MENAGEMENT IN HEALTH CARE PRACTICE A Handbook for Teachers, Researchers and Health Professionals	
Title	**MENTAL HEALTH IN COMMUNITY LIFE**
Module: 5.6	**ECTS (suggested): 0.5**
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Keywords	Mental health, community mental health services, integrated mental health services
Learning objectives	After completing this module students and public health professionals should: • Be aware of the mental health as a community's public health problem; • Recognize the main determinants of mental health; • Understand the way public health can contribute to mental health improvement; • Have increased knowledge on the types of mental health services; • Identify the steps to be taken for developing community mental health services.
Abstract	Mental health is considered a public health problem due to the following particularities of the mental diseases: high incidence and prevalence; long term duration, with consequences over family, social and professional life; cause severe disability; high cost imposed on individual, family and community; associated stigma and discrimination. The main determinants of mental health are: socio-economic, demographic and psychological factors. Public health can bring a major contribution to the improvement of mental health by its main functions, such as: needs evaluation, priority setting, policy development, health promotion and disease prevention, mental health services research and development. According to WHO recommendations, mental health services should be organized based on principles of accessibility, coordinated care, continuity of care, effectiveness, equity and respect for human rights. As well, mental health care should be provided through general health services and community settings. Large and centralized psychiatric institutions need to be replaced by other more appropriate mental health services. The shifting of patients from mental hospitals to care in the community should be based, primarily on the existence of a mental health policy that promotes the development of community-based care. Policies should be drawn up with the

	involvement of all stakeholders and should be based upon up-to-date and reliable information. Mental health policy and service provision should take into account the context of general health systems organization and financing. For a successful implementation of the mental health policy, political, legislative, financial and administrative support is required.
Teaching methods	Teaching methods include: lectures, group discussions, group exercises, role playing. The students will be split in three groups and asked to work on three different subjects for undertaking a situation analysis. The students will do a role play, having assigned different roles in a 'working group' (policy-makers, health professionals, patients, family members, NGOs and other interested parties) appointed to formulate a mental health policy (that includes development of community-based care) and to plan for a community mental health service.
Specific recommendations for teachers	60% work under teacher supervision, 40% individual students' work. No special facilities, equipment or teaching materials are necessary.
Assessment of Students	Multiple choice questionnaire (MCQ) and/or groups work presentations.

MENTAL HEALTH IN COMMUNITY LIFE

Silvia Gabriela Scintee, Adriana Galan

THERORETICAL BACKGROUND

1. Mental health – a community's public health problem

In the *World Health Report 2001 - Mental Health: New Understanding, New Hope*, World Health Organization is making the following statement: *mental health – neglected for far too long – is crucial to the overall well-being of individuals, societies and countries and must be universally regarded in a new light* (1). Mental health deserves special attention and it is considered a public health problem due to the following particularities of the mental diseases:

- High incidence and prevalence. Of the 870 million people living in the European Region, at any one time about 100 million people are estimated to suffer from anxiety and depression; over 21 million to suffer from alcohol use disorders; over 7 million from Alzheimer's disease and other dementias; about 4 million from schizophrenia; 4 million from bipolar affective disorder; and 4 million from panic disorders (2);
- Long term duration, with consequences over family, social and professional life. Neuropsychiatric disorders also account for over 40% of chronic diseases. In many countries, mental health problems account for 35–45% of absenteeism from work (2);
- Cause severe disability. It was estimated that, in 1990, mental and neurological disorders accounted for 10% of the total Daly's lost due to all diseases and injuries. This was 12% in 2000. By 2020, it is projected that the burden of these disorders will have increased to 15% (1);
- High cost imposed on individual, family and community. There are very few studies that estimate the aggregate economic costs of mental disorders. WHO 2001 World Health Report quotes one such study (Rice et al. 1990) that concluded that the aggregate yearly cost for the United States accounted for about 2.5% of gross national product, a study from the Netherlands that has estimated expenditure on mental disorders as 23.2% of all health service costs (Meerding et al. 1998) and a study in the United Kingdom that found that inpatient expenditure only was 22% (Patel & Knapp 1998). Indirect costs arising from productivity loss account for a larger proportion of overall costs than direct costs. However, all the estimates of economic evaluations are most certainly underestimates, since lost opportunity costs to individuals and families are not taken into account (1).
- Associated stigma and discrimination. Because of this stigma, people with mental disorders experience limitations in employment, education and housing. This in turn affects their ability to gain access to appropriate care, integrate into society and recover from their illness (2).

