We should consider twinning services in Europe with local counterparts, where they exist. These could then develop into 'demonstration sites' and become examples for a region. ... Perhaps we could also use our network of intercontinental MPs to devote some time to a particular group of countries, linking with politicians, doctors and health managers there. (John Bowis)

For the first time, an international cooperation agreement between the Dutch and the Gujarat state government, in the case of Gujarat, focused on mental health as a thematic area of development. This example can be emulated in other parts of India. (Bhargavi Davar)

Training partnerships that extend over a substantial period with external training institutions can be extremely effective. The best example of this has been the experience in Cambodia with the sustained commitment of the University of Oslo to the development of a training programme for psychiatrists and mental health nurses in that country. (Harry Minas)

Dainius Puras argues that the lack of partnerships is a substantial cause of inadequate mental health leadership, writing that, in Lithuania, "the main barrier is weakness of civil society and lack of culture of partnership ('horizontal' relations)". John Mahoney recommends a global network among developers of community mental health services, to share experiences, stressing the importance of:

... an international network of staff who have developed good community mental health services to help and advise their colleagues; and ways must be found of sharing these

experiences through regular conferences in resource-poor countries, e.g. a website and publications.

Regional networks, which involve more direct contact and which are problem-focused, are advocated by Alberto Minoletti and Pedro Gabriel Delgado:

For example, a course about community mental health and public health could be organized for mental health leaders in Latin America, based on WHO's Mental Health Policy and Service Guidance package, to be repeated every three to five years. This course could have face-to-face activities and distance learning, and it could also include some form of follow-up and reinforcement which allow exchange and learning among peer leaders of different countries. (Alberto Minoletti)

Some respondents call on international organizations and mental health professionals from outside LAMI countries to train local leaders:

As an example, a two- to three-week Leadership Training Institute could be developed in partnership with leading educational institutions in the US and Europe, bilateral development partners and the World Bank. The reason for including the World Bank in the partnership is because this would provide mental health leaders with the knowledge and skills to access World Bank funds. Such institutes are already regularly held on reproductive health, emergency reconstruction and on health sector reforms. (Florence Baingana)

Leadership can be fostered by the mentoring of mental health professionals in LAMI countries, stimulating their association and fostering links with colleagues in the developed world. (George Alleyne)

In the meantime I think it would be a good idea for organizations such as the WHO to run short courses [on public mental health] and to get people together to share their experiences and together to work out strategies for improving mental health in their countries. (Melvyn Freeman)

In addition to mentorship and short courses to develop knowledge and skills for leadership, some respondents suggest sponsorship for mental health professionals to study abroad (Rita Giacaman), and an expanded programme of WHO advisors (John Mahoney). Richard Mollica recommends the creation of model programmes in LAMI countries that could be supported by WHO:

WHO and international donors need to set up in each LAMI/post-conflict country a mental health 'Centre of Excellence'. This team of practitioners from psychiatry, public health, primary health care and the social services should be trained and financially supported by WHO and the international community for a minimum of 5–10 years to be sure the centre of mental health excellence establishes programmes in treatment, supervision and mental health linkages to the media and the general public.

Respecting concerns that any programme should be adapted to local settings, respondents strongly endorse lateral, regional and global cooperation for mentoring and for sharing models of success.

The need to develop mental health leaders with public health vision and rigour and to develop networks of such leaders laterally, regionally and globally is an issue that has strong support from respondents, yet these methods have seldom been used. The

international community and general public health leaders can play a role in training mental health providers in public health principles, and in cultivating leadership through networks that allow communication on challenges and facilitate the replication and adaptation of successful strategies.

## **4. Discussion and Conclusions**

While the discussion above is varied, and there are certainly areas of controversy, there is also substantial agreement among respondents on barriers and facilitating factors.

### **4.1 Barriers and facilitating factors to developing mental health services**

Respondents highlight many barriers to the implementation of existing mental health knowledge in mental health services. A lack of funds for mental health services is explained by a number of factors, including inadequate coordinated and consensus-based national mental health advocacy and plans, the absence of mental health in major donor priorities, marketing of expensive pharmaceuticals by industry, cost-effectiveness information on mental health services that is unknown to senior decision-makers and social stigma, among others. This lack of funding is further challenged by the heterogeneity in the field of mental health, both in terms of problems (diverse types of disorders, absence of well-being) and types of services.

