

Neglected priorities of mental health programmes

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Editorial

Until relatively recently it seemed clear what the answer about the priorities for mental health programmes should be. Often quoted they include the formulation of explicit government policies about mental health, the enactment or modernization of mental health laws, the development of community mental health, the provision of care to the mentally ill by general health care workers and the treatment of the severely mentally ill in their homes. The choice of these priorities was rational and followed the principles of overall development in which the maximal utilization of available resources had been given a place of pride.

Since governments have to develop policies before they can act in a coherent and rational way, why not put a maximum of emphasis on the development of positive and progressive policies concerning mental health care?

Since the number of highly qualified mental health specialists is small and unlikely to grow sufficiently to make them look after people with mental illness, why not give the general practitioners and other non-mental health specialists the necessary training so that they can take on the tasks of diagnosing and treating mental illness as they do with other illnesses?

The mental hospitals in many countries of the world are often in a terrible state and it would take a lot of money and effort to modernize the architectural and human structures of these institutions. On the other hand, there is no doubt about the fact that most persons with a mental illness would be happier (and would get better sooner) if they could live in the community, be respected and given support by a loving and caring family or friends that would work hand in hand with the medical and social institutions in providing the best of medical care. So, why not open the door of hospitals and place the patients into their family and community and use the land and the buildings of the hospitals for other purposes while making the patients better cared for?

Similar rationality marks the other priorities for mental health programmes. The choice of priorities is logical, easy to understand and it is clear that its implementation would bring benefits to people with mental illnesses. What is more, the changes that were proposed could be done -it was claimed and shown by several examples- without additional

investment: thus, even the poorest countries could use this strategy and provide better care to the mentally ill.

But, as reports from many countries show, progress in improving mental health programmes over the past forty years since these principles and priorities have been announced by the World Health Organization* has been slow and insular. There were, here and there, examples of a successful mental health programme conducted in line with these priorities, but most often a more focused analysis could show that the success was due to the presence of an extraordinarily gifted and devoted individual (or a small group of people) or of a powerful politician who had a mentally ill relative rather than to governmental action along the principles and priorities mentioned above, or to insistent demands of mental health workers or the community.

Most governments did not develop an explicit mental health policy and among those that have it many did not act very vigorously to implement it in the planning of health programmes. Mental health legislation was introduced in a number of countries but it usually dealt mainly with coercive treatment and its application was anything but rigorous. In some countries, general practitioners and non-mental health specialists became involved in the provision of mental health care: the proportion of those who did so, however, has not been very high. In other countries general practitioners who accept to treat mental disorders—possibly with the exception of depressive and anxiety states—are still rare. The discharge of people with chronic mental illness or impairment into the community worked well when the community was prepared through considerable effort and by significant moral and material investment to accept them: in other settings the mentally ill were exploited or abused, suffered violence and humiliation and often ended in hospitals with an exacerbation of their illness. Families who were only rarely given adequate support and education found it difficult to look after the

* Numerous individuals and organizations have been proposing action along these lines before the World Health Organization did so in its Technical Reports and Resolutions of the WHO governing bodies: the late 1960's were however the time when governments represented in the World Health Assembly formally adopted this way of proceeding.

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mentally ill who were to rely on their care for survival and rejected the patient. The vagrant mentally ill people in many countries are homeless and left at the mercy of others because their families could no longer afford the time and the expense involved in looking after them at home.

It thus seems obvious that the logical plans for the implementation of mental health programmes made in the middle of the past century need to be amended by the addition of measures that will make it possible to improve mental health care.

These «additional» priorities should precede those previously selected because they will remove the obstacles that are currently blocking progress and thus make it possible to introduce the significant reforms of mental health care that are clearly necessary.

The first and probably most important of these is an investment into action that will reduce the stigma attached to mental illness and all that is related to it –the persons suffering from mental illnesses, their families over generations, mental health specialists, institutions providing mental health care, the medications used in the treatment of mental illness as well as its various methods of treatment. The investment into fighting stigma has to be substantive and continuous, not an isolated effort or a campaign.