1.1 Main determinants of mental health

As known, the health status of a population is determined by: (a) biological factors, (b) environmental factors (economical, social and physical), (c) lifestyle (behavioural and cultural factors) and (d) health care systems. The main determinants of mental health are: socio-economic, demographic and psychological factors.

1.1.1 Socio-economical factors

Public health literature shows with evidence based arguments that the main determinants of poor health are poverty and inequity. Furthermore, poverty and associated conditions of unemployment, low educational level, deprivation and homelessness are not influencing mental health only in poor countries, but also affect a sizeable minority of rich countries. Data from cross-national surveys in poor countries (Brazil, Chile, India and Zimbabwe) shows that common mental disorders are about twice as frequent among the poor as among the rich. In the United States, children from the poorest families were found to be at increased risk of disorders in the ratio of 2:1 for behavioural disorders and 3:1 for comorbid conditions (1). The poverty determines not only the onset, but the evolution of psychiatric disorders, as well. The stigma attached to mental diseases creates a vicious cycle of alienation and discrimination – leading to social isolation, inability to work, alcohol or drug abuse, homelessness, or excessive institutionalization – which decreases the chance of recovery and normal life.

1.1.2 Demographical factors

Gender

In general, the behavioural and mental disorders affect equally the both sexes. There are sex differences on each diagnostic category. Thus, the depressive and anxiety disorders are more frequent in women, while substance abuse and antisocial personality disorders are more common in men (3). Among the reasons of higher prevalence of depressive and anxiety disorders in women there are: hormonal changes as part of the reproductive life cycle, the social role of the women that burdens them with higher responsibilities and exposes them to greater stress, high rates of domestic violence and sexual violence against women, high prevalence of physical disorders among women.

Age

Mental disorders have a high prevalence among children and adolescents. The most frequent disorders in children are the impairments or delays in the development of specific functions such speech (dyslexia) or overall pervasive development (autism). A high prevalence of mental disorders is also seen in old age, especially for dementia and depression. Thus, the increase in life expectancy of persons with mental disorders, as well as the increasing number of persons who reach an age for which the risk of developing a mental disorder is higher determines a high prevalence of the psychiatric pathology.

Urbanization

This process is accompanied by increased homelessness, poverty, higher levels of pollution, overcrowding, violence, rapid technological change and disruption in the family structures and loss of social support – factors that have a negative impact on mental health (4).

1.1.3 Psychological factors

Individual factors

The presence of a serious physical disorder may affect the mental health of individual as well as of entire families because of psychosocial consequences such as an infirmity

(i.e. surgical removal of one breast) or stigma and discrimination (AIDS). Other individual factors refer to the different life events, either positive (such as: unexpected substantial gains, a great success) or negative (professional failures, losses), or even life change events (job or professional responsibilities change, migration).

Familial factors

Unstable or disrupted family environments have a role in the outset and the evolution of mental disorders. A well known example is the concept of ‚expressed emotions' studied in the families of patients with schizophrenia. ‚Expressed emotions' in these studies have included critical comments, hostility, emotional over-involvement and warmth (1). As well, family life events such as changes in family structure, a serious disease or disability of a family member are affecting mental health.

Environmental factors

Mental disorders are firmly rooted in the social environment of the individual, at both micro-group level and the whole society level. At the micro-group level the person could be affected by conflictual relationships, or negative life events such as the disease, the death, the injustices or losses suffered by the members of the group (friends, relatives, colleagues, neighbours, etc). At the whole society level the wars, civil wars, natural disasters, can traumatize entire populations and the effects are higher in the less developed countries with less problems solving capacity (1).

Even if the biological factors, the factors from the physical environment and the health care systems have a smaller influence on the onset of the mental disorders, these are not to be neglected. Almost all of the common severe mental and behavioural disorders are associated with a significant genetic component of risk. As the many other physical illnesses the mental disorders are the result of a complex interaction of two or more factors.

1.2 The contribution of public health to a better mental health of the community

Public health can bring a major contribution to the improvement of mental health by its main functions, such as: needs evaluation, priority setting, policy development, health promotion and disease prevention, mental health services research and development.

