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Improving global mental health

From Asylum to Community Care: Reflections and Perspectives

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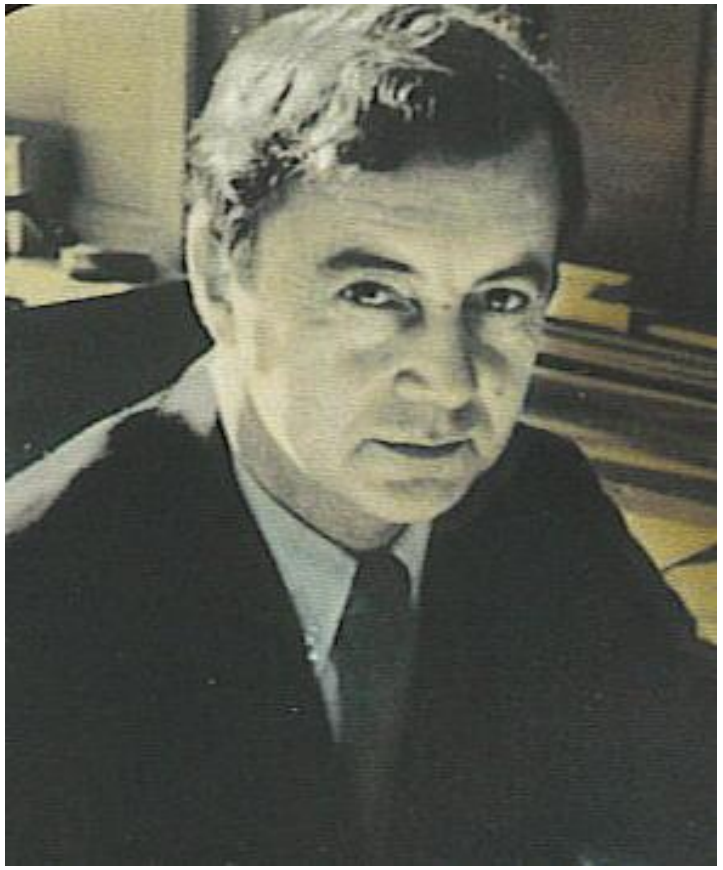
OUTLINE

1. Change of attitudes
2. Evolution of MH services
3. Global MH
4. Current views
5. Towards a new concept

Asylums

- State Hospitals = total institutions
- Impersonal, inflexible and authoritarian institutions

Goffman 1961



Factors in Support of Deinstitutionalisation

- Economic Growth
- Human Rights
- Scandals – Enquires
- Alternative Models to Institutionalisation

Change of attitudes

- Deinstitutionalisation: 1960s- 1980s
- Community Care: 1970s – 1990s
- Normalisation (USA, Wolfensberger 1972) creating normal experiences through service settings and attitudes, and responses to people. Also helping people with disabilities to take on valued social roles

The 60s and the 70s

- Psychiatric units in District General Hospitals
- Health and welfare systems
- Community Psychiatric Nurse service emerged
- But also:

MH Care in the community

- "Service that provides a full range of effective mental health care to a defined population, dedicated to treating and helping people with mental disorders, in proportion to their suffering or distress, in collaboration with other local agencies."

