MENTAL HEALTH POLICY

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Mental health is a key development issue. The development of mental health services in individual countries is a means of contributing towards the United Nations' Millennium Development Goal (MDG) of reducing extreme poverty and hunger by 2015. Mental ill health accounts for 11 per cent of the total Global Burden of Disease . Conflict, disasters, increasing numbers of displaced people, the impact of HIV/AIDS, and nutritional deficiencies contribute further to the mental ill health burden. Just as poverty and ill health are intertwined (poor countries tend to have worse health outcomes than less poor countries, and poor people have worse health outcomes than those who are better off) so poverty and mental health are also intertwined, and the association reflects causality in both directions. Poverty worsens mental ill health, and mental ill health makes poor people poorer.

Conversely, at a societal level, good mental health is an important resource for individuals, families and communities. Mental health is an indivisible part of public health, contributes to the functions of society and has an effect on overall productivity. Mental health contributes to human, social and economic capital and overall development, and is an important component of any strategy to reduce poverty. Positive mental health enhances the individual's capacity to contribute to family and other social networks, the local community and society at large, and is fundamental in enabling avoidance of risk-taking behaviour.

BASIC CONCERSNS

Thus it is important to develop and implement mental health policy and to integrate mental health policy into public health policy and general social policy[1] because mental disorder causes a heavy burden for society,[2] impedes the development of other health and development targets, contributes to poverty and differentially affects the poor;[3,4] and last but not least, because mental health itself is of intrinsic value as is physical health.

This chapter advocates the integration of mental health service provision into generic health and social (e.g. social welfare, education, labour, criminal justice, child protection) policy, and reform programmes. Mental health services are a key component of any basic health service package, and should be available to all, at the level of primary care, supported by hospital services. This will require strengthening of health systems, and new approaches to community involvement

Stigma and its consequences

In developing mental health policy, it is important to include consideration of stigma about mental health issues and mental illness.[5] As well as the impact on the individual with mental illness, stigma results in a lack of attention from ministers and the public, which then results in a lack of resource and morale, decaying institutions, lack of leadership, inadequate information systems, inadequate legislation, and inadequate attention to key public health committees. By resulting in social exclusion of people with mental illness, stigma is detrimental not just to people with mental illness, but also to the health of society as a whole. All too often our services are departure points for exclusion when they should be stepping stones for social inclusion.

International Perspective

In 2001, WHO devoted both its annual health day and its annual health report to mental health, which called on countries to develop mental health policies.[6,7,8] In the same year, the Institute of Medicine, in Washington, launched a scientific report on Neurological, Psychiatric and developmental disorders in low income countries which called for immediate strategic action to reduce the burden of brain disorders[3]. The EC plays an important role both in Europe and elsewhere and has recently produced a public health framework for mental health[9]. At national level, various governments, national NGOs, professional bodies and the media have played important roles in prioritising mental health in their countries.[10,11,12]

Need for locally tailored solutions - local epidemiology

Epidemiology is fundamental to the overall goals of mental health policy.[13] Mental health policy will need to take account of contextual factors, the epidemiology (range, severity, frequency and duration) of disorders, their accompanying social disability, their mortality and relationship to sociodemographic variables including geographic variation. A few countries are embarking on a specific rolling programme of detailed national mental health surveys[14] and WHO is coordinating a world mental health survey programme in a variety of participating countries.[15]

Cultural and religious issues

Cultural and religious issues are very important. They influence the value placed by society on mental health, the presentation of symptoms, illness behaviour, access to services, pathways through care, the way individuals and families manage illness, the way the community responds to illness, the degree of acceptance and support experienced on the one hand, and the degree of stigma and discrimination on the other hand experienced by the person with mental illness.

Context, needs, resources, provision and outcomes

Thus, each country is very different, with different context, culture, resources and type of existing service structures, and each will require its own mental health strategy containing locally tailored solutions for addressing both the general and specific challenges and issues.[16,17,18] Rapid situation appraisal methods exist for countries to assist the policy development process (e.g., WHO Atlas, Consortium publication, websites).

In order to tailor the policy to the country situation, it is therefore recommended (resource permitting) that each country carry out a country situation appraisal through a detailed scoping and needs assessment exercise.