1.2.1 Needs evaluation and development of policies addressed to the priority problems

Until not so long, accurate evaluation of the mental health status has been impeded, on one hand by the difficulties in defining and identifying the mental disorders, and on the other hand by the inadequacy of data collection systems. Advances during recent decades in standardizing clinical assessment made possible as mental disorders to be diagnosed as reliably and accurately as most of the common physical disorders. Structured interview schedules and diagnostic symptom/sign checklists allow mental health professionals to collect information using standard questions and pre-coded responses. The symptoms and signs have been defined in detail to allow for uniform application. Finally, diagnostic criteria for disorders have been standardized internationally (1).

Data on mental health status of a population is not usually found in the routine statistical records and specially designed epidemiological and medico-social surveys are necessary in order to get information on the incidence and prevalence of mental disorders. Besides information on mental health diseases, information on major determinants of mental health and health care systems are necessary in order to identify priority problems and to formulate policies to address these problems.

In fulfilling its role of technical adviser to the Member States in mental health related matters, World Health Organization noticed that there was not enough information on mental health, especially on the available resources to alleviate the mental health problems. Thus, in 2000, the World Health Organization launched the project Atlas to address this gap. The objectives of this project include the collection, compilation and dissemination of relevant information about mental health resources in different countries. The first set of publications from the project appeared in 2001 and the second editions with updated information in 2005. One significant addition in 2005 was the inclusion of information on epidemiology of mental disorders for all low and middle income countries.

Emphasizing the necessity of a well-functioning and coordinated information system for measuring a minimum number of mental health indicators for both the formulation and evaluation of policies on mental health, World Health Organization mentions 'Monitoring of community mental health' among the ten recommendations for action in its *World Health Report 2001 - Mental Health: New Understanding, New Hope* (1).

1.2.2 Health promotion and disease prevention

Taking into account the high economic and social costs of mental diseases for the society, mental health promotion and mental disorders prevention have a tremendous importance. Mental health promotion strategies have also a positive impact on other problems such as: delinquency among youngsters, school abandon and violence against children. These strategies should take into account both the community needs, and the social and cultural environments.

Mental health promotion strategies could be classified in three main categories (1):

1. *Interventions targeting factors determining or maintaining ill-health.* As an example – programmes that enhance the quality of children-parents relationship, given the fact that psychological and cognitive development of children depend upon the interaction of the children with their parents;
2. *Interventions targeting population groups*. A population group that might need such programmes are elderly. By 2025, there will be 1.2 billion people in the world who are over 60 years of age, close to three-quarters of them in the developing world, which represent an important determinant of mental health disorders increase;
3. *Interventions targeting particular settings*. An example could be school targeted programmes. Besides family, the school is crucial in preparing the children for life. Thus, schools should teach life-skills such as problem solving, critical thinking, empathy, communication skills, interpersonal relations development and methods to cope with emotions. As well, schools should offer a friendly environment, where the tolerance, the equality between sexes, ethnical, social or religious groups, the creativity, the self-esteem and self-confidence should be encouraged.

Mental health prevention could be done at three levels.

1. *Primary prevention* is predominantly targeted to the mental health determinants and avoids the diseases development, reducing in this way the incidence of the diseases. Community based primary prevention programmes can bring a huge contribution to the well-being of individuals by controlling mental health determinants that action at community level.
2. *Secondary prevention* has the purpose of early detection of diseases, arrest the disease evolution, avoid further complications and sequelae and limit disability. Through cure and reduction of disease duration secondary prevention reduces the

prevalence of the diseases. Even if the main contribution belongs to the psychiatric services, the primary health care services or services provided at the community level can help by early detection of the diseases and by monitoring the treatment prescribed by specialists.

3. *Tertiary prevention* reduces the handicap, helps the socio-professional recovery, assures the independence and self-satisfaction on the quality of life of the individual. It comprises both interventions at the level of the individual and modifications of the environment. The best interventions are the integrated tertiary prevention programmes in which community participates covering the social needs of the individuals.

1.2.3. Mental health services research and development

Mental health services have some particularities that make them different. Primarily, in many countries they are not integrated in the general health services. Mental disorders are common and most patients are only seen in primary care, but their disorders are often not detected as the medical team from the primary care level is not trained in detection of mental disorders.