Thornicroft and Tansella, 1999

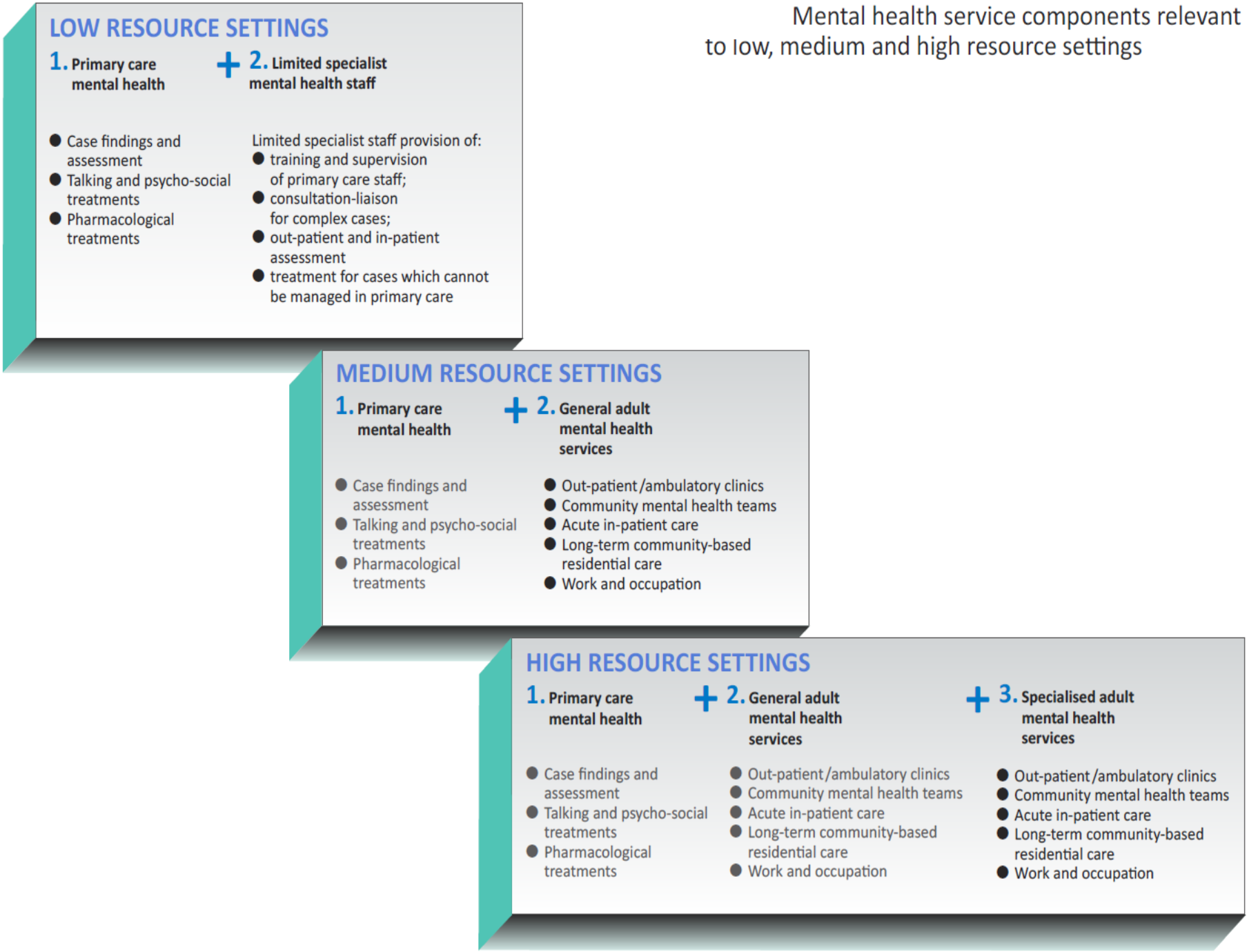
Evolution of MH Services

Evolution of MH services

- The rise of asylum
- The decline of asylum
- The reform of mental health services
  - Deinstitutionalization
  - Community care
  - Significant variation among countries but even within regions

Thornicroft and Tansella, 2002

Mental health service components relevant to low, medium and high resource settings



The changing context of MH services I

Positive developments I

- Sustained reduction of long-stay beds in the old institutions
- Combined treatment of medication and psychosocial interventions
- Shift towards more 'community-based' patterns of care

The changing context of MH services II

Positive developments II

- Emergence of new models for effective community treatment and management, based on specialised teams

- New, effective models of vocational

- Rehabilitation – e.g. '*Individual Placement and Support*' (potential very significant contribution to improved social outcomes)

The changing context of MH services IV

The challenges

- New social problems – increased availability of highly potent 'street drugs'
- Risk Behaviour
- Perceived threats from various immigrant and minority communities (e.g. refugees, economic migrants, prisoners, old age, ID, etc.) breakdown of 'social capital'
- New emphasis on 'market' models for health care - based on transactions of health 'goods', provided by 'suppliers' (mental health professionals) and 'chosen' by 'consumers'. The 'market' then takes care of quality (and rationing)

Key policy trends in Europe

- Continued shift away from institutional care, but access to community care still variable
- Increased emphasis in policy on non-medical support for independent living: social welfare benefits, employment and training, education, housing
- EU policy putting focus on cross-sectoral approach to action - role including education, employment, justice and housing
- Broader focus: MH promotion, early intervention, treatment, rehabilitation