THE POLICY PROCESS

Health policy at the national level will identify the range of health, morbidity, disability and mortality issues it intends to tackle, the relevant settings covered by the policy, the overall framework for implementing policy in the relevant settings including, for example, health services, social services, the education sector, the workplace and the criminal justice sector. The policy may set our desired goals and will set a framework for planning at the local level. Examples of desirable goals are given in Table 1:

Table 1: Some goals for mental health policy

- Promote mental health in the general population, schools and workplaces
- Promote the psychological aspects of general health care
- Reduce the incidence and prevalence of mental disorder (prevention and treatment) Reduce the extent and severity of associated disability and accompanying increased poverty (rehabilitation)
- Reduce the mortality associated with mental illness
- Develop integrated intersectoral services for people with mental illness
- Reduce the stigma and discrimination surrounding people with mental illness
- Protect the human rights and dignity of people with mental illness
- Research the causes and treatment of mental disorders

Key steps in policy development

In order to get mental health into national policy, it is important firstly to identify and engage key agencies and stakeholders in the overall process so that there is shared ownership of the vision and its implementation; secondly to obtain a good understanding of the current situation (the context, needs, demands, current policy, service inputs, processes and outcomes); thirdly to develop an overall mission statement, set goals and targets to aim for; fourthly to identify and engage key agencies, and develop strategic plans and implementation frameworks with those agencies which take the local situation into account, and which specifically tackle local issues, constraints and disincentives; fifthly to regularly review progress using a variety of outcome measures, and to fine tune the strategy accordingly.[16]

Ensuring input of service clients and families

The views of service users and carers will be particularly important, as they will be directly affected by the strategy and will have personal experience of the problems in the current system. They will also be able to comment on those aspects of the current mental health system that are working well.

Common policy components

Some of the components within mental health policy that need to be addressed include the following. Firstly, the *national components* including the construction of a national strategy to promote mental health, reduce morbidity and reduce mortality; the establishment of policy links with other government departments including home affairs, criminal justice, education, housing, finance etc; enacting specific mental health legislation (to set the overall philosophy of approach to the care of people with mental disorders together with precise provision for assessment and treatment without consent under certain defined conditions in the interests of the individual, the public and with regard to safeguarding human rights); financing (to remove perverse incentives, to ensure sustainable local financing, and develop funding streams for disseminating good practice models); implementation plans and overall system of accountability and governance. Secondly, the *supportive infrastructure components* include a human resources strategy, a consumer involvement strategy, a research and development strategy, and a mental health information strategy (which should include context, needs, inputs, processes and outcomes). Information systems provide an essential resource for clinicians, managers, planners and policy makers, it allows the audit cycle to proceed, users and carers also require relevant information, and the general public require information for public accountability). Thirdly, the *service components* include primary care, specialist care, the links between the two, good practice guidelines, liaison with NGOs, police, prisons, social sector, dialogue with traditional healers, mental health promotion in schools, workplaces and the community.

POLICY PARTNERSHIPS

Mental health policy needs to be linked in with *generic health policy*. It is particularly important that any general public health strategy addresses mental as well as physical health so that national mortality indicators include death from suicide - with attention to enhancing the accuracy of recording of suicides;[23] so that national morbidity indicators plan to include relevant measures of morbidity due to mental illness; and so that any health impact assessments explicitly include mental health.[24] Some of the generic health policy issues that will impact on mental health include primary care funding, training and incentive arrangements, and government generic health targets.

It can be helpful to ensure mental health is included in *generic health reforms* that are occurring such as development of health information systems, (it is important to develop the facilities and instruments for routine monitoring of needs, inputs, processes, and outcomes, so that the information can be used for planning purposes); hospital optimisation programmes, quality standards, basic training standards, accreditation procedures.

Governments need to ensure that all r*elevant agencies* are aware of the importance of mental health for the population; that they are aware of the influence that their activities can have on mental health; and that appropriate co-ordination between relevant agencies tales place. This coordination is often in place for action on alcohol and drugs, and for AIDS programmes but is as yet rarely in place for mental health programmes despite mental illness forming the greater burden across the population.

Partnership with those working on communicable diseases

There is a need for a partnership rather than a competition for resources between those working on non-communicable diseases and infectious diseases. For example, mental health promotion is essential in schools if we are to reduce the risk of AIDS from unprotected sex and drugs, support girls to be assertive and confident in ensuring their sexual health and safety, if we are to address lack of acceptance of condoms in the male culture, and if we are to encourage abstention from drugs and concomitant harm reduction, treating maternal depression improves compliance with vaccination, nutrition, oral rehydration and hygiene regimes to reduce infection diseases in children.