The prejudice towards mental health service users, together with the silent debut of mental diseases, keeps a low level of addressability to mental health services. As well, denying their disease, the patients do not address to health services until their disease is too serious and they need hospital care. Numerous studies show that rates of service utilization by people with mental health problems remain low. For instance, in the Netherlands more than 40 per cent of people with bi-polar disorder are estimated not to come into contact with mental health services. The ESEMED study (European Study of the Epidemiology of Mental Disorders), covering six European countries (Belgium, France, Germany, Italy, the Netherlands and Spain), concluded that there was insufficient use of both general and specialist mental health services relative to the prevalence of mental health problems in the population, with only one in four people in need coming into contact with services, although contact rates were higher for some problems such as mood disorders (5). For this reason the active detection of the mental diseases is very important.

A broad range of ingredients of care are requested to meet both medical and social needs of people with mental disabilities, including medication, psychotherapy, psychosocial rehabilitation, vocational rehabilitation, employment, housing, etc. As well, mental health services can be effective only when provided within a multidisciplinary care team: psychiatrist, psychologist, social worker, etc. The complex needs of many persons with mental disorders cannot be met by the health sector alone. Intersectoral collaboration is therefore essential. Collaboration is needed both within the health sector (intrasectoral collaboration) and outside the health sector (intersectoral collaboration) (6).

Decentralization and health financing reforms have largely been driven by a desire to improve access to health care, advance equity in health service provision and promote the use of cost-effective technologies so as to obtain the best possible health outcomes for populations. On the other hand, financing reforms have also been seen by governments as a method of controlling the cost of providing health care and spreading the cost to other players, especially the users of services. Health financing reforms include changes in revenue collection based on the concept of pooling and reforms in the purchasing of health services. However, general health reforms might have negative impact on mental health: the fragmentation and exclusion of services for people with mental disorders through decentralization; increased out-of-pocket payments that would harm the interests of people with mental disorders, as they are unlikely to have the resources to pay for services;

exclusion from the treatment for mental disorders by introduction of pooling systems such as public and private insurance schemes (4).

World-wide, out-of-pocket payment is the most important method for financing mental health care in 17.8% of WHO member countries. In 62.8% of WHO member countries the most important method is tax based; in 14.4% of countries: social insurance; in 1.7% of countries: private insurance; and in 3.3% of countries external grants from international organizations and other countries. In the European Region social insurance is the primary method of financing in 44.9% of countries. Out-of-pocket payment is the second most used method of financing mental health care in 28.9% of countries in the European Region (7).

Mental health services are widely underfunded, especially in developing countries. Nearly 28% of WHO member countries do not have separate budgets for mental health. Of the countries that have such budgets, 37% spend less than 1% of their health budgets on mental health. Expenditure on mental health amounts to under 1% of the health budgets in 62% of developing countries and 16% of developed countries. Thus there is a significant discrepancy between the burden of mental disorders and the resources dedicated to mental health services (4). In order to properly finance the mental health system, decision makers should find ways to mobilize sufficient funds, should use economic research methods to identify how the funds should be allocated to cover the needs and to find cost control tools (8).

2. Mental health care in community based services

The provision of mental health care in community settings has been highly debated in the last two decades. The starting point was the discontent with the long term care hospitals. Long term hospitalization was held accountable by progressive loss of life skills and accumulation of "deficit symptoms" or "institutionalism". Other concerns included repeated cases of ill-treatment to patients, the geographical and professional isolation of institutions and their staffs, poor reporting and accounting procedures, failures of management, leadership and administration, insufficient finances, ineffective staff training, and inadequate inspection and quality assurance measures. The resulting response was deinstitutionalization (9).

As there was no scientific evidence that community services alone can provide satisfactory comprehensive care, the best alternative was considered a *balanced care model*. Balanced care is essentially community-based, but hospitals play an important backup role. This means that mental health services are provided in normal community settings close to the population served, and hospital stays are as brief as possible, arranged promptly and employed only when necessary. The balanced care approach seeks to provide services that (9):

- are close to home, including modern hospitals for acute admissions and long-term residential facilities in the community;
- are mobile, including services that provide home treatment;
- address disabilities as well as symptoms;
- provide treatment and care specific to the diagnosis and needs of each individual;
- adhere to international conventions on human rights;
- reflect the priorities of the service users themselves; and
- are coordinated among mental health care providers and agencies.