Ten proposals for community MH

1. Set specific targets to increase treated PWMD over set time periods
2. Recognize the lower life expectancy of PWMD and reduce this health disparity
3. Evidence-based interventions to reduce stigma
4. Accessible and acceptable MH care to services users & families
5. Balance of hospital and community care
6. Invest only in treatments known to be effective
7. Evaluate & improve shared decision making
8. Integrated systems of MH care
9. Dedicated recovery programs
10. Developments to improve mental health

Thornicroft et al 2016

Eastern Europe

- Building capacity and leadership
- Collaborative efforts to plan and monitor
- Implementation of MH policies, plans and legislation
- Empowering service users
- Proper resources for redirection of services from hospitals to community
- Strengthening human rights approach
- International collaborations – young psychiatrists

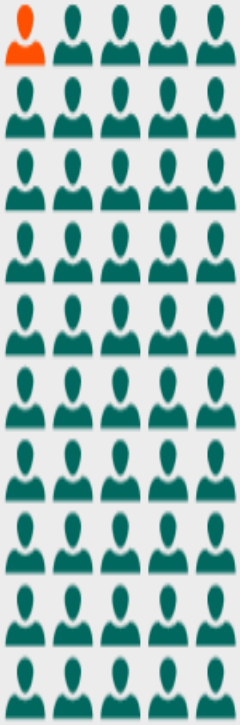
Krupchanka & Winkler BJP-International 2016

3/4

of people with mental health problems live in low- and middle-income countries

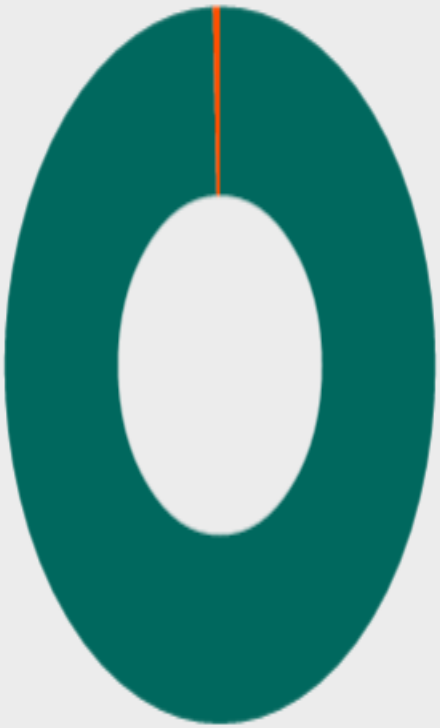
<1 in 50

people with severe mental disorders in low-income countries receive evidence-based treatment



<1%

of low-income countries' annual health budgets is allocated to mental health



Global MH: The Call for Action

- Movement to scale up the coverage of countries

- Based on two principles:

  - an evidence-based package of services for mental disorders and
  - strengthening the protection of the human rights of persons with mental disorders and their families

MH in Sustainable Development Goals (SDGs)

- To promote physical & MH & well-being, & to extend life expectancy for all, we must achieve universal health coverage & access to quality health care (Paragraph 7)

- Commitment to prevention & treatment of non-communicable diseases, including behavioural, developmental and neurological disorders, which constitute a major challenge for sustainable development (Paragraph 26)

Current Views

MH in high – income countries I

Increasing concern in resource – rich countries about efficacy, efficiency & acceptability of MH services

Sashidharan et al 2016

MH in high – income countries II

- Task-sharing: delegating tasks to existing or new workers with less training from local human resources

- Development approach : Basic Needs model – Emphasis on

user empowerment

community development

strengthening health systems

influencing policy

MH in high – income countries III

Evidence suggests that community-based models that integrate health care and social interventions can have a positive impact on clinical outcomes and social and economic functioning

A global commission on MH institutions II

- Examples of mental hospitals that have been transformed into institutions of excellence and repute
- Close the "knowledge and transformation gap"
- Through a combination of internal changes & the development of integrated community services, in collaboration with service users and local partners from multiple sectors

A global commission on MH institutions III

- To develop a working definition of "MH institution"
- Map MH institutions in Europe, Asia, the Americas and Africa
- Document and understand the determinants of poor conditions in mental institutions
- Identify the determinants of long-term stay in such institutions
- Compile a comprehensive report on successful strategies for bringing about institutional changes

