Community mental health care worldwide: current status and further developments

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This paper aims to give an overview of the key issues facing those who are in a position to influence the planning and provision of mental health systems, and who need to address questions of which staff, services and sectors to invest in, and for which patients. The paper considers in turn: a) definitions of community mental health care; b) a conceptual framework to use when evaluating the need for hospital and community mental health care; c) the potential for wider platforms, outside the health service, for mental health improvement, including schools and the workplace; d) data on how far community mental health services have been developed across different regions of the world; e) the need to develop in more detail models of community mental health services for low- and middle-income countries which are directly based upon evidence for those countries; f) how to incorporate mental health practice within integrated models to identify and treat people with comorbid long-term conditions; g) possible adverse effects of deinstitutionalization. We then present a series of ten recommendations for the future strengthening of health systems to support and treat people with mental illness.

Key words: Community mental health care, mental health services, low- and middle-income countries, evidence-based interventions, schools, workplace, chronic care model, deinstitutionalization

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Most people in the world who have mental illnesses receive no treatment[1,2]. This "treatment gap" is increasingly appreciated worldwide[3-6]. The World Health Organization (WHO) published in 2010 the first edition of its Mental Health Gap Action Programme (mhGAP) Implementation Guide[7-9], which contains case finding and treatment guidelines for nine categories of mental and neurological disorders that have a major global public health impact.

This evidence-based approach is now being put into practice in over 90 countries worldwide. But what pattern of services and what systems of care best support the provision of the quality and quantity of treatment and care required for people with mental illnesses in the different scenarios (not only high- vs. low- and middle-income countries, but also high- vs. low-resource areas within countries)? That question is addressed in this paper, which focuses on the current status and new developments of community mental health care worldwide.

DEFINING COMMUNITY MENTAL HEALTH CARE

Our definition of community mental health care highlights several fundamental issues.

First, community mental health care encompasses: a) a population approach, b) viewing patients in a socio-economic context, c) individual as well as population-based prevention, d) a systemic view of service provision, e) open access to services, f) team-based services, g) a long-term, longitudinal, life-course perspective, and h) cost-effectiveness in population terms[10]. It also includes a commitment to social justice by addressing the needs of traditionally underserved populations, such as ethnic minorities, homeless persons, children and adolescents, and immigrants, and to provision of services where those in need are located and in a fashion that is acceptable as well as accessible[11].

Second, community mental health care focuses not only upon people's deficits and disabilities (an illness perspective), but also upon their strengths, capacities and aspirations (a recovery perspective). Services and supports thus aim to enhance a person's ability to develop a positive identity, to frame the illness experience, to self-manage the illness, and to pursue personally valued social roles[12].

Third, community mental health care includes the community in a broadly defined sense. As a corollary of the second point, it emphasizes not just the reduction or management of environmental adversity, but also the strengths of the families, social networks, communities and organizations that surround people who experience mental illnesses[13].

Fourth, community mental health care melds evidence-based medicine and practical ethics. A scientific approach to services prioritizes using the best available data on the effectiveness of interventions. At the same time, people who experience mental illnesses have the right to understand their illnesses (to the extent that professionals understand them), to consider the available options for interventions and whatever information is available on their effectiveness and side effects, and to have their preferences included in a process of shared decision making[14,15].

Thus, we define community mental health care as comprising the principles and practices needed to promote mental health for a local population by: a) addressing population needs in ways that are accessible and acceptable; b) building on the goals and strengths of people who experience mental illnesses; c) promoting a wide network of supports, services and resources of adequate capacity; and d) emphasizing services that are both evidence-based and recovery-oriented[16].