Barriers to successful implementation of services have included deficient training and supervision of general healthcare staff in the absence of supportive, functional community mental health services, an inadequate workforce for mental health and, in many countries, continued centralization of resources in large mental hospitals. Decentralization and deinstitutionalization are often slowed down by the resistance of various groups, such as trade unions, managers of government departments or professional associations when there are vested interests at stake. Finally, mental health leaders are often unfamiliar with public health (population-based) approaches to mental health problems. Many of the barriers mentioned above are maintained by existing incentive structures.

Respondents also suggest many potential facilitating factors for implementing mental health services. Efforts to formulate national mental health plans and to facilitate the inclusion of families, users, community organizations and service providers in advocacy may enhance mental health funding and reform of services. A clear distinction between which group of disorders (severe/complex vs common mental disorders) is being targeted by such a mental health plan is needed for consistent and coordinated advocacy, and for coherent mental health services.

Many respondents suggest developing primary and secondary (community-based) mental health care systems that interact closely with one another. It is suggested that large mental hospitals should be downsized, and that community mental health services be developed to provide accessible mental health care, including acute in-patient care. To further address the enormous barrier of an inadequate, under-staffed workforce for mental health, respondents suggest a more formal involvement of families and community members in rehabilitation. To reach higher levels of population coverage, mental health professionals – with appropriate incentives – must focus a major part of

their efforts on training and supervising healthcare staff and non-professional mental health providers to expand the workforce for mental health.

Facilitating factors for fostering public mental health leadership include incentives for a public health approach, education in public mental health and the creation of lateral, regional and global networks for global cooperation, mentoring and sharing successes and challenges in public mental health.

#### **4.2 Comparison with *WHR 2001* recommendations**

By considering the respondents' discussion within the frame of each of the *WHR 2001* recommendations (see Appendix 3), we can assess how this analysis supports, questions and informs the 2001 recommendations. A summary is provided here.

*WHR 2001*'s first recommendation was to provide treatment in primary care. Although respondents emphasize that mental health skills should be made available in primary care, a clear message is that this should form part of a mental health system that is able to ensure ongoing training, supervision and referral options for primary care workers.

Regarding the recommendation to make psychotropic drugs widely available (Recommendation 2), respondents agree, but at the same time insist on the need for sufficient training and supervision of general health workers. The recommendation to give care in the community (3) receives strong support among respondents, while the call for public education (4) is discussed in terms of focused campaigns targeting policy-makers, as part of a plan for coordinated advocacy.

The involvement of communities, families and consumers (5) is supported, especially with regard to mobilization and recognition of non-formal resources for advocacy and the provision of care. The need for national policies, programmes and legislation (6) is supported and there are calls for a unified and coordinated national plan for mental health, developed in a participatory way by the Ministry of Health.

The development of human resources (7) is often discussed by respondents. However, respondents emphasize that the training process should be continuous, should involve close clinical supervision and should take place in the community setting. The need to link with other sectors (8) is discussed by respondents, as complementary to a decentralized community mental health service provision. The monitoring of community health (9) receives little discussion among respondents, but the recommendation to support more research (10) is supported by respondents in terms of calls for research on health services and systems, and social research.

#### **4.3 Lessons learned**

Among the many lessons that can be drawn from the survey of experts concerning the challenges to developing mental health services, we highlight four prominent ones. First, many of the barriers to progress in developing mental health services can be overcome if there is sufficient political will. The authors agree with Thom Bornemann, who writes:

Historically, the political will necessary for building up mental health capacity and leadership has been lacking and continues to be a significant challenge. At the core, the

challenge is really one of low political will and how to go about influencing it in an effective and consistent way over time.

As we have seen, mental disorders are usually low on the public health priority agenda of international agencies and donors – whether they are intergovernmental organizations, bilateral aid agencies or international NGOs. Mental health is typically also low on the agenda in most Ministries of Health. Political will to address the well-being of people with mental disorders is needed to substantially increase funds. At the national level, political will is necessary to face the resistance of various groups – whether trade unions, managers of government departments or professional associations – who may object to mental health reforms when these involve decentralization of resources or affect vested interests.