Primary care - a key policy consideration

Out of the several issues identified above, primary care is selected here for more detailed consideration because it is a particularly important service issue.[25] Logistical consideration is required of the availability of primary care services, and of the specialist services relative to the population epidemiology of disorders. Specialist capacity is important. The precise framework for primary-secondary care integration depends on a country's specialist capacity. In low income countries there is often only 1 psychiatrist per million population, and in a few countries this is as low as 1 psychiatrist per 5 or 6 million. By comparison, in the UK there is 1 adult psychiatrist per 50,000, and in much of the former Soviet Union there is 1 psychiatrist per 10-20,000.

Taking severe disorders first including the psychoses, in richer countries, people with severe mental illness may be cared for by specialist services, with some shared care with primary care for long term support. In poorer countries, on the other hand, there may often only be capacity for a small number of people with psychosis to be cared for in specialist care, and most will need to be assessed, diagnosed and treated in primary care, with support from specialist services where available. Thus in poor countries, where there is often much less than one psychiatrist per million population, most people with psychosis will need to be cared for much of the time in primary care.

Considering the common mental disorders second, we know from epidemiological studies that there is a high prevalence of mental disorders in the general population and in primary care.[3] Contrary to popular view, the common disorders seen in the general population and in primary care are not only frequent, but may also be severe, disabling and of high duration.[26,27,28,29,30,31] This high prevalence in all countries of the world means that not even rich countries can afford sufficient specialists to look after everyone with a mental disorder.

Burden of common mental disorders

Because of their high socio-economic costs, it is not tenable to argue that the burden of common mental disorders should be ignored. These costs arise from the repeated primary care consultations if they remain untreated, sickness absence, labour turnover, reduced productivity, impact on families and children, and the difficult to quantify but nonetheless important concept of the emotional well-being of a country and nation. Primary care therefore needs to play a central role in overall mental health care in rich countries as well as in poor countries.

Besides these logistical reasons why primary care is crucial, it also has particular advantages in that it allows attention to physical health care needs and accompanying social needs, it allows continuity of care, it is often preferred by consumers, is often more accessible than specialist care, and studies have shown it is possible to achieve good clinical and social outcomes in primary care.

However, a minimum basic package should include:

- The provision of medicines for patients with psychosis, epilepsy and severe depression
- Ability to refer very ill patients for hospital admission
- Primary care workers supported by specialists (liaison, education and supervision) in the community (access to local transport or to the district hospital transport to enable such regular support)
- Closer working between community workers and the primary health care team
- Mental health promotion in the community
- Intersectoral linkages

The importance of primary care for mental health has a number of implications for the training of the primary care team. In developing policy on training, it is helpful to understand the current situation in relation to the basic training for each tier of primary care and for each of the professional cadres. How much mental health if any is included? For example, in Iran and Pakistan, the village health workers receive a few months training in selected priority topics so that they can screen, assess, diagnose and treat.[32,33] In Zanzibar and mainland Tanzania, there is a four year basic training for all nurses and the fourth year is devoted to mental health. Since primary care in Zanzibar, as in a number of other countries, is largely run by nurses, this results in the systematic availability of mental health expertise in primary care.

What continuing training is available in primary care? It is important that mental health policy pays appropriate attention to the continuing professional development of primary care nurses.[34,35] In Zanzibar, the education coordinators organise and deliver continuing training for all staff in primary health care units which is regular (on several weekends a year), is accompanied by transport allowances and incentive payments, and affords an opportunity for mental health to be included in the programme. In low income countries, it is important to give mental health education to midwives and traditional birth attendants who have the opportunity to detect and refer post-natal psychosis and severe depression. The physical, cognitive and emotional development of children is influenced by parental mental health, and so ensuring prompt treatment of maternal depression is one of the most important preventive activities we can do.

In low income countries where there are few medical practitioners in primary or even in secondary care, nurses are likely to be given responsibility for prescribing and managing medicine, and it is important that their basic training and continuing education programme support them in this role.

What quality monitoring exists in primary care? In Iran, health psychologists perform a quality monitoring role for the village health workers, and visit every month to support, supervise and check on the quality of the work. Who is in the front line? Are the primary care doctor and nurse in the front line for initial assessment or are there other tiers? For example health workers with a few months training in Iran are responsible for 2000 population and primary care doctors are in the second tier responsible for 10,000 population. In Tanzania, first aid workers are responsible for 50 people, dispensaries for 2000 and primary health care units (nurses and medical assistants) for 10,000 or more.

Systems for information collection in primary care are needed for adequate planning. This can be effective without involving expensive technology. For example, in Iran, health workers routinely collect and display annual data on prevalence and outcome of priority disorders: infectious diseases, epilepsy, schizophrenia, depression and anxiety.