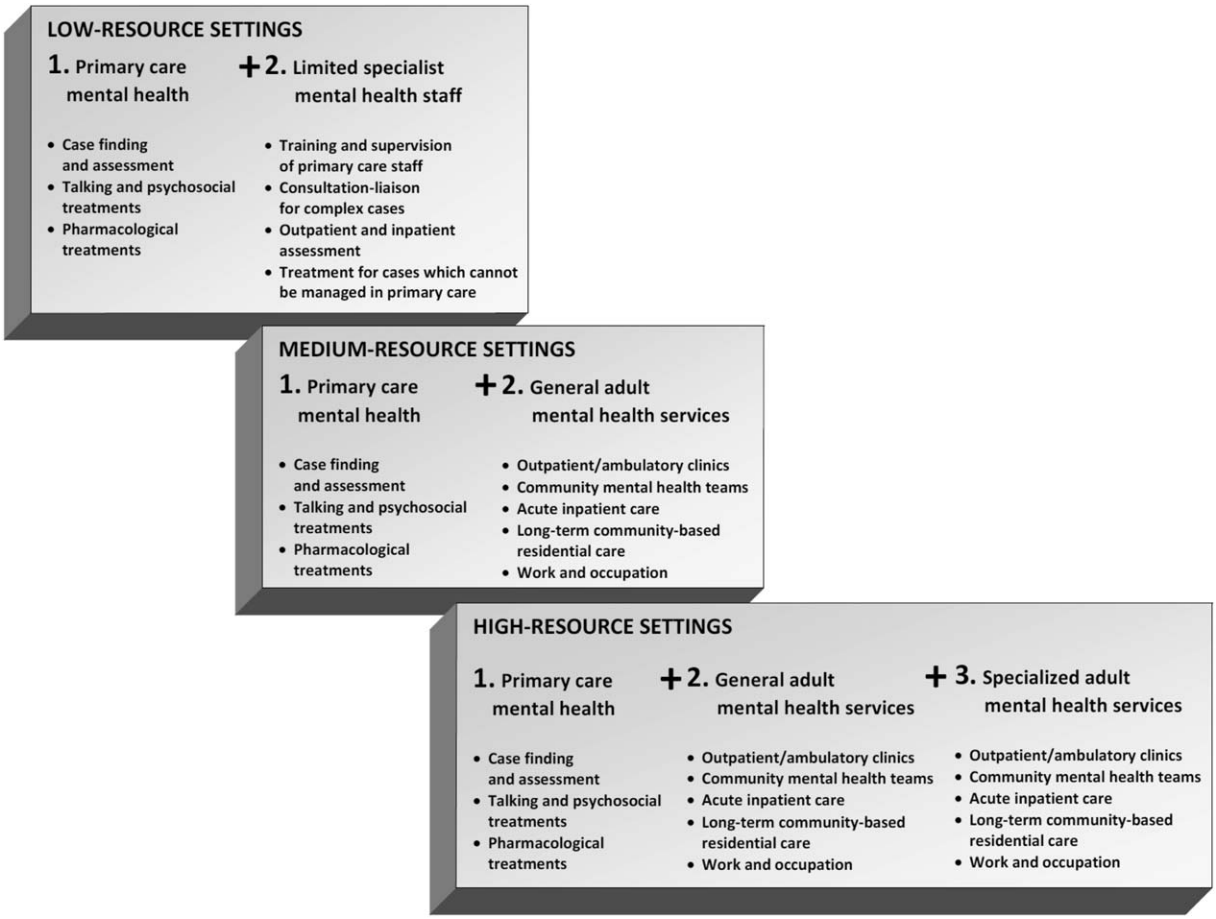

Figure 1 Balanced care model in relation to high-, middle- and low-income countries

A CONCEPTUAL FRAMEWORK FOR COMMUNITY MENTAL HEALTH CARE

The available evidence[17-20] suggests that a model of care including solely hospital based provision (usually inpatient and outpatient care) will be insufficient to provide access for people facing barriers to care, and to offer continuity of follow-up for those with longer-term disability. At the same time, there is not strong evidence that community-based services alone can offer the brief spells of intense treatment sometimes needed during mental health crises. The balanced care model has been formulated as a conceptual framework for providing both hospital and community based services[18].