2.1 Types of mental health services

According to WHO recommendations, mental health services should be organized based on principles of accessibility, coordinated care, continuity of care, effectiveness, equity and respect for human rights. As well, mental health care should be provided through general health services and community settings. Large and centralized psychiatric institutions need to be replaced by other more appropriate mental health services. WHO does not make any recommendation on a specific model for organizing mental health services. The organization and delivery should take into account the country's social, cultural, political and economic context. The various components of mental health services are grouped in three main categories: services integrated to the general health system, community services and institutional services (6).

2.1.1 Mental health services integrated into the general health system

Mental health services in primary care include preventive and curative services and it is delivered by primary care professionals: general practitioners, nurses, community health workers and other health staff based in primary care clinics. This requires significant investment in training primary care professionals to detect and treat mental disorders. Furthermore, primary care staff should have the time to conduct mental health interventions. Clinical outcomes of primary care integrated mental health services depends on the knowledge and skills of primary care staff in diagnosing and treating common mental disorders, as well as on the availability of drugs and of psychosocial treatment. Primary care services are easily accessible and are generally better accepted than other forms of service delivery by persons with mental health disorders. This is mainly attributable to the reduced stigma associated with seeking help from such services. Both providers and users generally find these services inexpensive in comparison with other mental health services.

Mental health services in general hospitals include certain services offered in district general hospitals and academic or central hospitals that form part of the general health system. Such services include psychiatric inpatient wards, psychiatric beds in general wards and emergency departments, and outpatient clinics. There may also be some specialist services, e.g. for children, adolescents and the elderly. These services are provided by specialist mental health professionals such as psychiatrists, psychiatric nurses, psychiatric social workers, psychologists. The clinical outcomes associated with these services are variable and depend on their quality and quantity. Mental health services based in general hospitals are usually well accepted. Because general hospitals are usually located in large urban centres, however, there may be problems of accessibility in countries lacking good transport systems. For service providers, mental health services in general hospitals are likely to be more expensive than services provided in primary care but less expensive than those provided in specialized institutions. Service users also have to incur additional travel and time costs that can create additional access barriers in some countries.

2.1.2 Community mental health services

Formal community mental health services include community-based rehabilitation service, hospital diversion programmes, mobile crisis teams, therapeutic and residential supervised services, home help and support services, and community-based services for special populations such as trauma victims, children, adolescents and the elderly. Community mental health services need close working links with general hospitals and mental hospitals, with primary care services and informal care providers working in the community. These services require some staff with a high level of skills and training, although many functions can be delivered by general health workers with some training in

mental health. Community mental health services provide an opportunity for many persons with severe mental disorders to continue living in the community and thus promote community integration. High levels of satisfaction with community mental health services are associated with their accessibility, a reduced level of stigma associated with help-seeking for mental disorders and a reduced likelihood of violations of human rights.

Informal community mental health services may be provided by local community members other than general health professionals or dedicated mental health professionals and para-professionals. Informal providers are a useful complement to formal mental health services and can be important in improving the outcomes of persons with mental disorders. Such service providers usually have high acceptability and there are few access barriers as the providers are nearly always based in the communities they serve.

2.1.3 Institutional mental health services

Specialist institutional mental health services are provided by outpatient clinics and public or private hospital-based facilities that offer various services in inpatient wards. Among the services there are those provided by acute and high security units, units for children and elderly people and forensic psychiatry units. Specialist services are usually tertiary referral centres and patients who are difficult to treat make up a large proportion of their case-loads. If well funded and well resourced they provide care of high quality and produce outcomes that are good enough to justify their continuation. Nearly all specialist services have problems of access, associated with a lack of availability, with location in urban centres that have inadequate transport links, and with stigma attached to seeking help from such services. Specialist services are costly to set up and maintain, mainly because of the high level of investment in infrastructure and staff.

Dedicated mental hospitals mainly provide long-stay custodial services. In many parts of the world they are either the only mental health services or remain a substantial component of such services. Mental hospitals are frequently associated with poor outcomes attributable to a combination of factors such as poor clinical care, violations of human rights, the nature of institutionalized care and a lack of rehabilitative activities. Stigma associated with mental hospitals also reduces their acceptability and accessibility.

