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CARE FOR THE MENTALLY ILL

Components of Mental Health Policies Governing the Provision of Psychiatric Services

WHO Collaborating Centre
for Research and Training
in Mental Health
Douglas Hospital Centre
Montreal, Canada

1987

Division of Mental Health
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INTRODUCTION

An Advisory Group on the Development of Guidelines for Mental Health Policy Formulation met at the World Health Organization (WHO) Collaborating Centre for Research and Training in Mental Health, Douglas Hospital Centre, Montreal, Canada, on November 10, 11, and 12, 1986. This document was developed from the report of that meeting. This group dealt primarily with the provision of services for the mentally ill, although a few other aspects were touched upon and have been included briefly in this document. More particularly, the group spent time discussing the promotion of mental health in order to put the care of the mentally ill into a broader mental health context. The subject of mental health promotion is therefore included as appropriate.

Thirteen participants, representing seven countries coming from the African, American, European and South-East Asian Regions of the World Health Organization as well as three invited guests (a list of participants is given in Annex 1), reviewed the complex issue of mental health policy formulation by studying current mental health care delivery systems and their supporting legislation or policies in a broad range of local, regional, and national settings. On this basis, the group attempted to identify key conceptual issues important in the formulation of a mental health policy and to report them here. The endeavor has not been to produce a draft universal mental health policy nor a formula for one. Rather, the goal has focussed on an objective of WHO's seventh general programme of work dealing with the protection and promotion of mental health: to develop methods and material which will facilitate mental health policy formulation especially in relation to that part of the programme dealing with mental disorders.

Dr Gaston P. Harnois, Director General of the Montreal W.H.O. Collaborating Centre, was elected Chairman, Dr John Orley, Senior Medical Officer, WHO Geneva, was elected Vice-Chairman, and Dr Terrence S. Callanan, acted as Rapporteur with Miss Nicole Germain as Co-Rapporteur.

The formulation of public policy is a dynamic and complex process. Social, political, and economic realities must be recognized in the formulation of policies at local, regional, and national levels. A stated policy becomes a reflection of the community itself in terms of its ethical, moral, and legal tone. Throughout the meeting, the orientation was towards the support of individual rights, the general promotion of mental health, and the importance of locating mental health services in the community. These themes recur frequently in this report and the Advisory Group recommended that they should be considered central in the preparation of all mental health policies.

MENTAL HEALTH POLICY FORMULATION:

CHALLENGES AND OPPORTUNITIES

The concept of mental health encompasses the notion of the optimum development and functioning of the individual allowing the realization of aspirations and satisfaction of needs as well as the ability to change or cope with the environment within the context of family, cultural, social, and community parameters. Mental health is an integral component of health in general but its promotion extends beyond the health field. Health is not just the absence of disease, but is a state of physical, mental, and social well-being. Clearly, we have no reason to think that mental well-being is less important than physical. Indeed, a well developed mental life is what distinguishes human beings from other life forms, and attention to this aspect of our lives must not be ignored. Yet, the promotion of mental well-being as an autonomous goal and as a constituent of health, the treatment of mental disorders, and their prevention are components of health related activities that have not been given due importance in health policy formulation.

It is important that governments draft full-fledged mental health policies that indicate the objectives that are being sought, both in the short and long terms. Such policies must identify reasonably attainable goals within existing resources, establish priorities for programme development towards these goals, provide an identification of those responsible for their achievement, and contain methods of assessment of progress towards the stated goals.

Mental health and well-being must be seen as a broad concept and its promotion considered of prime importance. It is not confined to the activities of health care professionals, but involves community groups, educators, social services, the legal profession, families, and others. The formulation of a mental health policy must be done within the context of overall government policy and, in particular, general health policy. Still, it must remain focused and have its own clear orientation within a general health policy. To consider this, one might review the objective of HEALTH FOR ALL BY THE YEAR 2000 by considering each of the components of this objective.

H.F.A. 2000

"Health"

Health activities imply curative services, rehabilitation, prevention, and health promotion activities. Most health resources go into curative activities, a certain amount goes into prevention and rehabilitation, but very little into promotion. Mostly, resources are spent on the identified sick. People will usually spend money once sick, and insurance payments are usually only paid once people are identified as sick in order to make them well. At times, some funds are made available for prevention in healthy populations, but very little is spent in actually improving the quality of life of those not necessarily identified as sick, or improving the quality of life of those who are sick in ways other than just directly treating their illnesses.

"For All"

The notion of "health for all" is often misunderstood. Much health development activity in the past was put into promoting centres of excellence which, it was hoped, would be replicated sufficiently in order that a whole country would eventually benefit. The resources required for such excellence, however, could never be made generally available within the short-term, and often not even in the long-term. The result was that good

services became available for a very small percentage of the population, usually for those living in the cities. The notion of providing health for all, therefore, encompasses the idea that we must plan now for providing a range of services that can be available for all in the relatively short term. When pilot schemes are started they should be in a form in which the resources required would allow them to ba applied throughout a country once demonstrated as successful.

The Year "2000"

A target date of the year 2000 is also included within this objective. Targets need to be formulated which can be reached within the foreseeable future. The targets should not be of a kind which requires a period of national prosperity or some hoped for increase in resources during the 21st century. They should be attainable within the existing resources of a country and thus a date is set which ties us to the present. The targets will vary from country to country, and, in some, may only include a basic minimum which should be universally achieved. This will include, for instance, the universal availability of clean water, adequate sanitation, or a system which will allow virtually all children to be immunized. It is imperative within this to formulate also some basic mental health objectives, be they to do with treatment of mental diseases or the carrying out of mental health promotion.

PRIMARY HEALTH CARE

To achieve Health For All By The Year 2000, the member states of W.H.O. have agreed on a strategy of primary health care. This does not just refer to a level of care, but also to a whole system of care, and, indeed, an underlying philosophy for care. It implies that we put emphasis on activities at the primary level. This is the level of first contact with the formal health system, and, indeed, before that, at the level of the individual, the family, and the community. Primary health care requires the provision of appropriate technology for people to look after their own health, as well as for the relevant levels of health workers to provide care or carry out health promoting activities.

Primary health care requires community involvement in the process of health care. This will include the identification of health needs to which health services can respond, as well as community involvement in the response to those needs. This response should include self-care and the encouragement of mutual-aid groups. The role of health professionals should be to provide guidance and support to those who bear the day to day responsibilities for care. A self-care and mutual aid support policy is not intended to shift the responsibility from the state to individuals, or to blame individuals for their own misfortune: it is simply a recognition of a reality that has always existed. Individuals and their families already carry out most of the care provided in times of illness. They need help to do this more effectively.

Community involvement is not just a question of people finding resources to pay health care providers to look after them. The resources rather should be used to support them in their own health care and health promoting activities. There should be no question of the state abrogating its health care responsibilities, but neither should there be a question of people abrogating their own duties in this respect. Although the community, including the state, should be ready to help those in need, people should not feel that it does not matter how they behave because the system has the ability to look after them regardless of the consequences.