Political will is also needed to overcome other challenges, such as accepting creative solutions in diversifying the workforce, appointing, if necessary, public health experts in mental health leadership positions, creating mental health units in Ministries of Health whenever such units are absent, engaging other sectors to ensure housing and livelihood supports for people with severe mental disorders and rapidly developing strong legislation and policies that protect people with mental disorders from human rights violations. Indeed, the words ‘politics’ and ‘political’ occurred 145 times in the answers of the 57 respondents to the survey, without being prompted by inclusion in the survey questions. Without increased political will, development of mental health services will probably continue to progress, as it has for the past 40 years, but the rate of progress is likely to remain slow in many countries unless there is more political will.

The second lesson is that advocacy for people with mental disorders needs to substantially expand and become more unified. Advocacy has been not been sufficiently clear, informative, consensus-based or focused – all of which are essential to achieve sustained political will. This observation has implications for national-level mental health planning. Indeed, few countries have consensus-based national mental health plans written in consultation with key stakeholders, who include NGOs, clients/consumer representatives and sectors other than health. Yet, according to the respondents to the survey, such plans are important – not just because sound planning is invaluable to successful development, but also because consensus-based plans are forceful vehicles for advocacy.

By functioning as a coherent proposal for services, a well-developed national plan for mental health, developed in a participatory way by the Ministry of Health and involving key stakeholders, can facilitate sound financing from different levels of government and can be an attractive proposal to international donors. Such plans need to be developed within a relatively short time span – rather than being perfected slowly over a number of years as is happening in some countries – for two reasons: (a) so that they do not lose the momentum that is generated through participatory processes and (b) to communicate to political decision-makers and funding sources that mental health actors can swiftly agree and act.

Third, there is a need to make the development of community mental health services at the secondary care level a priority. Although this report does not go into detail on the technical aspects of developing mental health services (this is available elsewhere: see, notably, WHO’s Mental Health Policy and Services Package), survey respondents offer broad-stroke but important observations.

Respondents argue that mental health care by PHC and non-formal community resources requires supervision and specialist back-up support, and that downsizing mental hospitals requires the availability of a range of services and supports in the community. From these observations, we infer that, in building a mental health system in a district or province, success may be highest if specialist community mental health services are developed *first* in order (a) to support responsible downsizing of mental hospitals and (b) to sustain mental health investment in PHC clinics, which is essential to reach proper population coverage. Investing in primary care or existing tertiary care (e.g. improving conditions in mental hospital) is vitally important, and opportunities to invest in primary and secondary care should not be ignored. However, such investments are likely to go furthest if they are preceded, or at least are implemented in tandem with, the development of community mental health services.

The fourth lesson is an old one, and it is that people responsible for developing services need to be much better at using the resources that are available, including non-formal resources. The need for deinstitutionalization and decentralization of resources is covered in detail in the *World Health Report 2001* on mental health, and the respondents' important suggestion to use specialist staff mainly as supervisors rather than as clinicians was also put forward in the *Institute of Medicine* report. However, our survey highlights that, in addition, there are large, unused opportunities to involve non-formal human resources.

The scarcity of formally trained human resources for mental health care in many LAMI countries suggests that considerably more action is needed to ensure that non-professional community members take part in mental health programming. The repeated calls by respondents to not only train and supervise general health workers but also to involve people with disorders, family members and other non-formal resources in the community are best answered by the use of participatory action approaches, which are common practice in community development.

These approaches are increasingly being applied to develop community mental health care for people with severe mental disorders in a range of LAMI countries. In addition, emerging networks of people with mental disorders – organized in movements such as the Pan African Network of Users and Survivors of Psychiatry – are set to play a significant part in making humane care more widely available in LAMI countries. Mobilization and recognition of non-formal community resources will need to be drastically stepped up to ensure access to care for the millions of people without such access.