The social and political level

- Community MH care was an aspiration in "well ordered societies"
- The spread of globalisation
- A framework of neoliberal economics
- Increasing social inequalities
- Increasing numbers of immigrants and refugees
- Uneven financing systems
- Disinvestment in 'social' care
- A context of constant change

From theory to practice

- It has been helpful to have a clear, central policy to drive through local changes
- Community-based services are '*systems* ' they comprise many different elements - housing, vocational, treatment, community support, public, private, formal, informal – balancing and integrating these different contributions is not easy
- Increased 'user involvement' is easy to say, but difficult to achieve – especially at the level of individual care
- Changed services don't necessarily mean better 'quality of experience' as experienced from a user perspective
- Change needs money - but most developments have come from 'remodelling' existing services

Towards a new concept

Meta - Community MH Care: Towards a new concept I

- Capitalises on the successes of community MH care but equally acknowledges the limitations
- The wide range of complexities in the implementation of community care plans
- Reflects into gained experience over time
- Wider understanding and acceptance by society of mental ill health and the damaging consequences of prejudice, discrimination and neglect

Bouras et al in press

In conclusion

Outcomes

- Most important innovations in 1950s-1970s
- There is more evidence-based knowledge now on effectiveness
- New generation of medications have fewer side effects, better tolerated, but modest effectiveness
- Promises of biological advances of treatments e.g. gene technology, neuro-imaging
- More expectations on psychological and psychosocial treatments including prevention
- Integrated treatment models balancing biological, psychological and psychosocial treatments

Overall lessons …

- For improvements to last, service changes need to take time, often developed over years and decades
- After the initiation stage of change, often led by charismatic individuals, need a consolidation phase
- Listen to users' and to family members' experiences and perspectives
- Do not allow services changes to be used as an occasion for budget cuts
- Consolidate service changes with alterations to training curricula, mental health laws and financial structures

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Thank you

The changing context for MH services III

Challenges: the risk or re-institutionalization

- Supported housing places up by 40%
- Prison population up by 57% (high proportion MH problems)
- Forensic beds up by 38%

Priebe (2007)

Impact on physical health

- Growing recognition of increased risk of co-morbid physical health problems
- Substantial costs within health care system of managing co-morbid conditions

Discrimination and the stigma of mental illness

- "Ghettoisation", urban decay, poor housing
- Attitudes changeable over time
- Major obstacle for better QOL
- Media representations of people with mental illness
- Anti-stigma Campaigns
- "Open the Doors", WHO programme

Some issues of Global MH

- Diversity across countries and communities
- Innovations
- Global exchange of information, evidence & knowledge
- Psychological interventions
- Human rights related to MH

Saxena 2016

MH is included within Goal 3 of SDGs in three targets

- By 2030, reduce by 1/3 premature mortality from non-communicable diseases through prevention & treatment & promote mental health & well-being (Target 3.4)
- Strengthen the prevention and treatment of substance abuse, narcotic drug abuse & harmful use of alcohol (Target 3.5)
- Achieve universal health coverage, financial risk protection, access to quality essential health-care services & access to safe, effective, quality & affordable essential medicines & vaccines for all (Target 3.8)

A global commission on MH institutions I

- To establish: a global commission on MH institutions comprised of MH professionals, social scientists, representatives of advocacy groups, and legal experts

Cohen et al 2016

Unfulfilled expectations of community MH care

- Expectations of full social integration not fulfilled
- Secluded in sheltered environments with limited social contacts
- Little or no prospect of work
- Not effective reduction of hospitalisation
- Significant number of people with psychosis have complications of substance abuse, mild ID or Asperger's syndrome and physical health problems
- This small group of "low volume, high cost" absorbs as much as 50% of budgets
- Increasing prison population with MH problems

Meta - Community MH Care: Towards a new concept II

- Embraces pluralism & helps to overcome biological, social or psychological reductionisms
- More finely tuned to the realities & needs of the current era of care
- Relevant to all settings where patients may be found across different setting
- Audit, quality assurance and routine outcomes - data collection will be crucial to success
- Can act as a catalyst of a more realistic approach to MH care to influence policy across countries with advanced community mental health programmes as well as those introducing implementation plans of MH reforms