Policy should address how proactive primary care should be. Should it mostly concentrate on active consulters or should it take a more population perspective and seek to find and treat common disabling conditions.

Primary care capacity for outreach is important. Transport is necessary for outreach from secondary care to primary care, and from primary care to the community. It may need to be subsidised, be appropriate to the terrain and preferably not shared with other specialties with different working patterns.

Integration of mental health into primary care is enhanced by training, by strengthening basic training, and continuing education in assessment, diagnosis, management and criteria for referral (criteria for referral of course need to be locally agreed in the light of specialist capacity); and by use of guidelines such as the WHO primary care guidelines.[36,37]

It is important to train specialists for the job they will need to do. i.e. not just individual patient care but also in delivering a service to the whole catchment area population. If that population is around 1 million, as is often the case, it is easy to see that the specialist must work to support primary care in assessment and management of all but the most severe cases, and to support what is often a largely nurse run hospital, outpatient and community outreach specialist service for the most severe cases. Thus, the specialist needs to spend a major proportion of his or her time as a supportive consultant advisor (e.g. supervision, teaching. local planning, service development, researching key local issues) for the service as a whole rather than purely as a hands on clinician if he or she is to able to have maximum impact on the population for which he or she is responsible, and if the specialist nurses and primary care teams are to be adequately supported for the tasks they have to do.

Integration is assisted by communication, including regular meetings, between primary and secondary care, to discuss criteria for referral, discharge letters, shared care procedures, need for medicines, information transfer, training, good practice guidelines and research, by agreeing prescribing policies and by ensuring supply of essential medicines.

Traditional healers are very common in high, middle and low income countries and will remain a key deliverer of health care for large proportions of the population for many decades if not centuries. Their practice is variable, and there is no doubt that some traditional practice is very harmful; but it is also likely that some of the herbal medicines used have helpful psychoactive properties and that some of the interventions give important psychosocial support to individuals, families and communities. Rather than seek to destroy all traditional healing, it would be more productive to research their provision and outcomes,[38] seek dialogue with the aim of eliminating frankly harmful practices, and engage in joint training using diagnostic algorithms to encourage referral of difficult or chronic cases, including psychosis.[39]

POLICY PARTNERSHIPS OUTSIDE THE HEALTH ARENA

Some of the generic *social policy* issues impacting on mental health are policies on education, employment, housing, prisons, police, social welfare, environment and urban regeneration, rural issues, and transport. Effective interagency working at national, local and individual level is fundamental to the delivery of good mental health care, and needs to be firmly addressed at policy level. There may need to be a pan-government working group on mental health, as well as regional and local groups to monitor and facilitate joint working. There may need to be policy action to address co-terminosity of geographic boundaries, synchronisation and communication of planning cycles, lines of accountability for joint working, joint financial and information systems, shared good practice guidelines and removal of perverse incentives against cooperation between agencies.

Schools

Children are a nation's most precious resource, and yet receive too little policy attention. Specific learning difficulties including dyslexia in schools lead to educational failure, school drop out, and unemployment and over-representation in prisons. It is therefore important for policy to address specific learning difficulties in schools. The WHO clear vision project has had a dramatic effect on reducing educational failure in poor countries.[39]

Looked-after children

Large numbers of children across the world are looked after in orphanages and children's homes which often contain children who have been abused and neglected, children whose home life has broken down, children with developmental delay and retardation, speech delay, fits, severe over-activity and aggression, chronic physical illness, disability and handicap. It should be an important policy imperative to ensure adequate mental and physical health promotion and care to "looked after" children and to prevent their subsequent over-representation in the prisons.

Prisons

Prisons are another key setting of concern for mental health policy. Mental illness is very common in the prisons, and in some countries suicide is very high in prisoners. Guidelines for health care staff in prisons may be useful.[40] We need systems to prevent and treat anxiety and depression in prison, ensure people with psychosis are treated in hospital rather than prison, prevent suicide and suicidal attempts, and tackle dyslexia and educational failure in prisoners.

Disaster preparedness

No country can afford to ignore the possibility of disasters, whether man made or natural. More than 50 countries have experienced conflict in the last 20 years. Conflicts are much more common in poor countries, and 15 of the 20 poorest countries of the world have had a major conflict in the last 15 years. Nearly all low income countries are next to a country that has experienced war and are therefore frequently carrying burden of caring for refugees. Women and children are particularly vulnerable to war, frequently being witness or forced participants in murder, victims of rape, infection with AIDS, rejection, abduction of child soldiers, and the subsequent difficulty rehabilitating child soldiers.