Self-care and mutual-aid groups should not be seen as strategies for the state to save money. Indeed, the promotion and support of this may take up considerable resources. The strategy should be advocated because this is a more effective method of care and will lead to an enhancement of health.

Primary health care should not be a separate system of care running parallel to other forms of service delivery. For primary health care, the whole system of health care should have as its orientation the support of care given at the primary level with the goal of achieving health for all. The focus of care in such a system is thus the community, and not the institution. Hospitals and specialized health professionals will be needed, but the focus of their activities must be one of support to action at the community level. This does not mean just taking referrals, it means support, supervision, and training for those working within the community. Hospitals do not become redundant when a system of primary health care is introduced, but rather become integrated into a broader therapeutic system with highly diversified care arrangements.

THE EFFORT SPECTRUM IN MENTAL HEALTH

There is a broad spectrum of activities in the mental health field that may be identified, ranging from cure of disease to promotion of mental health. These activities can be conceptualized as a frontier of efforts dealing with a range of overlapping targets in the mental health field. This spectrum of activities includes the following:

Cure - This is where the complete termination of mental disorders and the returning of the individual to normal health is sought. This end of the spectrum typifies the traditional medical model though it is rarely achieved in mental illness, except for those in which there is a mainly organic etiology (for example, some vitamin deficiencies).

Care - These activities focus on the reduction of discomfort and disability rather than cure. Such an activity characterizes the treatment of mental disorders where symptoms and their disturbing qualities are mitigated and the individual returned to acceptable levels of social functioning. Disability is reduced or eliminated, and the issue of cure is generally not addressed. Improvement is the hallmark of progress.

Rehabilitation - Activities in this area aim both at maximizing the opportunities of the individual for recovery, and attempt to minimize the disabling effects of chronic conditions. Frequently, this requires manipulation of the environment at individual, family, or community levels. The inborn natural healing processes in the individual are fostered, and environmental changes can be aimed at minimizing the effects of any impairment brought about by illness.

Prophylaxis - The prevention of relapse in recovered persons is the primary focus of activity at this level. As an example here would be the recent evolution of the concept of expressed emotion as a clinical construct with predictive value in the relapse rate of individuals suffering from schizophrenia.

Primary Prevention - This effort is aimed at the prevention of first occurrences of illness. It involves three main notions: the reduction of environmental hazards and stresses, the development of support systems and other resources, and the development of coping or managing abilities.

Mental Health Promotion - This is a broad concept aimed at enhancing mental health through integrated actions at different levels of activity that influence health, and the factors that influence health. The activities here include prevention, but are broader and deeper so as to include biological, environmental health, and sociological issues. It provides a possible source of criteria from which agreed upon priorities can be established, and activities across the entire effort spectrum in mental health can be monitored.

A clear understanding of the range of activities encompassed by the Effort Spectrum in Mental Health can serve as a conceptual guideline in the formulation of mental health policies. The range of activities, from Cure, on one hand, to Mental Health Promotion on the

other, as well as a clear identification of the range of problems, challenges, and needs within the components of the spectrum can help clarify the relationships and priorities of the individual activities, and their respective importance in helping a country more realistically towards its ideal model of service in the mental health field.

FACTORS INFLUENCING MENTAL HEALTH POLICY

A nation's mental health policy is commonly established within a complex body of health, welfare, and general social policies. The mental health field will be affected by many policies, standards, and philosophies not necessarily directly related to mental health. These policies may set the framework for the delivery of mental health services by defining a country's stand on personal liberties, and the protection of incompetent persons. Similarly, various policy areas determine the nature of the psychiatric patient's community support services, retraining, resocialization, and economic welfare programmes.

Other policies may determine practices and approaches to specific target groups such as the young, the elderly, the handicapped, victims of crime, offenders, as well as many others. Some of these groups, and certain activities, may require special consideration in the formulation of a mental health policy. Attention must be paid to the needs of special groups, as well as to the influence which activities in other sectors may have on the mental health field. All policies should ensure that all government activities contribute to (not detract from) mental health. To maximize the positive effects, the formulating of a mental health policy must consider the social and physical environment in which people live, and inter-sectorial collaboration to benefit from education programmes, health and welfare policies, employment policies, city planning and municipal services, the maintenance of law and order, and policies addressing the young or the old. In order to facilitate such an inter-sectorial collaboration, each country should establish, at a senior ministerial or departmental level, an administrative post to give focus to the coordination and potential integration of activities and policies affecting mental health and mental health promotion within the general health services, as well as with other sectors of governmental and non-governmental organizations.

THE UNDERLYING VALUES FOR MENTAL HEALTH

Underlying any mental health policy will be certain values which should be made explicit. Uppermost should be the value placed on psychological well-being, the enhancement of which will underlie mental health promotion activities. Another underlying principle will be the concern for the mentally ill, with an acceptance that interventions on their behalf must be the least restrictive and least intrusive that are reasonably available and likely to be effective. A balance is pursued between the rights of those identified as ill and the needs and resources of their families, and of the communities in which they live. This balance will vary from culture to culture, but there should bea predominance given to the rights of patients.

For mental health care, as already discussed for health care in general, the individual and the community should have the opportunity to contribute significantly to determining policy, and appropriate mechanisms should be available for people to express their opinions. Activities intended to enhancement well-being should arise from a consensus between the citizens and those working in the mental health field, and must be acceptable to the population in order that they can be carried forward through maximum participation of the community. The goal of mental well-being cannot be achieved without such participation which may require the assessment of community attitudes towards mental illness and the possible introduction of appropriate awareness programmes.

Most countries have some form of institutional care for the mentally ill. Most have also formulated some kind of intention to move towards a community orientation, either through an identified community mental health service, or by integration within the general health care system. The extent to which any country or community has moved towards community-based care will vary depending on the resources available and on how the situation has developed up till now.

Similarly, whereas all countries accept that the promotion of mental health falls within the scope of legitimate health activities, the extent to which any country carries this out, or has even formulated a plan to do so, will vary. While ideal models of community-based mental health services may exist with emphasis on mental health promotion in addition to the treatment and prevention of mental disease, the extent to which any country is achieving this will again vary according to resources available and the investment in the status quo which often favours institution-based services.

If, however, the vision of a society of mentally healthy persons is to be achieved, the objectives must be realistically formulated. This will involve setting out the direction in which people must go, and giving an indication of who has what responsibilities on this journey. It will need careful reviews all along the route to make sure that the travellers are still on course, with a readiness to change direction when this appears necessary. It will require the participation of everyone, with an acceptance that the goal of perfect mental health will never be reached, but that the struggle to achieve it must never be given up.