The challenge to develop more public health skills among mental health leaders needs to be addressed in a sustainable way. One of the greatest public health actions in the previous century was the establishment of public health schools at major universities. These schools disseminated important knowledge and led to the creation of a public health workforce. Inspired by this historical example and noting the absence of public health knowledge in most mental health professionals, it is recommended that universities in both LAMI and high-income countries establish public mental health courses, covering mental health epidemiology, policy, legislation, organization of services and prevention. Such courses could be mandatory for senior psychiatry and clinical psychology students and for graduate students in degree programmes on public health, and optional for graduate students in community development and public

administration. This would provide a long-term solution to the current challenges of leadership.

Many factors are associated with progress in mental health services. Although it is important that we have good science – and we definitely need more science – this report suggests that population-wide progress in access to mental health care is also closely associated with increased attention to politics, leadership, planning, advocacy and citizen participation.

## Appendix 1: Letter to invited survey respondents

As you may know, *The Lancet* is currently organizing a Series of papers on 'global mental health' (see Patel V, Prince M, Saxena S, *The Lancet* 2006;367, 1471-72) to be published in April 2007. In addition to soliciting original research papers, the journal has commissioned four review papers that will give an update of the evidence presented in the *WHR 2001*. The Series will close with a paper presenting a Call for Action, outlining steps for the way forward.

Although previous *Lancet* Calls for Action have had substantial impact on public health, I am concerned that the implementation of the Call for Action on global mental health may face the same obstacles as that of the 10 recommendations of *WHR 2001*.

*The Lancet* has agreed that this is a concern and has asked me to examine the question of why existing knowledge on mental disorders (large burden, existence of effective treatments, need for accessible and humane services, etc.) is not having much impact on mental health service development in most LAMI countries.

In my role as Director of the Department of Mental Health and Substance Abuse at the World Health Organization (WHO), I am approaching you to ask for your thoughts. My concern has been that little is changing in mental health services in most low and middle income (LAMI) countries, and I am seeking your help to better understand this.

In 2001 WHO focused its work on mental health, and its *World Health Report 2001* (*WHR 2001*; <http://www.who.int/whr/2001/en/>) was entirely devoted to mental health. *WHR 2001* summarized available evidence and thereby raised awareness that the global burden of mental disorders is enormous, that the rights of people with severe mental disorders need to be far better protected, that most mental disorders can be treated effectively and that in 2001 very limited resources were dedicated to mental health. Informed by the evidence, the report outlined 10 recommendations to describe WHO's advice on the way forward.

In addition to *WHR 2001*, other significant and substantial reports have been published in the last decade with the same aim of putting mental health on the agenda. Despite the wide circulation of these reports, despite awareness raising at the highest government level and despite numerous extremely valuable activities organized by governments, UN organizations, professional organizations and civil society, little is changing in mental health services in most LAMI countries. Although notable exceptions exist, there has not been much improvement in services for most people with mental disorders in the vast majority of LAMI countries.

You are among a select group of experienced, high-profile, international leaders. We are asking you to spend some of your valuable time to respond to the attached questions. **In order for your observations to influence this *Lancet* Series, I am seeking your response by 1 December 2006.** I apologize for the somewhat inflexible timeframe. Indeed, on 2 December 2006, we will send all answers to an independent qualitative data analyst for content analysis. The results of the analysis will be shared with you for comments and will most likely be published as a separate paper in *The Lancet*. This analysis will influence the contents of the Call for Action.

Your contribution to this exercise will be gratefully acknowledged in the paper that I will develop together with Chris Underhill (BasicNeeds), Rajaie Batniji (University of Oxford) and Mark van Ommeren (WHO). We hope that you are willing to make a contribution to this important endeavour. I would be happy to answer any questions that you may have and look forward to learning from you.

Thank you for your kind consideration.

Yours sincerely,

Benedetto Saraceno  
Director  
Department of Mental Health and Substance Abuse

Enclosure: Questions

## Appendix 2: Survey questions

Thank you for helping us understand why there has been so little improvement in services for people with mental disorders in most low and middle income (LAMI) countries.

Please kindly consider the following points when answering questions

- These questions pertain to LAMI countries only.
- Where relevant, please mention the LAMI country that you have in mind when responding to the question.
- If it happens that a question covers technical issues that are too specialized for you to answer, then please feel comfortable skipping the question.
- Please provide specific examples to illustrate your answers where possible.