Psychosocial issues are often neglected in post conflict situations despite the fact that the presence of psychosocial disorders contributes to low compliance with vaccination, nutrition, oral rehydration, antibiotics and risky sexual behaviour; and hence to the high morbidity and mortality from preventable and treatable infectious disease. Sometimes the sheer volume of refugees and their movements make practical arrangements very difficult. For example, in Macedonia during the Kosovo crisis, there were over 250,000 refugees and large transfers at short notice between camps as new refugees arrived, making psychosocial work very difficult during the initial phase.[41] In Georgia, with a population of around 5 million, and an economic crisis which has reduced government health expenditure from 200 USD to 7 USD per year, there are more than a quarter of a million internally displaced people with largely unmet needs for psychological support, and a further 7,000 refugees from Chechnya for whom the government does not accept responsibility so they have no access to medical care other than that supplied by the Red Cross.[17] The central importance of involving primary care teams in the management of the medium and long term psychological consequences of a disaster has long been argued.[42]

IMPLEMENTATION ISSUES

Strengthening primary care services

Maximising the impact of mental health services will be dependent on strengthening existing health systems. The focus should be on improving the existing primary health care services in order to provide a range of prioritised, preventive and curative services for all areas of health, including mental health. The key elements are:

- Human resources: introducing appropriate training, supervision, and continuing education
- Ensuring that essential drugs are available and affordable (drugs for depression, psychosis and epilepsy)
- Transport between hospitals and primary care centres to enable specialist supervision of primary care workers and others in the community
- Linkages with secondary services - referral pathways, support from specialists
- Close working with the community -carers, traditional healers, dispensers, social workers, religious organisations, schools, the police
- Management and information systems (including main categories of mental disorders)
- Treatment guidelines and locally adapted treatment protocols, quality assurance.

Strengthening and rationalising specialist and hospital services

In order to ensure that patients with acute, severe mental illness can be hospitalised if necessary, small psychiatric units should be established in district hospitals. These would comprise a small number of (short stay) beds, with specialist nursing staff, with an outpatient facility. Local provision of a specialist service will ensure closer liaison with the primary care team and the community. The role of mental health specialists should be expanded, to include training and supervision of the primary care team (through regular visits to primary care clinics). This supervision of primary care is important, because for logistical reasons, it is likely that the responsibility of managing most of the severely ill patients will rest with the primary care team, particularly in a decentralised system. Thus mental health should be a regular item on the agenda of district health management teams to ensure access to transport (so that specialists can support and supervise clinics on a regular basis), the availability of essential drugs in the primary care clinics (drugs to treat depression, psychotic illness, and epilepsy), continuing education, access to guidelines, and intersectoral liaison. The specialists, working with the primary care team, should engage with the sectors involved with those with mental illness, encouraging team working and work sharing through ongoing training and support.

Implementation is even more challenging than strategy formulation, and particular attention needs to be paid to *communications* (public relations about the strategy, cascading information within organisations, organising feedback, alliance building between key partners); *resources* (accessing key budgets, securing capital, ensuring revenue flows, maximising the use of generic budgets, sponsorship and aid), *staff* (planning the development of the human resource, re-skilling for changing service configurations, basic and continuing education for mental health staff, skilling generic staff such as primary care and teachers, communicating with staff, engaging professional bodies and educational institutions); and *embedding the strategy* (engaging generic organisations, managers, politicians, disseminating good practice, implementing an R&D [research and development] strategy, including evaluation, learning from mistakes and successes and fine tuning the strategy, quality assurance, accreditation and inspection).

There is a need to address high level stigma within government surrounding mental health so that mental health policy is well integrated with general health policy, and so that de-institutionalisation is seen as an important step towards achieving better health and social outcomes for people with mental illness, but not as an opportunity to save money on the costs of health care.

Political will

We need political will at the national level to support mental health in public policy (including a high profile for mental health within the Ministry of Health, liaison with other ministries and a cabinet committee for mental health, as in Iran).

CONCLUSIONS

All countries are a mixture of developed and developing, and we can learn from each other. Large-scale applications are dangerous and we need locally tailored solutions. We need to build capacity for strategic policy work, tackle stigma, enhance human rights, consumer involvement, individual assessment of needs and individually tailored care plans, evidence of interventions, public relations and evaluation of outcomes. Psychiatrists and other mental health professionals have a key role to play in influencing their governments to increase the priority afforded to mental health, to develop well tailored mental health policies and to support their implementation and fine tuning.

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