ISSUES EMERGING FROM A REVIEW OF NATIONAL SITUATIONS

The group reviewed the activities of 23 national, subnational, and regional endeavors in the field of mental health care delivery, as well as the activities of several other working groups dealing with mental health policy and mental health promotion (see Annex 2).

Emerging from this review were a number of key issues which warrant consideration in the process of formulating a mental health policy. Despite the dissimilarities between countries, regions, and specific populations within individual communities, these issues are at the heart of new patterns of service and initiatives in the field of mental health care and, as such, should be considered within the overall priorities and needs of all regions in the process of formulating a mental health policy.

ALTERNATIVES TO INSTITUTIONAL CARE

Although there are differences observed in the stage of development of mental health services in the various countries and regions under review, there is considerable agreement with respect to the need for the development of a comprehensive community-oriented mental health care policy as an alternative to the historically prevailing pattern of conventional psychiatric hospitalization.

The role of psychiatric hospitals must be defined in the overall array of services needed for the treatment of mental illness, and the promotion of mental health. Services should be community-based and should be comprehensive in the sense that they provide a range of facilities differentiated to meet the mental health needs of the population at large, as well as of special risk groups.

A comprehensive mental health policy should, in particular, promote community care, and redirect functions of hospitals mainly to diagnosis and active treatment in emergency situations, for conditions requiring prolonged active care, and for those patients who cannot

give enlightened consent to the administration of their care when their condition may endanger themselves or others. Simultaneously, oversized psychiatric institutions should be reduced, while increasing the diversification of services provided in general hospitals and community centres, and developing alternatives to hospitalization that are community-based and which do not cut patients off from society.

DECENTRALIZATION/REGIONALIZATION

A key concept in the planning and delivery of mental health services emerging in recent years has been that of the sector or catchment area. This requires the designation of precise geographical spheres of responsibility for mental health services, and necessitates the creation of facilities for defined populations, small enough to allow most patients to be treated within easy traveling distance of their homes. The development of such an approach is felt to be best suited to the real needs of patients, their families, and their communities. The definition of a catchment area or of sectors however should not imply the domination of an institution over that population. Rather, the institution, if it exists at all, should be just one of a variety of mental health facilities which serve that population.

The transition from adopting a zone or catchment approach to the creation of community based programmes often proceeds slowly; however, it may be an important element in the creation of coherent community-based services. In countries or regions of countries where services are in transition, and in countries where services are being newly created and where comprehensive services and programmes by catchment areas are not yet possible, a degree of sectorization can allow the development of more rational patterns of care, more efficient use of resources, and the development of community alternatives to institutional care.

COMMUNITY PARTICIPATION AND ATTITUDES

Comprehensive mental health promotion programmes and mental health care services within community-based programmes will never be provided by health services alone, nor by the community alone. Effective programmes and policies must be developed on the basis of a consensus with respect to needs identified both by those responsible for services and policy, and the members of the communities they are meant to serve. Prevailing community attitudes towards mental illness and the mentally ill must also be taken into account. This will help ensure that policies and services respond to the specific needs of different regions and to the different needs of individual groups within a community. All parties should be taken into account and a clear consensus will assist in providing a sound beginning point.

COMMUNITY SUPPORT MODELS

A community support model is defined as an organized network of caring and responsible people committed to assisting a vulnerable population to meet their needs and develop their potentials without being unnecessarily isolated or excluded from the community. Such a model recognizes that traditional mental health services alone are not enough. The concept includes the entire array of services, support, and opportunities needed by individuals in order to function within the community, including services to address basic human needs and rehabilitative services. The community support model is not based upon any one model but rather draws upon elements of the medical model, rehabilitation model, and social support model in an attempt to consider the comprehensive needs of persons living with long term mental illnesses. Most policy makers and experts have agreed that such programmes, combined with a thorough community-based orientation, can assure services which will meet the needs of all community groups, including widely dispersed populations.

INTEGRATION AND COORDINATION

An effective mental health policy will be integrated into a country's or region's overall general health policy and will designate individuals responsible for implementation and coordination of services. At the governmental level, it is vital that all of a government's policies be reviewed to insure they enhance mental health. At the community level, responsible individuals can ensure the optimum use of existing resources and help establish priorities in creating new programmes responding to unanswered needs. Administrative coordinators or coordinating groups should be established as appropriate at national, state, and regional levels, with a specific mandate to ensure the exchange of information and to facilitate the planning, budgeting, implementation, and evaluation of mental health oriented programmes. The terms of reference of such groups and individuals should be formulated through governmental decisions and be a component of the mental health policy itself.

BASIS FOR POLICY FORMULATION

RESPONSIBILITY FOR MENTAL HEALTH POLICY

The first step in the elaboration of a region's or country's mental health policy is the identification, by the government, of those responsible for the formulation of the policy itself. An individual or group, under the responsibility of the ministry or department of health, should be designated, and the necessary resources made available. Those producing a draft policy should be mandated to outline the basic orientation of the mental health sector and to define as clearly as possible what choices must be made by government in the field. The mandate should further require the inclusion of recommended approaches for intervention, examine how to insure that services are appropriate to the mental health needs of the population, and be based upon a consensus among the various parties concerned. Finally, while perhaps ultimately outlining an ideal model for mental health care and mental health promotion within the policy statement, a description of priorities, based upon identified needs taking into account available resources, should also be included. These issues have been further dealt with in other recent WHO documents pertaining to National Mental Health Programmes (see selected references).

THE NEED FOR INFORMATION

The formulation of a policy must be based upon factual, reliable information concerning the community, its existing resources, mental health indicators, and so-called "state of the art" information from a number of domains related to the mental health field.

Demographic and epidemiological data: Wide consultation should be sought in an attempt to clearly identify the risk factors and the epidemiologic, socio-economic, and cultural characteristics of the people to be served by the mental health policy. To the extent possible, measurements of the level of mental health problems in the communities and regions to be served should be carried out. Where necessary, existing instruments should be adapted, standardized, and used in accordance with sound research principles. Alternatively, the use of sound academically valid data from similar communities can be sought as a general guideline for defining the parameters of the services to be recommended within the context of the policy.

Existing resources: A thorough survey of existing resources and structures within communities and regions should be carried out, along with a critical analysis of the extent to which they are fulfilling the defined need. This survey should be comprehensive and, in addition to reviewing traditional mental health care delivery services, must include a review of all services that might affect or assist in promoting mental health in a fully integrated and functional mental health system.

State of the art information: Wide consultation among experts in many fields should be conducted in order to ensure the formulation of a contemporary and manageable policy for the country and regions to be served by the policy. Issues relating to the definition of mental health, the efficacy of interventions with respect to prevention, treatment, and rehabilitation within the mental health field, the needs of special groups, and the experiences of other countries and policy groups will be needed. It will be important to identify indicators that can serve as an index of the mental health of the population, for example, the crime rate, incidence of child abuse, drug and alcohol abuse, the availability of housing, the incidence of divorce and measures of a sense of well-being of a population are all as important as the incidence of mental health or the number of acute care beds.

