Improving Mental Health Care

THE GLOBAL CHALLENGE

EDITED BY

Graham Thornicroft,
Mirella Ruggeri and
David Goldberg

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Dedication

This book is appearing at the time Michele Tansella is due to retire. His colleagues both in Italy and elsewhere have marked the occasion by considering the enormous contribution he has made to mental health services in community settings. He has made the services in South Verona known to mental health professionals across the world and has been immensely influential in influencing the development of community care internationally.

The volume that has resulted has aimed to provide clear guidance on how mental health services can be provided in both high- and low-income countries, bearing in mind both the manpower and resource available in each. It is still sadly the case that most beds for patients with mental disorders are situated in mental hospitals in low-income countries: this book describes the way in which services can progress beyond this, so that community-based services can be developed. The book describes these developments and emphasises the important part that primary care services must provide in all countries, regardless of their income, in providing mental health services that are truly comprehensive.

New services need new research methods and new planning decisions. These topics are fully covered and there are also two chapters (Chapters 3 and 24) on the good and bad points in community services that have developed in high-income countries. New services need to take account of conditions that exist in

any particular country, but wherever they are developed services need to be readily accessible and provided in environments which are non-institutional.

Michele Tansella arrived in Verona from the Istituto Mario Negri in Milano in 1969, then soon left to spend six months at the Institute of Psychiatry in London. At that time, he had little to learn about community mental health services at the Maudsley Hospital but a great deal to learn about epidemiology and the systematic collection and analysis of data. He also widened his circle of professional colleagues and has brought many of the authors of the present chapters to visit the Verona service and publish comparative studies. During an earlier visit to the Institute, he met his wife Christa, who has assisted him at every stage in building up a united and happy Department, publishing many joint papers [1, 2]. Michele returned to Verona in early 1970 and collaborated with the team charged with the responsibility of setting up new mental health services in South Verona.

Michele quickly made his mark, insisting from the start on the meticulous collection of data about every aspect of the developing service [3]. In those early years, he advocated the changes introduced to Italian psychiatry by Law 180 which eventually prevented new admissions to mental hospitals, in favour of services offered in less formal community settings [4, 5]. The first formal description of the South Verona service in a high-impact journal was published in 1985 [6], followed by the first description of the all-important case register [7] dealing with the epidemiology of schizophrenia in a community setting. Since that time, he has published many informative accounts of the local services [8].

Over the next few years Michele trained many future Italian academic psychiatrists, building up a formidable team of psychiatric researchers. Since these early years, he has published 286 papers in international peer-reviewed journals, as well as numerous books and chapters. A most important development was his book with Graham Thornicroft called *The Mental Health Matrix*, which sets out a detailed plan for providing mental health services to a community. The book was translated into four languages [9] and more recently brought up to date [10] in *Better Mental Health Care* (now translated into eight languages).

Since 1992, Michele has edited *Epidemiologia e Psichiatria Sociale* (now retitled *Epidemiology and Psychiatric Sciences*), which has been important in providing Italian psychiatrists with a forum for exchanging views and data. The journal has continuously increased its international reputation; in 2011, it was ranked 22nd of the 117 Journals quoted by the *Journal Citation Reports* within the category 'Psychiatry'. Since 1997, Michele has edited *Social Psychiatry and Psychiatric Epidemiology* and is a member of the board of several international journals. Between 2006 and September 2012, he served two consecutive terms as Dean of the University of Verona's medical school.

Under Michele's leadership, Verona was designated by the World Health Organization as "Collaborating Centre for Research and Training in Mental Health" on February 1987, confirmed in 2001, 2005, 2009 and still active. By

2005, his team of 23 tenured staff had produced 2000 citations in high-impact journals, and this figure climbed to 12 400 in 2011. In that year, there were 58 papers published by the team, including high-impact journals such as *Lancet*, *BMJ*, *American Journal of Psychiatry* and *Biological Psychiatry*.