Yet, it is clear that high-income countries have about 200 times more financial resources for their mental health services than do low-income countries[21]. Many low-income countries in sub-Saharan Africa, for example, have only about one psychiatrist for every million people (Chad, Eritrea and Liberia each have only one psychiatrist in the entire country), compared with 137 per million in the US[22]. So, a single global model of care simply cannot apply. The balanced care model, therefore, applies somewhat differently to countries which are classified by the World Bank Group[23] as high-, middle- or low-income countries (see Figure 1) and, if utilized, needs to be carefully considered for minor or major adaptation in any particular site or country.

The balanced care model suggests that, in low-income countries or sites, most of the available mental health provision should be invested in staff for primary health care and community settings[24]. The roles of these staff include case finding and assessment, brief talking and psychosocial treatments, and pharmacological treatments[25,26]. The very limited numbers of specialist mental health care staff (usually in the capital city and sometimes also in regional centers) are only able to provide training and supervision of primary care staff, consultation-liaison for complex cases, and outpatient and inpatient assessment and treatment for cases which cannot be managed in primary care[27,28].

In middle-income settings, the balanced care model indicates including as investment priorities, in addition to a continuing emphasis upon primary care, five key elements of general adult mental health services: a) outpatient/ambulatory clinics[29]; b) community mental health teams[30-33]; c) acute inpatient care, even though there continues to be relatively

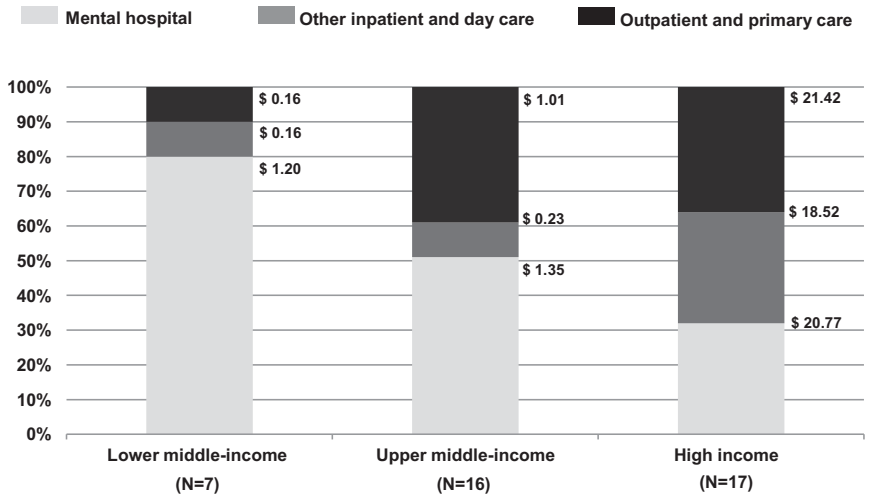

Figure 2 Global distribution of mental health expenditure per capita, by health setting (data from the WHO Atlas[21])

weak evidence about several aspects of inpatient care or highly supported alternative settings[34-38]; d) long-term community-based residential care, with an appropriate range of support[16]; and e) options for work and occupation[39].

In high-income settings, in addition to primary care services and to the provision of general adult mental health services, the balanced care model implies that a series of specialized services should be provided, as resources allow (see Figure 1). These services will need to be provided in the same five categories as set out for middle-income countries.

COMMUNITY SERVICES PROVIDED ACROSS WIDER PLATFORMS OF CARE

Some interventions intended to improve mental health may be better provided from outside health services. The recent edition of the Disease Control Priorities Manual (DSP-3) sets out the arguments for this case[40]. The bases for these wider types of intervention are sometimes called "platforms", and two are particularly relevant here: population-level and community-level platforms. Examples of the former include legislation, regulations, and public information campaigns, and examples of the latter include schools, workplaces, and neighborhoods/community groups[41,42]. A recent review[42], based upon the best available evidence from low- and middle-income settings, has shown which such interventions are most cost-effective.