Evaluation and Research: A good and comprehensive policy will take into account the need for periodic review of the policy, will allow for continuation, modification, expansion, or elimination of programmes implemented on the basis of the policy. It should incorporate objectives as well as methodologies for measuring success or failure, and failures should be identifiable. At this level, inter-community, inter-regional, and international cooperation is important to allow the institution of common methodologies leading to the compilation of comparable national summaries of epidemiologic data relating to the mental health field. Specific research should be recommended for the evaluation of all programmes and ongoing review of the policy itself.

POLICY AND LEGISLATION

There can be difficulties in the implementation of mental health policies when legislation in the field of mental health has not been integrated with general health services legislation and policies or is incongruent with existing policies. Most countries of the world have legislation dealing with the severely mentally ill; however, the drafting of a full-fledged mental health policy, as is being discussed here, is not yet common practice. Nevertheless, various sub-fields can often be distinguished within general health care and other social policies, and there can be express legislation on mental health care, all of which affect and reflect a country's attitude and approach to mental health. Divergent laws, policies, and persons or bodies who formulate or implement these, especially isolated official departments in charge of various aspects of enforcement, must all be harmonized for any effective plan for the promotion of mental health. Basic issues with respect to the need for legislation include the initial presumption of whether or not it should be used, and the various risks and benefits involved in its use or non-use. These must be considered within each jurisdiction considering the mechanisms for formulating and implementing a mental health policy. The following sections summarize the discussions of the Advisory Group with respect to a number of aspects of legislation dealing with health care policy formulation and implementation, and some key points pertaining to legislation dealing with mental health services.

INTERRELATIONSHIPS IN POLICY FORMULATION

A mental health policy will be country-specific in content and implementation. All health care policies of a country must be related to its needs, demands and resources, and should contain stated priorities as to the reasonable expectations for servicing in light of available resources.

In the formulation of mental health policies, the structure of governmental responsibility in a centralized government or in a federal government must be considered. In central government structures, the primary responsibility will be at the national level for both operation and funding support. In a federal government structure, primary responsibility for mental health policy may be placed at the sub-federal (e.g., state or provincial) level, with some funding support from the federal level.

In most countries, mental health services are operationally a part of the Ministry or Department of Health. Therefore, a major portion of mental health policy formulation and implementation will be interrelated with general health policy. This interrelationship is founded upon the principle that the personal mental health of people cannot be divorced from their overall health. Health, as opposed to illness, is a unitary concept of personal well-being and achievement or fulfillment of life goals.

Interrelationship of mental health policy with general health policy is important but, the development of a mental health policy, especially one focussing on mental health promotion, must be broader in scope, that is, relate to more than health matters alone. These other matters should include consideration of the relevance to mental health of policies affecting education, the police and criminal justice system, social welfare, environmental and work-place matters, as well as those affecting identified groups such as immigrants, the young, the elderly, substance abusers and others.

In some countries (or sub-national jurisdictions), there may be considerations of mental health policy related to separate departments of mental health or to separately operated community mental health services. In general, however, most countries (and sub-national jurisdictions) will formulate a mental health policy and operate mental health services, especially at the community level of primary care, in conjunction with other health and social welfare services.

LEGISLATIVE FRAMEWORK FOR MENTAL HEALTH POLICY

Legislation may fulfill multiple roles in any given society or legal system while providing the framework for mental health policies as well as other social policies. The role may be to serve as a declaration of policy, as a statement of principle, as a social ideal, or to create and promote social values. In doing so, such legislation will reflect a society's ethical tone, its consensual values, and, as well, symbolize both spoken and unspoken social attitudes. In nature and content, the legislation may be directive, permissive, prohibitive,or promotive of certain conducts, and can utilize substantive principles or procedural safeguards to govern relevant matters such as respect for individual rights or provision of treatment services.

Rights enshrined in legislation may have either positive or negative content. "Positive content" legal rights include those of access to health care and can be based on international legal instruments, for instance, the Universal Declaration of Human Rights, or national or regional laws. "Negative content" legal rights include rights against wrongful discrimination in being denied treatment. These latter rights are important rights when resources are available but access is refused. A right to treatment is only meaningful when treatment is available; however, if treatment is available, legislation will often determine whether or not there is a right to it. When treatment is not available, the former rights are critical. They will determine whether a health care system, for instance, has a duty to make it available. Whatever its stated purpose and approach, the existing legislation of a country, in the field of health care and mental health care, must be taken into consideration when formulating a mental health policy and revising the framework within which all health care policies will exist.

A MODEL FOR MENTAL HEALTH POLICY

A basic model can be suggested for the structure of a system of legislation to support mental health policy formulation and implementation.

The essential areas for such legislation are as follows:

Area 1. Mental Health Policy

The establishing of a national policy with clear objectives to be achieved in regard to improving and promoting people's mental health.

Area 2. Authority to Operate a National Mental Health Programme

The designating of the proper agency (or commission, or ministry, etc.) with authority for planning and carrying out the national policy on mental health.

Area 3. Budgetary Authority

The establishing of budgetary policy and continuing fiscal support for the mental health programme.

Area 4. Operational Structure

The providing of adequate structure and detail about the operation of the national policy and programme on mental health to allow administrators to follow and to implement the policy and building in accountability and evaluation processes.

Area 5. Research and Training in Mental Health

The providing of financial and operational support for research at adequate levels in regard to national mental health policy objectives, and other aspects of the national mental health programme, and financial and operational support for the training and education of new mental health personnel.

Area 6. Assurance of Access to Mental Health Services

The setting of a national policy of equitable, non-discriminatory access to mental health services provided within the national programme.

Area 7. Protection of Individuals

The setting of a national policy of protection by law (through the courts, special mental health tribunals, etc.) to complement the general law in this area in regard to personal rights, welfare, property, and dignity of the mentally ill and retarded and other patients and clients of the national programme. Special laws may have to be adopted to protect this group where remedies or solutions under the general law are inadequate for this purpose.

Area 8. Minimum Standards for Mental Health Manpower and Resources

The establishing of minimum standards (in such detail as deemed necessary and desirable) for mental health manpower and resources within the overall national policies for distribution of health programme resources.

Area 9. Regulation of Therapeutic Drugs and other Treatment Methods; Control of Dangerous Drugs in Programmes of Drug and Alcohol Dependence Control, Prevention and Treatment

The regulating of the quality, supply, and distribution of therapeutic drugs for the treatment of mental illness; the regulating and setting of standards for treatment methods; the regulating of "controlled substances" or "dangerous drugs" within the national programmes of drug and alcohol dependence control, prevention, and treatment. The extent to which alcohol and drug policies should be included within policies concerned with the mentally ill will need to be decided within each jurisdiction. Guidance related to the formulation of such policies are given in separate WHO publications and documents on alcohol policies and drug policies (see selected references).