These bare facts give little impression of the man. Michele is warm, witty and excellent company. He is fiercely proud of what has been achieved in South Verona and has been a major influence on the development of services for people with mental illness across the world.

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SECTION 1
The global challenge

CHAPTER 1

The nature and scale of the global mental health challenge

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Introduction

In the last 20 years, there has been an unprecedented surge of research aimed at identifying improvements in psychiatric treatments and mental health care. This builds upon the earlier foundation of psychiatric epidemiology, which considers the occurrence and distribution of mental disorders across time and place. Yet, increasingly this work has evolved from describing these realities to going even further to understand which interventions deliver real advances in care. However, until relatively recently almost all such studies took place in high-income (HI) countries, even though most of the world's population live in low- and middle-income countries (LAMICs).

The nature of the challenge

The definition of 'Global mental health' appeared for the first time in an Editorial by Eugene Brody published in 1982 on the *American Journal of Psychiatry* [1]. However, the roots of this discipline can be found much earlier, in the field of cross-cultural epidemiology of severe mental disorders. Originally, these studies had the aim of determining the relevance of a biomedical perspective and, later on, to compare psychopathology in different contexts, as a basis for classification and clinical decision-making. This research effort found that mental disorders affect people in all cultures and societies. Since then, a growing body of cross-national research has shown that neuropsychiatric disorders constitute 13% of the world health burden, and demonstrated their substantial impact on disability, on direct and indirect societal costs [2] and the strong association of mental disorders with both societal disadvantage and physical health problems [3].

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A clear-cut discrepancy in both the resources and treatments availability for mental health between HI countries and LAMICs emerged, with resource allocation for mental health disproportionately low in the latter. This *resource–needs gap* [4, 5] goes in parallel with a *mental health treatment gap*: of all adults affected by mental illnesses, the proportion who are treated is around 30.5% in the United States and 27% across Europe, while more than 90% of individuals with serious mental illness in less-developed countries do not receive treatment for those problems [6, 7]. This stands as disconcerting evidence of a major failure in global health delivery [8–10].

To propose a framework to address the treatment gap, Thornicroft and Tansella have extended their balanced care model (BCM), originally aimed at mental health service planning based on a pragmatic balance of hospital and community care [11], to refer also to a balance between all of the service components that are present in any system, whether this is in a low-, medium- or high-resource setting, and identified three sequential steps relevant to different resource settings [12].

According to this model, in low-resource settings, the crucial resource allocation decisions will be how to balance any investment in primary and community care sites against expenditure in psychiatric hospitals. Following the *World Health Report 2001* recommendations [13], in these countries, an optimal balance between resources and response to population needs can be given by promoting mental health service delivery within the primary care system. Different forms of collaboration between psychiatric and primary care setting should be pursued, stemming from the less to the most expensive and elaborate ones. In rural areas in many low-income countries, the nearest mental health service may be very far away, and it is necessary for the primary care service to take the lead in providing basic mental health care. In places where it is practicable to refer some patients to the mental health service, then some form of stepped care should be adopted (see Chapter 7). The provision of mental health training to primary care staff is therefore of the greatest importance. Several studies have shown that these kind of mental health services based in primary care are less stigmatising, more accessible, efficacious and cost-effective [10, 14–17].

In medium-resource settings, the BCM approach proposes that services are provided in all of the five main categories of care: outpatient clinics, community mental health teams, acute inpatient services, community residential care and work/occupation.

In high-resource settings, these complex choices apply to an even greater extent, as there are even more specialized mental health teams and agencies present, resulting in a greater number of possibilities for resource investment to achieve a more balanced mix of services, as long as there is a strong emphasis upon primary health care, and attention is paid to the training needs of primary care staff. In these countries, primary care should be the priority setting especially for patients with a combination of anxious, depressive and somatic symptoms, while major disorders could benefit from more specialised and dedicated interventions [18].