A second important component that needs to be added to mental health programme priorities is the involvement of the private health care sector in measures that are taken to improve mental health and mental health care. Private institutions, private practitioners, the industry (pharmaceutical and other, such as that involved in the production of medical apparatus and in the construction of health care buildings) play an increasing role in the provision of care and are at present not involved in its evaluation nor in its planning. The establishment of an ethically acceptable and mutually useful relationship between governments and industry is not an easy task.

Traditionally, the governmental agencies responsible for health avoided contact with the industry and restricted their relationship with it to controlling products and collecting taxes. The acceptance of industry's representation and concrete participation in the planning and evaluation of programmes would require a lot of negotiations and a readiness to accept compromise solutions by all concerned. The process might be cumbersome but it is certainly worth trying.

Physicians in private practice and the privately owned and operated institutions have, until now, not even been mentioned in documents about the development of mental health programmes. They play a considerable role in the care of the mentally ill and are often very influential. In order to involve them in programmes it would be necessary to help them overcome their mistrust of the government and make the governments drop their prejudice about the private practitioners' motives and ways of working. Both

aims are reachable but require sustained action and should be among priorities.

Another priority that has to be added to mental health programmes is the involvement of representatives of service users in designing a programme and in deciding about matters such as the evaluation of services and budgeting for specific activities. Involvement does not mean the token presence of a user representative on committees or the request for advice on draft plans for the service. «Users» of services are also providers of service and participants in the process of care: they should therefore have as much to say as do the other participants in the programme.

A fourth element to add to the infrastructure of programmes is a change of the relationship of psychiatry and other medical disciplines. At present, in most countries of the world, the relationships are bad. Psychiatry is not accepted as a medical discipline and psychiatrists are often outside of the academic and clinical mainstream of medicine. The geographical distance between psychiatric institutions and other medical institutions is an outward sign of distance: but the distance is also noticeable in the parallelism of sub-specialities of psychiatry with those of general medicine. Psychiatry has «its» epidemiology while the rest of medicine relies on public health specialists and institutions acquiring epidemiological data relevant to their discipline. Psychiatry has «its» social and «its» biological branches as if mental illness could be exclusively explicable by social or biological factors. Psychiatry has «its» child branch while the rest of medicine has pediatrics. Psychiatry has «its» psychogeriatrics while the rest of medicine has gerontology. The distance of psychiatry from general medicine makes it less trustworthy than general medicine and excludes it, to a large extent, from the processes of distribution of funds, personnel and other resources reserved for the health care system. What is worse, psychiatrists often refuse to treat physical illness and physical illness specialists are very reluctant to treat people who have the diagnosis of a mental disorder. As a consequence, the prognosis of comorbid illnesses is worse than it could be if equal attention were to be given to both the physical and mental disorder. The physical morbidity and the mortality of people with mental illness is higher than that of the general population. Among other reasons for this deplorable finding, the separation of psychiatry from general medicine and the tendency to provide incomplete care to people with co-morbid mental and physical illness plays an important role.

A fifth addition to the priorities for mental health programmes is a significant change of the attitude and legislation concerning the families of mentally ill people. Families have decreased in size, worldwide, and can no longer easily accommodate and provide care to its members with a mental illness. In order that they continue looking after mentally ill members, families must be given

opportunities to learn how this is done and should receive substantial and continuing financial support to compensate for the loss of income and of other advantages that they might get if they did not have to look after a severely ill person in their home. The financial support to families should be similar to the amount that the government or insurance companies would pay for the care of the patient if he were in an in-patient institution. The care in the

community is a better way of surviving mental illness, but it is not a cheaper way of providing care.

There are other additions to the 20th century strategy of improving mental health programmes, but attention to the priorities listed above would be a major step forward and might give them a chance to be realized to the benefit of all concerned: the patients, their families, mental health workers, the health system and society.