Area 10. Delegation of Regulatory Powers

The delegating of authority, under specific legislative guidelines, to governmental agencies to adopt administrative regulations, decrees, and other instruments for further implementation of the national policy on mental health programmes.

PATIENTS' RIGHTS AND RESPONSIBILITIES

Contemporary with the evolution of medical science in recent years has been the capacity of interventions in the mental health field both to confer benefits and to produce deleterious results such as complications of treatment. With this change has come a new perception of patients' rights and responsibilities.The concept of patients' responsibilities is a recent development. It is concerned with supporting patients to use optimally the human and financial resources to which they have a right of access, to be reasonable in compliance or non-compliance with treatment directives, and to be responsible, in a reasonable fashion, in maintaining their health or treatment gains. This concept is an emerging one and will be the focus of greater debate and discussion in time to come. Somewhat greater attention has been paid to the concept of patients' rights.

One can envisage a spectrum in relation to patients' rights from one end-point of pure paternalism with the patient having no personal decision-making power (for example, informed consent to treatment is not needed, or a competent person's refusal of necessary treatment is not respected), to the other end-point of a highly egalitarian health care professional client relationship, which recognizes absolute rights of self-determination on the patient's part. The end-points of this same continuum can also be characterized as moving from giving absolute priority to patients' needs (pure paternalism) to giving absolute priority to their rights. It is when a given patient's needs and rights conflict that one must determine where the balance is to be struck on this continuum. Every country should determine where its approach to patients' rights, as exhibited in legislation or other law, falls on this continuum, and decide whether this is an acceptable balance. It needs to be noted that each right of a person can be placed on this continuum and the same "balance point" will not necessarily be chosen in relation to different rights and almost certainly will not be. Further, the "balance point" chosen for any given right can change both from time to time and with different circumstances, and may even change with different patients although the circumstances are otherwise identical.

Rights to Treatment - Allocation of Resources

Rights to treatment must be considered within the context of a country's available resources. The nature of a country's legislation will establish the framework for patients' rights and these rights may exist as implied legal rights, moral rights, and politically-based claims of access to care.

A right can be said to be implied when it is the necessary consequence of an agreement, a law or a governmental act or of a mandate. Thus, when a government sets up a health care system, it could in certain circumstances be considered as assuming the responsibility to provide health care in the community concerned. Because the government has assumed this legal responsibility, or has at least given the community reason to believe that it has, it may be required to provide necessary health care to persons who rely on the apparent availability of health care services, giving up the possibilities that they previously had of obtaining such services from other sources. Through reasoning of this kind, courts in some countries may recognize duties to provide health care and, correlatively, rights of individuals to have care provided.

Moral rights can also form the basis of a claim to health care. These can be converted into "natural obligations" and, thence, to legal rights in some legal systems. But, even if one seeks to rely only on a moral right, there may be relevant distinctions. Not all moral rights are of the same strength. Avoidance of harm (for example, relief of suffering) is a stronger moral claim, in general, than conferment of a benefit. However, the distinction between avoiding harm and conferring benefit can sometimes be more a matter of semantics than reality.

A claim to health promotion may be a claim to conferment of a benefit. This may be perceived as being a weaker imperative than a claim to relief or avoidance of harm. Individuals may personally identify more with illness and the need to respond to it, than with health promotion, which means that they may be more willing to allocate resources in the former case. Moreover, reactions of compassion may be more stimulated by being presented with illness and suffering than simply by being asked to promote health. In other words, persons may be more inclined to act to avoid or ameliorate harm, than to confer a benefit. Such factors need to be kept in mind in choosing the language in which mental health legislation is framed, if it is to be of maximum efficiency.

Politically based claims of access to mental health care are also relevant. These can range from the keeping of election promises, to being concerned to set a high ethical tone of the society. It is often said that such a tone can best be judged by how a society treats its weakest and most in need members.

Decision-making concerning allocation of medical resources may occur at governmental, institutional and individual levels. Different principles can apply to govern decisionmaking at each of these different levels. For instance, utilitarianism and efficiency may be acceptable principles to apply to decision-making at a governmental level, but are definitely not acceptable at an individual level when to do so would harm the individual towards whom the physician has an obligation of personal care.

Patients' Rights - The Mental Health Context

It is always necessary to consider a person as an individual and to respect patients' rights. However, patients are also part of family and community networks and maintenance of these can be crucial to both the mental and physical well-being of the patient. There is a difference between maintaining a network for its own sake and maintaining it as necessary for the individual patient. To do the latter is to give priority to the individual's needs and rights and is not in conflict with his or her best interests.

"Liberty and security" of the person are respected through recognition of rights to autonomy, self-determination and inviolability. The legal mechanism used to implement these rights in the health care context is that of requiring informed consent and informed refusal of treatment. Informed consent means that the patient must be given all material information concerning consequences,risks and benefits of the proposed treatment and its alternatives, including no treatment at all, and must freely consent to or refuse the treatment, that is, be free of coercion, duress or undue influence.

In order to give informed consent, persons must also be competent. Findings of incompetence can be used as a subtle mechanism for social control, because incompetent persons' decisions can be overridden. The legal definition of competence is related to understanding, that is, cognitive mental functioning. If a person can understand the information necessary to give informed consent, he or she is competent. This definition can cause problems when a person is cognitively competent, but very emotionally disturbed. Such cases need great care in order neither to abuse the patient of his or her rights nor to neglect him or her by failing to fulfil needs.

When a person is incompetent, decision-making must be undertaken on his or her behalf. The basis for this decision-making can be the patient's "best interests" or "substituted judgement", in situations in which the patient's wishes regarding treatment were expressed before he or she became incompetent and are known.

It is also important to determine who decides for an incompetent patient. Members of the family are not always the most appropriate persons. New legal mechanisms relevant in this regard include the "durable power of attorney", in which a patient, while competent, selects and appoints a person to make decisions, should he or she become incompetent.

Involuntary hospitalization raises major and far-reaching legal and ethical issues and concerns. Respect for a person's rights has to be balanced with reasonable protection of the person himself or herself and others. Dangerousness is a clear basis on which such confinement is allowed, as is protection of the person's life or health when this is imminently threatened in a serious manner. Procedural controls are very important in this area and have become stringent and sophisticated. Further, because legislation allowing involuntary hospitalization is a rare infringement of liberty allowing incarceration outside the criminal context, it must be narrowly interpreted.

Rights against "wrongful discrimination" and rights to equality before the law are also important legal mechanisms in protecting the rights of patients in a mental health care context.