### **1 How do you explain the low levels of financial investment in mental health services?**

(In most LAMI countries very few financial resources are available for mental health services, whether by national/local government or by most international donors. A variety of explanations are often given, such as lack of general mental health knowledge among decision makers on what the problems are and what can be done; unsatisfactory experiences with past and current investments, lack of perceived importance of mental illness and other noncommunicable disease; mental health is not explicitly named in the Millennium Development Goals (MDGs) nor in most poverty reduction strategies; relative unattractive cost-effectiveness of investing in mental health services compared to investing in some other health interventions; donors may be more interested in funding activities related to specific diseases rather than for broader notions such as 'mental health' or 'psychopathology', etc. There may be many more explanations and some of the above explanations may perhaps not be valid for the LAMI countries that you know. We would like to have your opinion on what indeed may be the key factors explaining why so little money is available for mental health services. Please be so kind to explain your answer.)

**2a In what type of services should LAMI countries invest their available resources for mental health care?** (This question refers to the importance of different types of services. It may be argued that little progress has been made, because the focus of limited investments in LAMI countries may have been 'wrong.' Although most people argue for a mix of different services, many experts, consultants and mental health system administrators believe that the emphasis of mental health investments should be especially on mental health care in primary health care services, others believe that the emphasis of investment should be especially on community mental health services (outpatient psychiatry clinics, acute inpatient psychiatry care in general hospitals, community mental health teams, etc.), while again others argue that the emphasis should be especially on care in mental hospitals. Also, arguments have been made that the emphasis should be much more on services outside the health sector (e.g. supported housing, social services, etc.). In your view in what type of services should available resources for mental health care be invested?).

**2b How can LAMI countries ensure that their mental health work force has the minimum level of clinical knowledge and skills needed for appropriate clinical care? What are the barriers to achieving this minimum level?**

**2c Overall, how can the currently available mental health resources (e.g. staff and funds) in LAMI countries be used in a better way? and what are the barriers for doing so?**

**3. How can effective mental health leadership be achieved in LAMI countries? and what are the barriers to achieving such leadership?**

**4. What has been your experience with improving mental health services in LAMI countries that you know? What has worked and what has not worked and why? (We are asking you to reflect on real experiences that you have had or that you are very familiar with.)**

**5. Please give us any further thoughts to help explain why there has been so little improvement in the services for most people with mental disorders in most LAMI countries. (We would welcome any other thoughts, including those that may be "out of the box".)**

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**6a. There is a chance that we may wish to use a suitable quote of some of your answers in the resulting report and article. Please kindly circle one of the three options below.**

(1) I would prefer not to be quoted at all.

(2) It is okay to quote me and to refer to my name, position and affiliation when quoting me.

(3) It is okay to quote me but please do so anonymously.

**6b. May we have your permission to mention your name as a respondent in the acknowledgments section of the article? Please kindly circle one of the three options below.**

(1) I would prefer not to be acknowledged.

(2) I would be happy to be acknowledged.

(3) I would prefer to decide on this only once I see a pre-final copy of the article.

**Thank you for your kind responses. Please kindly send your response to Benedetto Saraceno ([saraceno@who.int](mailto:saraceno@who.int)) by 1 December 2006.**

### **Appendix 3: Comparison with the World Health Report 2001 recommendations**

Below, we consider each *WHR 2001* recommendation and briefly discuss how this was reflected among respondents.

*1. PROVIDE TREATMENT IN PRIMARY CARE: The management and treatment of mental disorders in primary care is a fundamental step which enables the largest number of people to get easier and faster access to services – it needs to be recognized that many are already seeking help at this level. This not only gives better care; it cuts wastage resulting from unnecessary investigations and inappropriate and non-specific treatments. For this to happen, however, general health personnel need to be trained in the essential skills of mental health care. Such training ensures the best use of available knowledge for the largest number of people and makes possible the immediate application of interventions. Mental health should therefore be included in training curricula, with refresher courses to improve the effectiveness of the management of mental disorders in general health services.*

The extensive discussion on this recommendation focuses largely on the challenges to providing treatment in primary care. Respondents suggest that provision of mental health treatment in primary care, especially for non-severe mental disorders, may be promising to increase population coverage but that its execution is usually disappointing. Although respondents emphasize that mental health skills should be made available in primary care, a clear message is that this should be part of a mental health system that is able to ensure ongoing training, supervision and referral options for primary care workers. Without community mental health services to sustain primary health care, many investments in primary care may be inefficient.