At the population level, interventions which are evidence based include: laws and regulations to reduce demand for alcohol use (enforcement of blood alcohol limits for drivers, alcohol taxation, advertising bans, minimum drinking age[43,44]); laws and regulations to restrict access to means of self-harm/suicide[45]; child protection laws[46]; laws promoting conditional cash transfers in order to alleviate poverty[47]; and mass public awareness campaigns[48-51].

At the community level, interventions of known effectiveness include: integrating mental health promotion strategies (e.g., stress reduction and awareness of alcohol and drug misuse) into occupational health and safety policies[52]; universal and targeted socio-emotional learning school programs for vulnerable children[50,53]; mental health awareness school programs[54,55]; methods for the identification and case detection of children with mental disorders in schools[56]; early child enrichment/preschool educational programs[57]; parenting programs for children aged 2-14 years[58]; gender equity and/or economic empowerment programs for vulnerable groups[59]; and training of gatekeepers (including community health workers, police and social workers) in identification of young people with mental disorders, including self-harm[60].

THE EXTENT OF COMMUNITY MENTAL HEALTH SERVICE DEVELOPMENT

There is a vast variability worldwide in the development of community mental health services[61]. The most comprehensive global source of information in this respect is the WHO World Mental Health Atlas[21], which summarizes the key characteristics of national mental health systems across the world, and is periodically updated. The most recent edition (2014) includes data from 171 of the 194 member states of the United Nations.

Figure 2 shows the proportional expenditure for mental hospital, other inpatient and day care, and outpatient and primary care services, across lower middle-income, upper middle-income and high-income countries. This clearly illustrates the very large differences in absolute spending, and also the differing relative expenditure across the three service categories, reinforcing the point that relatively little of the small mental health budgets in low- and middle-income countries is spent outside inpatient care[21].

Several important trends emerge from the WHO Atlas. Compared with the results from the 2011 survey, globally, there was a slight decrease (5%) in the number of mental hospitals, and a larger reduction in the number of mental hospital beds, which fell by nearly 30%, with a more substantial decrease (45%) in the Region of the Americas. At the same time, there was an increase of over 20% in the rate of admissions to mental hospitals, indicating an increasing bed turnover rate and decreasing average length of stay[21].

At the global level, the number of beds available in psychiatric wards in general hospitals increased by 60% between 2011 and 2014. In the Western Pacific Region, in particular, psychiatric beds in general hospitals increased more than 8-fold since 2011.

The WHO Atlas does not contain data allowing conclusions on whether reducing number of beds in psychiatric hospitals is associated with greater expenditure on community services.

DEVELOPING COMMUNITY MENTAL HEALTH MODELS IN LOW- AND MIDDLE-INCOME COUNTRIES

The work of the WPA Task Force on the Steps, Obstacles and Mistakes to Avoid in the Implementation of Community Mental Health Care reveals more detailed patterns in the development of community mental health services in recent years[11,62]. This work combined a review of the relevant literature with detailed consultation processes in many regions of the world to identify challenges and solutions in implementing community based models of mental health care. A series of regional papers describe the findings in detail[63-68]. Table 1 summarizes the main challenges which were identified and gives examples of approaches through which progress has sometimes been made.

The continuing lack of trained mental health practitioners is a substantial issue that affects most countries of the world[21]. In response to this, alternative approaches have been implemented which allocate duties previously reserved for psychiatrists or psychiatric nurses to non-specialized staff. This redistribution of clinical tasks is usually referred to as task shifting or task sharing[69], and has been applied to a range of health conditions, including HIV/AIDS[70], epilepsy[71], surgery[72], hypertension and diabetes[73].