The medical relationship is an unusual mixture of a relationship between intimates, which is usually governed extra-legally, and between strangers, which is often governed by law. For this reason, it presents many challenges in achieving a proper balance of respect for rights and response to needs. Above all, there is a need for honesty and integrity, especially in ensuring that we are not claiming to give a certain approach priority for acceptable reasons but,in reality, are motivated by unacceptable ones. There is a difference between respecting a patient's refusal of treatment, for example, in order to respect him or her as a person and his or her rights, and adopting such an approach merely to cut costs.

FUNDING IN RELATION TO MENTAL HEALTH POLICY

Funding policies significantly influence the structure, function, and development of mental health service systems. Consequently, creating, improving, and expanding mental health services can be facilitated by formulating funding policies based upon clinical and service delivery system objectives. However, in many mental health systems, funding policies are inconsistent with service goals, and funding patterns hamper efforts to make mental health services more accessible and responsive to mentally ill persons and their families. Therefore, it is of great importance, in planning decentralized community-based alternatives to institutional care and regionalized services, that the financial control is also decentralized.

Funding may be considered from two perspectives: absolute levels, and strategies for shifting existing funds to address priority needs.

ABSOLUTE LEVELS OF FUNDING

Absolute levels of funding for mental health services are insufficient world-wide. In light of the prevalence and incidence of mental disorders, major gaps exist between service availability and needs. In comparison to other human and health needs, treatment of mental disorder does not command equal attention or priority. In the attempt to achieve sufficient funding for mental health services, many factors must be considered, including:

- societal costs of mental illness, and the cost-benefit of treatment;
- relief of suffering, effective treatment, individual self-determination, individual productivity;
- containing medical costs and reducing medical services utilization;
- mental health and physical well-being as equivalent values.

STRATEGIES FOR SHIFTING FUNDS

Strategies for shifting funds from centralized to decentralized programmes for mental health services vary considerably within countries and between countries. In many countries, despite an already existing emphasis on community-based alternatives to institutional care, the bulk of funds goes to in-patient treatment while an even larger proportion of individuals served (and in need) are in the community. In some countries reviewed, 70% of public mental health funds are devoted to operating institutions that serve less than 10% of the people who receive services. A persistent over-centralization of funding authority and funding allocation can mean that the formation of services in the community is not accomplished, thereby making it easier for the patient, family, and providers, to continue to seek institutional care. Hence, it becomes of paramount importance for policies to consider ways of ensuring the necessary flexibility to shift funding from an in-patient oriented system to a community-based system.

The specific implications for mental health policy formulation here become the need to state clear objectives with respect to decentralized, individualized, and community-based services, as well as a clear approach to the promotion of mental health, with the provision of all available financial resources. Funding strategies will be accomplished only through an appreciation of all available needs and resources within the context of a particular community, region, or country, and the establishment of well coordinated organizational services that are aimed at enhancing the integration of service delivery, management, and information.

FUNDING FOR PERSONAL SUPPORT PROGRAMMES

Additionally, an integrated approach to the funding of personal support programmes must be included in the formulation of any comprehensive mental health policy. Personal support may be defined as the social and financial support required by the mentally ill to enable them to live harmoniously in the community. It also includes the health services required from time to time by the mentally ill. Such programmes will include, though not exclusively, direct financial support in the form of disability pensions, social services, health care services, home care, work and work retraining programmes, and employee assistance programmes.

With respect to personal support programmes, major differences exist between developed and developing countries. In general, developed countries with a strong social security system provide similar financial and service support to the mentally disabled as they provide to the physically disabled. However, in practice, the local priorities tend to favour the physically disabled over the mentally disabled. This may be because of widely held negative attitudes towards the mentally ill. The intent of such social and financial support is to maintain the mentally disabled at a similar standard of living to the rest of the population. Established policies should attempt to avoid discrimination against the mentally disabled by providing the same mental and physical support to all those requiring support in the community for whatever reason. Although not achieved in most countries, a continuum of personal support should be provided to the mentally disabled so that not all of the persons requiring support have to be identified "sick" before receiving support.

In most developing countries, little or no personal or social support is provided for the chronically mentally ill living in the community. While health care is a state responsibility and no distinction is made between physical and mental care, so few services are available that most of the chronically disabled live their lives without having received professional support. A philosophy of mental health promotion underlying a mental health policy would encourage the creation and expansion of personal support programmes in both developed and developing countries.

SPECIAL POLICY NEEDS

A comprehensive mental health policy should take into account certain priority target groups for which special needs and considerations exist. Some special issues which must be considered in the formulation of a mental health policy have been identified for three major subgroups: children and adolescents, the elderly, and young adult chronic patients with substance abuse problems.

CHILDREN AND ADOLESCENTS

The largest sub-group of concern comprises children and the young, from birth to age 21. This is a time of extremely rapid changes in physical, cognitive and social/emotional development, with many important motivational tasks to be mastered for normal development to occur. Survey studies indicate that the prevalence of persistent and socially handicapping health problems among children aged 3-15, in developed countries, is between 5 to 15%, and there is reason to believe that similar rates exist in developing countries. For example, a recent epidemiological study in Canada, involving over 2500 children between the ages of 4 and 16, found that 18% of the children showed symptoms severe enough to be considered of clinical significance (Orford, 1986). The disorders included neurosis, somatization, conduct disorders, and hyperactivity.

The majority of mental health problems in children are quite different from adult disorders. Very few children show severe psychotic symptoms, and despite the long-standing interest in infantile and childhood autism (or pervasive developmental delay), these problems are extremely rare and difficult to diagnose reliably. In childhood, mental health problems are characterized by quantitative rather than qualitative deviations from healthy or normal development, children often show severe difficulties in one situation but not in another (for example, at school but not at home), and many problems can be seen as responses to specific situations. These characteristics indicate that the children's mental health problems are linked to environmental factors in a more direct way than at any other age period, and may be best understood as deviations from normal psycho-social development, resulting from disrupted or chaotic experiences in the family, at school or in peer relationships.

Despite the increased awareness of the severity of children's mental health problems, as well as the resultant long-term personal, social, and financial costs, there are limited resources for dealing with these problems. The mental health needs of children receive too little attention in health education programmes, and available methods employed in developed countries focus almost exclusively on the cure or treatment of problems, despite the fact that these procedures have been consistently criticized as providing "too little, too late, and for too few".

There is an urgent need to examine alternative forms of service delivery for youth mental health problems, for example, by using schools, family physicians, and pediatricians for initial problem identification. Due to the strong linkages of childhood problems with environmental factors, effective treatment may require the active involvement of parents, teachers, or peers. Such approaches are quite different from most adult interventions which predominantly involve the individual client alone. As a result, clinical activities may involve working with teachers, peers or family members rather than only with the individual child; also, coordinating efforts of a variety of agencies or sectors which are involved with a given child may often be necessary.