2.2 Community care based mental health services

Community mental health services can include a wide array of settings and different levels of care provided by mental health professionals and para-professionals, usually working in multidisciplinary teams (10). Examples of services provided in community care settings are presented below.

Community-based rehabilitation and treatment programmes - aiming to assist people with mental disorders to live a full community life. There are many models of community-based service provision such as case management, hospital diversion programmes, intensive home support and outreach services. In the case management model, each patient is allocated a ‘case manager’ who assesses the patient’s needs, develops a care plan, offers linkages with the care providers and advocacy. Intensive case management services can be provided for a short period during a crisis in order to avoid or prevent hospitalization (hospital diversion programme).

Specialist mental health services for treatment and care of people with severe mental health problems in the community. Specialist teams need to be organized. Examples are specialist community services to care for people with severe problems such as schizophrenia, bipolar affective disorder, dementia and severe depression. These

services need to be accessible 24 hours a day, 7 days a week, and should comprise multidisciplinary staff.

Housing services include supported, residential and emergency housing (11). Supported housing ensures the provision of affordable accommodation and a range of supporting services enabling patients able to live independently to maintain their living arrangements. Residential housing enables patients that cannot live independently to acquire skills and confidence in a group setting in order to maximize their independence. Emergency housing provides services to homeless patients who require intensive stabilization (but no hospitalization).

Crisis intervention services need to be provided in association with primary care providers, who are usually the first "port of call" in a crisis. This requires good referral and linkage systems with primary care services, as well as with mental health services in general hospitals. In some countries, community mental health teams also provide home-based intensive crisis intervention services through mobile and outreach crisis teams. Hospital diversion programmes in other countries try to divert people in crisis from a hospital admission to other community-based facilities such as crisis shelters.

Education and training community mental health services are usually involved in education and training of staff for their own services, as well as of primary health care staff and mental health professionals working in general hospitals.

Community mental health services need to develop good *intersectoral collaboration*, because people with mental disorders have complex needs that cut across service sectors. Links need to be established with primary health care services and with services provided through general hospital settings.

Community mental health services need to participate in *research* especially in the area of service delivery, for example by investigating the effectiveness of different models of service delivery. Community mental health services have first-hand knowledge of delivering community-based services, and this can usefully feed into the framing of research priorities and questions.

People with mental disorders have multiple needs related to health, welfare, employment, housing, criminal justice and education. For these reasons, community mental health services *need to work collaboratively with other sectors and establish clear referral pathways*, mutual supervision and training.

All these services could be combined in different community mental health care models, from country to country, depending on various factors including the socio-cultural context, how national health services are organized and the availability of financial and human resources.

2.3 Developing community mental health services

Community care facilities exist in only 68.1% of WHO member countries, covering 83.3% of the world's population. Across different income groups, community care facilities in mental health are present in 51.7% of the low income countries and in 97.4% of the high income countries. There were also significant differences between income group and the presence of community care facilities within countries (7). Currently 28% of countries in Europe do not have any community-based mental health services. There is wide variability according to levels of economic development. Only 33% of low-income European countries have community-based mental health services, whereas 91% of high-income countries have such services. Among those countries that do report having community services, the actual extent of service coverage also varies widely (10).

Recent developments in the understanding, treatment and care of people with mental disorders have shown that the most effective care of people with mental disorders is provided at community level. The importance of the community for mental health is highlighted by the World Health Organization in the *World Health Report 2001 - Mental Health: New Understanding, New Hope*, where 3 out of 10 recommendations refer directly to the community (1):