#### **2. MAKE PSYCHOTROPIC DRUGS AVAILABLE**

*Essential psychotropic drugs should be provided and made constantly available at all levels of health care. These medicines should be included in every country's essential drugs list, and the best drugs to treat conditions should be made available whenever possible. In some countries, this may require enabling legislation changes. These drugs can ameliorate symptoms, reduce disability, shorten the course of many disorders, and prevent relapse. They often provide the first-line treatment, especially in situations where psychosocial interventions and highly skilled professionals are unavailable.*

Respondents suggest that while essential, generic psychotropic drugs should be made available at all levels of care, there are risks involved in making them available to staff who lack skills in using them. This recommendation should thus only be implemented in those settings where the workforce is sufficiently developed to make rational use of the drugs.

#### **3. GIVE CARE IN THE COMMUNITY**

*Community care has a better effect than institutional treatment on the outcome and quality of life of individuals with chronic mental disorders. Shifting patients from mental hospitals to care in the community is also cost-effective and respects human rights. Mental health services should therefore be provided in the community, with the use of all available resources. Community-based services can lead to early intervention and limit the stigma of taking treatment. Large custodial mental hospitals should be replaced by community care facilities, backed by general hospital psychiatric beds and home care support, which meet all the needs of the ill that were the responsibility of those hospitals.*

*This shift towards community care requires health workers and rehabilitation services to be available at community level, along with the provision of crisis support, protected housing, and sheltered employment.*

Overall, the recommendation to focus on care in the community receives very strong support from respondents. The need to decentralize resources by downsizing large mental hospitals and developing care and rehabilitation in the community is repeated by respondents, and specific strategies for doing so are shared. Further, placing secondary care in the community facilitates training of PHC workers and the corresponding expansion of the mental health provider base. In agreement with the *WHR 2001* recommendation, respondents suggest that acute inpatient care should be available at the community level, and that a community-based model of care can more easily form links with social and other health services. Thus, the aim of giving care in the community is critical to the integration with general health services, to expanding the workforce and to more soundly spending mental health resources. Despite the strong support for this recommendation, however, it is noted that few respondents discuss protected housing or sheltered employment. Rehabilitation through involvement in agricultural work is recommended for people with mental disorders living in rural settings.

#### **4. EDUCATE THE PUBLIC**

*Public education and awareness campaigns on mental health should be launched in all countries. The main goal is to reduce barriers to treatment and care by increasing awareness of the frequency of mental disorders, their treatability, the recovery process and the human rights of people with mental disorders. The care choices available and their benefits should be widely disseminated so that responses from the general population, professionals, media, policy-makers and politicians reflect the best available knowledge. This is already a priority for a number of countries, and national and international organizations. Well-planned public awareness and education campaigns can reduce stigma and discrimination, increase the use of mental health services, and bring mental and physical health care closer to each other.*

There is limited discussion on efforts to educate the public on mental health: some respondents mention ambassadors of mental health and education to reduce stigma, which could in turn increase popular support for mental health spending. Efforts to educate policy-makers and to influence professionals are critical to developing the coordinated mental health advocacy that respondents recommend.

#### **5. INVOLVE COMMUNITIES, FAMILIES AND CONSUMERS**

*Communities, families and consumers should be included in the development and decision-making of policies, programmes and services. This should lead to services being better tailored to people's needs and better used. In addition, interventions should take account of age, sex, culture and social conditions, so as to meet the needs of people with mental disorders and their families.*

Many respondents suggest that communities, families and consumers should play a major role in advocacy and, crucially, some respondents suggest that ex-users, families and community members should be mobilized to become part of the mental health workforce. The *WHR 2001* recommendation is supported, though the respondents' emphasis is on advocacy and the involvement of communities, families

and consumers in care perhaps goes beyond the development of programmes and decision-making.