In formulating a mental health policy for children and adolescents, serious consideration should be given to the importance of developmental processes and environmental factors on mental health problems, and to the potential value of preventing such problems through the systematic promotion of psycho-social skills and personal achievement. When attempting to improve the system of care for this group, the following principles should be kept in mind:

- emotionally disturbed children should have access to a comprehensive array of services;
- they should receive services within the least restrictive environment that is clinically appropriate;
- their families or surrogate families should be full partners in planning their service needs;
- they should be provided with case management services to assure that multiple services are delivered in a coordinated manner.

THE ELDERLY

Because of their increasing number, and of the relative specificity of many of their mental health problems, the elderly deserve a "special place" in the elaboration of mental health policies. Increasingly, greater percentages of the population are attaining old age; in Canada, approximately 9.6% of the population is above 65 years of age; this will increase to 11.7% after the turn of the century. In Sweden, 23% of the population will be above 65 by the year 2025. The figures tend to be lower for developing countries and higher for many European countries, but they are all going in the same direction. In Canada, the elderly account for 50% of days of hospitalization. In the U.K., it is expected that 75% of all admissions to all hospitals in 1995 will be for persons 65 years of age and above. It is known that somatic and psychological issues are much less separate in old age than in earlier life. One longitudinal study in Sweden shows a prevalence rate of 3.3% for psychosis, and 17.3% for neurosis in cohorts of elderly people above the age of 70 (Harnois, 1986). A six-month prevalence rate study in the United States shows that for men over 65, the most frequent psychiatric disorders are cognitive problems, phobias, alcohol related problems, and dysthymia. For women over 65, the order is different: first phobias, next cognitive problems, and depression. Generalized anxiety is also high in both sexes.

Most authors insist that careful medical assessment is the corner stone of geriatric care; there is, however, a need to go beyond pure pathological issues and always include an assessment of social, environmental, and emotional factors. Such a "holistic" approach makes it evident that the care of the elderly does not rest on any single profession, but requires the input of the general practitioner, the social worker, the community nurse, and, very often, the specialist team, including the geriatrician, the psycho-geriatrician, the physiotherapist, and others. Spiritual needs should also be taken into account. The involvement of the family, at all phases, should be solicited along with that of relevant community agencies. Because of the growing elderly population,the costs inherent in the frequent use of health and social services by this sub-group, and the impossibility as well as the undesir- ability of providing increasingly institutional answers to their problems, the elderly constitute a serious challenge to the health systems and to policy makers.

There appears to be a consensus developing around the following principles for the provision of services to the elderly (including their families) with mental health problems:

- the need for careful broad-based systematic evaluation;
- the necessity to intervene rapidly;
- the provision of a range of options with the possibility of going back and forth as needs change;
- the necessity for services coordination;
- the adoption of financial regulations whereby it is not simply most economic for families to rely upon institutional care for the elderly;
- the provision of information programmes concerning aging as well as on the resources available from both the government and the voluntary sector.

YOUNG ADULT CHRONIC PATIENTS WITH SUBSTANCE ABUSE PROBLEMS

Across North America and in Europe, during the 1980's, there has been increasing attention paid to the emergence of a new generation of individuals with mental disorders - the so-called "young adult chronic patients". This term refers to those younger adults, between the ages of 18 and 40, and who comprise the highest risk group for mental disorders since the beginning of the era of deinstitutionalization.

Like many others of their generation, this is a highly mobile group of individuals. Partly because of the nature of their psychiatric disorders, and partly because of changing social norms, they tend to evidence little sense of connection with their families, their peers, or social institutions. They account for an undetermined but surely significant number of the homeless who are mentally ill. They are said to be different from seriously mentally ill patients of earlier generations in several significant ways. They tend to be more aggressive in behaviour; they are more often in trouble with the law; they account for a disproportionate number of suicide attempts and completions. They also have a high incidence of drug and/or alcohol abuse concurrent with their serious mental illness and, with their combined problems, they do not quite "fit" into the existing service delivery systems.

New models of service must be developed with well-defined and realistic objectives to fit the behaviour patterns of this group. Several states and many communities in the United States are in the process of identifying the specialized service needs of this population. It appears that many of these individuals can be helped significantly if provided a range of

diverse day-programmes tailored to their emotional, habilitation, and vocational needs. While the therapeutic community approach of many drug abuse treatment services is sometimes too confrontational for many of these individuals, in modified form, it may offer the desired degree of structure these individuals need. Key features of adequate services seem to be flexibility, informality, easy accessibility, and supportiveness.

This group of dual-diagnosis patients are generally young, predominantly male, single, and unemployed. Often, they have no remaining natural support system, they have alienated or isolated themselves from families, friends, and other social groups normally used in times of crisis. Their abuse of drugs and/or alcohol tends to increase during times of crisis.

It is clear that there are many sub-groups in this population; however, clear diagnosis is often difficult as drug use can mask deficits associated with the psychiatric diagnosis. There is evidence that substance abuse can precipitate psychiatric conditions, as well as interfere with the treatment of mental illness. Research and ongoing clinical studies will help identify meaningful sub-groups and allow the development and modification of intervention techniques and strategies that will best respond to their needs. For the present, general principles for consideration in the delivery of services to this group should include the following:

- a thorough evaluation when they do present for services;

- community residential facilities with related support services;

- coordinated alcohol, drug abuse, and mental health services, and, when necessary, the criminal justice system.

NEW ROLES FOR THE COMMUNITY AND MENTAL HEALTH CARE PROVIDERS

MENTAL HEALTH PROMOTION

The activities involved in formulating a mental health policy will be different for the different state, regional, and national levels. The roles of governments, government departments, communities, and individuals will need to be defined and/or redefined. An orientation of mental health promotion should underline the process of formulating a mental health policy. It is an orientation that includes prevention, but is broader and deeper, including biological and environmental health, and sociological issues. Its aims, as stated by the World Health Organization, include the prevention and reduction of psychiatric, neurological, and psycho-social problems (including those related to alcohol and drug dependence); efforts to increase the effectiveness of general health services for appropriate utilization of mental health skills and knowledge; and, the development of strategies for intervention based on an increased awareness of mental health aspects of social action and change. A mental health promotion programme gives central attention to the development of ways which can help in the preservation and enhancement of psychological well-being at all ages, and in the specific socio-cultural contexts of the individual communities and countries. It requires the conscious and continuous involvement of a community and of all of its members to facilitate a process of enabling people to increase control over, and to improve, their mental health.

Historically, the mental health promotion concept can be seen to have its predecessors in what is sometimes known as Human Relations Psychology and Industrial Psychology, as was researched and put forward in the 1930's and 1940's. The initiating concepts and principles

of the Human Relations field were seen to overlap a great deal with the concepts and principles of health promotion. These early ideas were picked up and integrated into the Japanese approaches to management which underscore the importance of participation and of long-range planning within industry. It would appear that some of the core ideas of the societal process in health promotion have had a considerable amount of practical testing in the one field of getting rather different types of human organisms to work together towards a common goal. The concept includes the possibility that it can prove to be a source of criteria upon which agreed priorities can be built, a process that can be so frustrating in the mental health field. One extremely important component here is the role that is played by information dissemination in this approach to community planning.