There is now emerging evidence that this approach can be a cost-effective method to provide treatment and care for people with depression[74-76], psychosis[77,78], and perinatal psychiatric disorders[79]. One part of this new approach is to provide training using clear and relevant guidance that staff can apply directly in the clinical situation, such as the WHO mhGAP Intervention Guide[7]. But training alone is insufficient, and it is increasingly clear that ongoing supervision is likely to be necessary to support staff to begin to apply the guidelines, and to gain and maintain clinical competence[80]. The costs of such supervision, therefore, need to be included in the core resources necessary to make community care sustainable[78].

The new cadre of staff includes front-line health care workers, such as community health workers, and posts between the traditional roles of nurse and doctor, such as the clinical officer or medical officer[81-84]. Such staff are often recruited from the local area, and will have rich understanding of the sociocultural context[82-84].

This reconceptualization of the role of the psychiatrist requires first of all a new training curriculum, one that emphasizes the public health need for psychiatrists to work both directly in secondary and tertiary services, and to act as *multipliers* by potentiating the capacity of primary care staff to detect and treat people with mental illness[4,85,86]. It has been suggested[87] that in high-income countries this capacity (in particular in the treatment of people with major depressive disorder) may well be enhanced by changes in the organization and function of health care teams, such as those already being used to improve outcomes in other chronic diseases. Responsibility for active follow-up should be given to a case manager (for example, a practice nurse); adherence to treatment and patient outcomes should be regularly monitored; treatment plans should be frequently adjusted when patients do not improve; and the case manager and primary care physician should have the possibility to consult and refer to a psychiatrist when necessary.

Flexible and accessible working relationships between the primary care doctor, the case manager and a mental health specialist are considered essential to allow most patients with mental disorders to access more effective treatment in primary care, as well as the minority needing ongoing specialist care to be identified and referred. The adaptation of the ideas behind this model to low- and middle-income countries is still to be investigated.

INTEGRATING CARE FOR PEOPLE WITH COMORBID LONG-TERM CONDITIONS

It is becoming increasingly recognized that chronic physical and mental conditions are often comorbid. For example, among patients with diabetes, hypertension, tuberculosis and HIV/AIDS, the rates of anxiety and depression are at least double those of the general population[88]. The common co-occurrence of these diseases in one person can interfere with the treatment regimen for a particular condition; for example, adherence to treatment for tuberculosis or antiretroviral therapy for HIV/AIDS is significantly undermined by the presence of untreated depression among these patients[89,90].

At the same time, in many low- and middle-income countries, primary care staff are trained to identify and treat physical but not mental conditions. The growing evidence of how commonly such comorbidities occur, and the inadequate health care system response to them, clearly indicates the need for structural change in how care is provided.

Within the context of increasingly strong calls to address the social determinants of health[91] and to move towards universal health coverage, few countries will be able to respond

Table 1 Obstacles, challenges, lessons learned and solutions in implementing community-oriented mental health care