#### **6. ESTABLISH NATIONAL POLICIES, PROGRAMMES AND LEGISLATION**

*Mental health policy, programmes and legislation are necessary steps for significant and sustained action. These should be based on current knowledge and human rights considerations. Most countries need to increase their budgets for mental health programmes from existing low levels. Some countries that have recently developed or revised their policy and legislation have made progress in implementing their mental health care programmes. Mental health reforms should be part of the larger health system reforms. Health insurance schemes should not discriminate against persons with mental disorders, in order to give wider access to treatment and to reduce burdens of care.*

Respondents emphasize that a unified and coordinated national plan for mental health, supported by the Ministry of Health, can be built to facilitate sound financing – and in some cases increase funding – of mental health and to make mental health care attractive to international funding agencies by acting as a proposal. Unlike the *WHR 2001* recommendation, most respondents discuss mental health system reform in isolation from larger health system reforms. Discussion on health insurance schemes is limited among respondents.

#### **7. DEVELOP HUMAN RESOURCES**

*Most developing countries need to increase and improve training of mental health professionals, who will provide specialized care as well as support the primary health care programmes. Most developing countries lack an adequate number of such specialists to staff mental health services. Once trained, these professionals should be encouraged to remain in their country in positions that make the best use of their skills. This human resource development is especially necessary for countries with few resources at present. Though primary care provides the most useful setting for initial care, specialists are needed to provide a wider range of services. Specialist mental health care teams ideally should include medical and non-medical professionals, such as psychiatrists, clinical psychologists, psychiatric nurses, psychiatric social workers and occupational therapists, who can work together towards the total care and integration of patients in the community.*

The development of the mental health provider workforce receives substantial attention from respondents. It is recommended that community-based training and supervision for existing primary care workers take place, and also that new cadres of staff, including paraprofessional staff, be developed and recognized in the mental health workforce. Unlike the *WHR 2001* recommendation, respondents emphasize that the training process should be continuous, involve close clinical supervision and take place in the community setting. Respondents suggest that incentives – including financial incentives and professional recognition – are needed to encourage trained staff to remain in their community or country.

#### **8. LINK WITH OTHER SECTORS**

*Sectors other than health, such as education, labour, welfare, and law, and nongovernmental organizations should be involved in improving the mental health of communities. Nongovernmental organizations should be much more proactive, with*

*better defined roles, and should be encouraged to give greater support to local initiatives.*

Links with non-health sectors, respondents suggest, can complement a decentralized, community-based mental health care system. Respondents discuss the crucial role of non-health sector organizations in rehabilitation, and in integration of users and services with the community. Some suggest that mental health programmes can be incorporated into successful initiatives in other sectors. The potential role in advocacy of NGOs and community organizations is suggested as promising. Respondents suggest that there are budgetary challenges to developing links with complementary sectors.

#### **9. MONITOR COMMUNITY MENTAL HEALTH**

*The mental health of communities should be monitored by including mental health indicators in health information and reporting systems. The indices should include both the numbers of individuals with mental disorders and the quality of their care, as well as some more general measures of the mental health of communities. Such monitoring helps to determine trends and to detect mental health changes resulting from external events, such as disasters. Monitoring is necessary to assess the effectiveness of mental health prevention and treatment programmes, and it also strengthens arguments for the provision of more resources. New indicators for the mental health of communities are necessary.*

Relatively little discussion occurs concerning the monitoring of community mental health. Notably, discussion on the need for community mental health indicators refers largely to how funding for care can be improved, and contains little on how services may be adjusted to information gathered from monitoring.

#### **10. SUPPORT MORE RESEARCH**

*More research into biological and psychosocial aspects of mental health is needed in order to increase the understanding of mental disorders and to develop more effective interventions. Such research should be carried out on a wide international basis to understand variations across communities and to learn more about factors that influence the cause, course and outcome of mental disorders. Building research capacity in developing countries is an urgent need.*

The research that is recommended by respondents differs substantially from that described in the *WHR 2001* recommendation. In contrast with *WHR 2001*, no respondents suggest that biological research, or research on clinical interventions in a university setting, is helpful to developing mental health services. Respondents suggest that it is not research on the pathophysiology, or cause and course of mental disorders that is needed, but rather research on health services and systems, and social research.<sup>14</sup>

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<sup>14</sup> It should be noted that the respondents form a select sample of people – most of whom have been involved in services and system development.