However, there must be some hesitation. This is based on the fact that the ideas of health promotion will require some major translation, transposition, and other adjustments to make the concepts appropriate for the mental health field. Its global characteristics are an invitation to magical and romantic thinking. It constitutes a medium in which projection of favored scenarios is easy. Care must be taken not to allow a dichotomy to develop between mental health promotion and response to mental illness. However, these are raised only as cautions, as an overall orientation towards health promotion and mental health promotion can prove to be extremely valuable in formulating a realistic mental health policy with priorities and objectives appropriate to any setting.

THE ADDITION OF NEW ROLES TO THE MENTAL HEALTH EFFORT

With the implementation of a mental health promotion programme, new roles will have to be added to the efforts of traditional mental health teams. There are several reasons for this.

- Health promotion calls for collaborative and catalytic modes of proceeding in the endeavors to bring about community change and development. Such work has to be flexible and generally involves a philosophy and method which are different from that found in the executive patterns of bureaucracies.

- Bodies of knowledge are required which are outside that usually found in the possession of mental health workers.

- Special technical skills in data gathering and analysis are apt to be required.

These points may be illustrated by a brief review of a health promotion programme that was initiated in "Stirling County", Nova Scotia, Canada, some years ago. The work of a Director of Community Development was integrated into the work of a local community mental health centre. The director's mandate focused on a selected group of small high-risk areas within the centre's catchment area and included three specific objectives: (i) reduce hazards, risks, and handicaps characteristic of the social environment of the settlements, (ii) increase the economic and socio-cultural resources present in these environments, and (iii) improve the coping skills of people living in the target areas.

In the realization of these goals, the assistance of a wide variety of professionals was required by the mental health team, including an epidemiologist, small group management consultants, sociologists, cultural anthropologists, economists, and others. These individuals were called upon at the planning stage and again from time to time in monitoring the progress of activities and the resolution of problems. Such an approach highlights the need for inter-sectorial cooperation as well as an expansion of the activities typically undertaken by mental health professionals. It is a multifaceted exercise that necessitates community and citizen participation in a diverse range of activities including education, training, research, legislation, policy coordination, and community development. It is an orientation which can provide a foundation for mental health policy and, ultimately, a mentally healthier community.

ROLES OF PROFESSIONAL, PARA-PROFESSIONAL, AND NON-PROFESSIONAL MENTAL HEALTH CARE PROVIDERS

A shifting focus of intervention from the institution to the community, and the increased participation of the community and its citizens in the development of mental health services will have far reaching effects. It will require a redefinition of the roles of many mental health care providers, be they professional, para-professional, or non-professional. The roles of traditional community mental health care providers will also be influenced if there is less recourse to institutions, whose roles will also be evolving.

The redefinition of roles will vary from country to country and will be further influenced by the size of mental health care resources (both public and private), as well as by such issues as professionalization and unionization.

Professionally trained mental health care providers have traditionally played and continue to play a paramount role in the provision of institutionally-based services; many of them have also shown leadership in promoting the development of community-based mental health services (socially-oriented psychiatrists have been the leaders of the Italian Mental Health Reform). It must be recognized that transferring the focus of intervention to the community often implies a blurring of roles and strong debates concerning issues such as power, hierarchy,control and leadership.

In the formulation and implementation of mental health policies, many issues will need to be fully discussed and explored. Included will be philosophical and organizational issues relating to possibly conflicting views over the mission of community mental health centres, community boards governing mental health services, and the adoption of an approach to provide treatment in the least restrictive environment. Within community teams, consensus will be needed to define responsibilities and leadership roles. Basic and continuing education programmes will be the prerequisite for the preparation of professionals for community-based treatment programmes. University faculties will need greater knowledge of the public sector for inclusion in training programmes, and training in psychiatry and psychology will have to be reinforced for members of primary health care teams. An introduction to psychopathology, the idea of prevention as regards mental health, knowledge of care methods in psychiatry, the organization of the system for prevention and care, and the legal aspects of psychiatry will be essential. These questions should be addressed by all professionals who work in the mental health field, and probably more specifically, by psychiatrists, social workers, psychologists, and psychiatric nurses.

Mental hospitals have traditionally employed large numbers of para-professional and non-professional mental health care workers. This varies widely within countries and between countries. In developing countries, these mental health care workers often provide the core of mental health care services and must work closely with traditional health care systems that are in place. In countries where a range of services exists, there can be wide national variations concerning the status of professional and non-professional staff; this can range from that of civil servants to unionized or to non-unionized status.

In countries where labour unions represent the interests of para-professional and non-professional mental health care providers, doubts have been expressed concerning the motivation behind the shift from institutional to community-based models for mental health services. The labour movement often views such a shift as a disguised attempt by governments to save money and have also expressed concern about issues relating to job security, job description, and the protection of gains for members obtained through years of collective bargaining. Conversely, the motivation of labour unions to resist efforts to change from facility-oriented services has been questioned.

Nevertheless, for an efficient functioning of services, the morale of health workers is an important factor. To work in an institution which is being denigrated and run down can be depressing for the workers and this can adversely affect the health of the patients. If, on top of this, the workers feel they are being taken advantage of by losing some of the priviledges they have gained over the years, this adds to their depression. It is important therefore that the staff, through their unions, feel involved in an active way in the change and do not feel like helpless pawns being thrown about and taken advantage of by the system.

The feasibility of mental health policies actually leading to change can therefore be greatly augmented if the concerns of the labour movement are taken into account from the start. If, for example, the number of hospital beds will be reduced, then planning should include the possibility of deploying these health care providers in new settings. Comprehensive planning will pay attention to the individual careers, the new job descriptions, pension plans, and retraining programmes for the affected staff. Suitable consultation will have to be undertaken to meet the needs of the staff which will be necessary to ensure their ability to continue providing good mental health care, and to avoid the impression that new policies disadvantage workers in institution based programmes for having carried on with traditional modes of service delivery which have been in place for a century.

Annex 1

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Annex 2

COUNTRIES, STATES, AND REGIONS REVIEWED

Documentation pertaining to, presentations concerning, and reviews of the current organization and practices with respect to the delivery of mental health services as well as activities undertaken in formulating mental health policies from 23 countries, states, and regions, formed the basis for the identification of those issues found to be important and warranting inclusion in this report. Those reviews looked at the following countries, states, and regions:

Austria	India	Spain
Belgium	Netherlands	Sweden
Botswana	Norway	Tanzania
Canada	Panama	Uganda
France	Poland	United Kingdom
Germany	Portugal	United States of America
Greece	Quebec	Zambia
Italy	Rwanda	

Annex 3

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