Obstacles and challenges		Examples of lessons learned and solutions
Society	Disregard for, or violation of, human rights of people with mental illness	• Oversight by: civil society and service user groups, government inspectorates, international non-governmental organizations (NGOs), professional associations
	Stigma and discrimination, reflected in negative attitudes of health staff	• Encourage consumer and family and carer involvement in policy making, medical training, service provision (e.g., board member, consumer provider), service evaluation (consumer satisfaction survey)
	Need to address different models of abnormal behavior	• Traditional and faith-based paradigms need to be amalgamated, blended, or aligned as much as possible with medical paradigms
Government	Low priority given by government to mental health	• Government task force on mental illness • Establish cross-party political support for the national policy and implementation • Effective advocacy on mental health gap, global burden of disease, impact of mental health conditions, cost-effectiveness of interventions
	Absence or inappropriate mental health policy	• Advocate for and formulate policy based upon widespread consultation with the full range of stakeholder groups
	Old or inappropriate mental health legislation	• Create powerful lobby and rationale for mental health law
	Inadequate financial resources in relation to population level needs	• Recruit key political and governance champions to advocate for adequate funding of initiatives
	Lack of alignment between payment methods, services and outcomes	• Provide small financial incentives for valued outcomes • Create categories of reimbursement consistent with system strategy
	Need to address infrastructure	• Government to plan and finance efficient use of buildings, essential supplies and electronic information systems
	Need to address structure of community-oriented service system	• Design the mental health system from local primary care to regional care to central specialty care and fill in gaps with new resources as funding grows
	Inadequate human resources for delivery of mental health care	• Task sharing to non-traditional staff cadres such as community health workers and health extension workers
	Brain drain and failure to retain staff	• United Nations agencies/international NGOs to optimize sustainability of their projects
	Non-sustainable, parallel programs by international NGOs	• Close relations with ministries and other stakeholders and international NGOs • Mental health plan in place so NGOs can help achieve these goals sustainably
Organization of health system	Need to design, monitor, and adjust organization of mental health system	• Set implementation plan with clear coordination between services • Prioritization of target groups, especially people with severe mental illness
	Lack of a feasible mental health program or non-implementation of mental health program	• Make program highly practical by identifying resources available, tasks to be completed, allocation of responsibilities, timescales, reporting and accountability arrangements, progress monitoring/evaluation systems
	Need to specify developmental phases	• Planners and professional leaders to design five- and ten-year plans
	Poor utilization of existing mental health facilities	• Improve awareness of benefits of facilities and services • Inbuilt monitoring quality of care, especially process and outcome phases
	Need to include non-medical services	• Include families, faith-based social services, NGOs, housing services, vocational services, peer-support services, and self-help services. All stakeholders involved in designing system
	Lack of multi-sectoral collaboration, e.g. including traditional healers, housing, criminal justice, or education sectors	• Development of clear policy/implementation plan by all stakeholders • Collaborate with other local service to identify and help people with mental illness • Familiarization sessions between practitioners in the Western and local traditions
	Poor availability of psychotropic medication	• Drug revolving funds, public-private partnerships

Table 1 Obstacles, challenges, lessons learned and solutions in implementing community-oriented mental health care *(continued)*

Obstacles and challenges		Examples of lessons learned and solutions
Professionals and practitioners	Need for leadership	• Psychiatrists and other professionals need to be involved as experts in planning, education, research, and overcoming inertia and resistance in the current environment
	Difficulty sustaining in-service training/adequate supervision	• Training of the trainers by staff from other regions or countries • Shifting of some psychiatric functions to trained and available practitioners
	High staff turnover and burnout, or low staff morale	• Emphasize career-long continuing training programs • Training of supervisors
	Poor quality of care/concern about staff skills	• Ongoing training and supervision • Encourage and reward quality by awards and similar processes
	Professional resistance, e.g. to community-oriented care and service user involvement	• Government and professional societies promote the importance of community-oriented care and service user involvement • Develop training in recovery-oriented psychosocial rehabilitation as part of training of new psychiatrists, including at medical schools in low- and middle-income countries
	Dearth of relevant research to inform cost-effective services and lack of data on mental health service evaluation	• More funding on research, for both qualitative and quantitative evidence of successfully implemented examples of community-oriented care
	Failure to address disparities (e.g., by ethnic, economic groups)	• All key stakeholders involved; advocacy for under-represented groups to develop policies and implementation plans
Users, families, and other advocates	Need for advocacy	• Users and other advocates may be involved in all aspects of social change, planning, lobbying the government, monitoring the development and functioning of the service system, and improving the service system
	Need for self-help and peer support services	• Users to lead these movements
	Need for shared decision making	• Users and other advocates must demand at all levels that the system shift to value the goals of users and families and that shared decision making become the norm

effectively to the future health and economic burden that mental disorders and other chronic diseases will pose simply by pursuing "business as usual" approaches. Rather, health systems need new approaches that are capable of mounting an effective, integrated and efficient response to the prevention and management of mental disorders and other chronic conditions.