- Give care in the community (3). '*Community care has a better effect than institutional treatment on the outcome and quality of life of individuals with chronic mental disorders. Shifting patients from mental hospitals to care in the community is also cost-effective and respects human rights. Mental health services should therefore be provided in the community, with the use of all available resources. Community-based services can lead to early intervention and limit the stigma of taking treatment. Large custodial mental hospitals should be replaced by community care facilities, backed by general hospital psychiatric beds and home care support, which meet all the needs of the ill that were the responsibility of those hospitals. This shift towards community care requires health workers and rehabilitation services to be available at community level, along with the provision of crisis support, protected housing, and sheltered employment.*'
- Involve communities, families and consumers (5). '*Communities, families and consumers should be included in the development and decision-making of policies, programmes and services. This should lead to services being better tailored to people's needs and better used. In addition, interventions should take account of age, sex, culture and social conditions, so as to meet the needs of people with mental disorders and their families.*'
- Monitor community mental health (9). *'The mental health of communities should be monitored by including mental health indicators in health information and reporting systems. The indices should include both the numbers of individuals with mental disorders and the quality of their care, as well as some more general measures of the mental health of communities. Such monitoring helps to determine trends and to detect mental health changes resulting from external events, such as disasters. Monitoring is necessary to assess the effectiveness of mental health prevention and treatment programmes, and it also strengthens arguments for the provision of more resources. New indicators for the mental health of communities are necessary*.'

The shifting of patients from mental hospitals to care in the community should be based, primarily on the existence of a mental health policy that promotes the development of community-based care. Policies should be drawn up with the involvement of all stakeholders and should be based upon up-to-date and reliable information concerning the community, mental health indicators, effective treatments, prevention and promotion strategies, and mental health resources. Mental health policy and service provision should take into account the context of general health systems organization and financing.

An analysis of the data gathered by Project Atlas (7) shows that only 62.1% of WHO member countries, accounting for 68.3% of the population, have a mental health policy. In European Region 70.6% of countries have a mental health policy. Most countries that report having a policy also have all the essential components incorporated into them: treatment, prevention, rehabilitation, promotion and advocacy. Intersectoral collaboration, collaboration with NGOs, provision of social assistance, human resource development, improvement of community care facilities especially for the underserved are some of the

other components also included in the policies of some countries. The Project Atlas does not have data on the degree in which these policies are implemented.

For a successful implementation of the mental health policy, political, legislative, financial and administrative support is required. Necessary investments have to be made in buildings, staff, training, and the provision of backup facilities. Monitoring and evaluation are important aspects of change: planning and evaluation should go hand in hand, and evaluation should, wherever possible, have an epidemiological basis. The policy will need to be reviewed periodically to allow for the modification or updating of programmes (1).

The main principles that should guide the development of community mental health care services are: accessibility, comprehensiveness, coordination and continuity of care, effectiveness, equity and respect for the human rights (6). The development of community mental health services should take into account the comprehensive and locally based provision of treatment and care, accessible to patients and their families. Services should be comprehensive in that they provide a range of facilities to meet the mental health needs of the population. If re-shaping of large hospitals is envisaged, developing of community services should come first. Deinstitutionalization can proceed in stages once community-based alternatives are in place and all the functions of the institution are reproduced in the community.

Planning for community mental health services should not be an isolated process. Service planners have to determine the exact mix of different types of mental health services and the level of provision of particular service delivery channels. No matter how developed a community care network is in place, there will always be a need for long-stay facilities for an extremely small proportion of patients. However, most of these patients can be accommodated in small units located in the community, approximating community living as far as possible, or alternatively, in small long-stay wards in hospitals that also provide other specialist services (6). As the complex needs of many persons with mental disorders cannot be met by the health sector alone, intersectoral collaboration should therefore be taken into consideration, both within the health sector and outside the health sector.

Also, financing issues should be considered. Primarily, the general health financing system should be well understood as even in the countries in which mental health financing is not distinct of the general health financing, it is shaped or determined by this. In order to understand the level of current resources and how they are used, the entire mental health system should be mapped, and the resource base for mental health services should be identified, as well as the allocation strategies. The selection of method for purchasing mental health services should take into account the increase of effectiveness and efficiency in services provision.

EXERCISE

Task 1 – Situation analysis

The students will be split in three groups and asked to work on the following subjects:

- Analyse the national mental health policy;
- Analyse the country's general health system: organization and financing, degree of decentralization;
- Analyse the country's mental health system: organization and financing, human resources.

Task 2 – Community mental health services development

The students will do a role play, having assigned different roles in a 'working group' (policy-makers, health professionals, patients, family members, NGOs and other interested parties) appointed to formulate a mental health policy (that includes development of community-based care) and to plan for a community mental health service focusing on the following issues:

- What needs should be covered;
- What services will be provided;
- What investments are necessary;
- Where the money will come from;
- What would be the implementation strategy.

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