In order to progressively reform or transform health systems so that they are better equipped to deal with the kinds of health problems that increasingly dominate the demands put upon them, an integrated model of chronic disease prevention and management is called for. Such an approach has already been articulated in the form of the "chronic care model", which was initially developed by US health service researchers and practitioners[92,93], and subsequently adapted to the international level by the WHO in its Innovative Care for Chronic Conditions Framework (ICCCF)[94].

This framework sets out critical principles and requirements for coordinated care, i.e., that it should be community-based, person-centered, and system-oriented. It has been shown to be effective in improving patient outcomes and patient satisfaction across a range of chronic conditions in high-income settings[95,96]. Yet, few examples to date have shown its successful implementation in low- and middle-income countries. We do have ongoing and completed examples of certain elements in India, Ethiopia and especially South Africa, where we can find perhaps the most ambitious effort to date to reform or "re-engineer" the entire health system towards chronic care[97-99].

The chronic care model codifies a number of systemic changes associated with quality improvements in chronic illness care, including: support of service users to manage themselves ("self-management support"); support of clinical decision making through guidelines; clear delineation of clinical roles and responsibilities; improved clinical information systems and service coordination; and collaboration with community groups[93]. The successful outcomes achieved by this model with hypertension and diabetes have led mental health service researchers and practitioners to apply it to mental disorders such as depression and anxiety, and evidence is growing of the effectiveness of the ICCCF approach[88,95,96,100-106].

One advantage of such an integrated care approach, to be empirically tested in future, is that it may be more effective in providing physical health care to people with severe mental illness, and so diminish the high levels of premature mortality in the latter group, which may lead to 20-30 years less life expectancy[107-110].

POSSIBLE ADVERSE EFFECTS OF DEINSTITUTIONALIZATION

Deinstitutionalization has taken place for over half a century in many high-income countries worldwide[111]. Although supported by both the WHO[112] and the WPA[11], this process has been subjected to a number of criticisms. Commentators have claimed a series of adverse effects, in particular high numbers of mentally ill people who are in prison, are homeless or are neglected. There has even been a recent call to "bring back the asylum"[113]. This contention has been advanced particularly where there have been concerns that reduced bed numbers, for example from hospital "downsizing" or closures, have not been accompanied by commensurate increases in the numbers of appropriately supported residential places in the community[114,115].

These objections to community care have been examined in a recent study which reviewed the consequences of reducing the number of beds for long-term psychiatric patients[116]. The authors of this review focused upon cohort studies of people with severe mental disorders who were discharged from psychiatric hospitals following an admission of one year or longer, and in whom data were analyzed at the individual level. They concluded that, contrary to the results of ecological studies, instances of homelessness, incarceration or suicide among those discharged were rare.

Indeed, where bed reduction is done responsibly, it has been shown that the overall costs of community-based care are similar to those of hospital-based services for long-term patients, while the quality of life and satisfaction among individuals receiving residential care in the community are higher compared to those in hospital[117-119]. On the other hand, where hospital closures are intended to be primarily cost-cutting exercises, without proper replacement by services in the community, then it is clear that the quantity and quality of care will suffer and may well lead to adverse outcomes for the people concerned, including the risk for "transinstitutionalization"[120,121].

IMPLICATIONS OF THE EVIDENCE BASE FOR DEVELOPING COMMUNITY MENTAL HEALTH CARE

The foregoing discussion raises profound questions about why treatment and care for people with established mental illnesses, as well as evidence-based methods to prevent mental illness, have remained a low investment priority for governments in most countries worldwide, indeed a level of disregard that has been described as structural or systemic discrimination[122,123]. What has been learned since the mid-20th century, when deinstitutionalization first gained momentum in some high-income countries? We frame this closing section of our paper in terms of a series of recommendations, based upon the lessons learned.

We consider the greatest challenge in mental health care to be the degree of disregard shown to the fact that the large majority of people with mental illness worldwide receive no treatment[124]. To scale up services to the quantum required necessarily means providing most services not in specialist care settings, but in primary, community health care services, and in population-level and community-level platforms as discussed above.

Proposal 1. Central and regional governments should measure the treated percentage of people with mental illness (coverage) and set specific targets to increase coverage over set time periods.

It is unacceptable that governments continue to allow people with all types of mental illness to die about 10 years before others in their communities[125], and people with severe mental illness to die 15-30 years earlier, in countries at all resource levels[107,109,110,126,127]. Taking this issue seriously means reducing cardiovascular and pulmonary as well as suicide risk factors, again tasks that are more feasible in primary and community care settings.

Proposal 2. Health care services need to recognize the far lower life expectancy among people with mental disorders, and develop and evaluate new methods to reduce this health disparity.

It is clear that stigma and discrimination act as a pervasive influence that affects all levels of planning and implementation of treatments and services related to mental health. Yet, there is now an evidence base that contact-based interventions are effective to reduce stigma[48,128-130]. The implication for community mental health is the need for population-level and community-level platforms to use contact-based interventions to reduce stigma and discrimination.

Proposal 3. Evidence-based interventions need to be provided in the long term at the population and community levels to reduce stigma and discrimination experienced by people with mental illness.

Part of the explanation for the mental health gap is that the services provided are often seen by people with mental illness and their carers as being inaccessible or unacceptable. Indeed, scaling up mental health care means paying attention both to the quantity and to the quality of care available[131,132]. While the question of institutionalization has usually been described within hospital settings, human rights issues also need to be quality assured within community mental health services[133].

Proposal 4. Mental health staff should provide care that service users (and their family members) find accessible and acceptable.

The available evidence shows that a reasonable portfolio of mental health services, for example for a district or for a

Table 2 References to mental health in Sustainable Development Goals (SDGs)[144]

Mental health is included in the Principles of the SDGs (formally called the "Declaration")

- To **promote physical and mental health** and well-being, and to extend life expectancy for all, we must achieve universal health coverage and access to quality health care (Paragraph 7)
- We are committed to the prevention and treatment of non-communicable diseases, **including behavioral, developmental and neurological disorders**, which constitute **a major challenge for sustainable development (**Paragraph 26)

Mental health is included within Goal 3 in three targets

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

region, will need to include provision of both (limited) inpatient care, and a range of outpatient and community services, according to the resources available[17].

Proposal 5. Mental health care should consist of a careful balance of hospital and community care, with most care provided at or near to people's homes.

Value for money in providing treatments to people with mental illness means both investing in evidence-based care, and disinvesting in harmful, ineffective or less-effective interventions. At present, in countries of all resource level, understanding of how to implement good practice is not well developed[134-136].

Proposal 6. Mental health planners, both in times of economic growth and recession, should invest in treatments known to be effective, and disinvest from treatments known to be ineffective or even harmful.

There is a particular need to pay attention to how far people with mental illness control their own treatment and care plans, as in most countries worldwide forms of involuntary or compulsory treatment are commonly practiced. The United Nations Convention on the Rights of Persons with Disability sets out a framework which can be used to improve the respect of human rights of people with mental illness (referred to in this context as person with psychosocial disabilities)[137]. Within both hospital- and community-based services, an important issue is how far patients/consumers actively participate in treatment through joint decision making processes.

Proposal 7. Health care staff and service users should develop and evaluate methods to improve shared decision making.

In several countries, high- and low-income ones, a wide range of health care practitioners from non-Western traditions provide health care related interventions[138], yet there are a number of challenges at present to an integrated approach, namely: a) the pathways to such practitioners for people with mental illnesses have not been documented in a systematic way; b) the methods of assessment and case formulation are rarely described, nor how far Western and non-Western staff cross-refer patients; c) the numbers of people receiving such care (and so their contribution to overall treatment coverage) is unknown; d) the nature of the interventions delivered is sometimes not described; e) the outcomes of care may not have been examined by scientific methods; and so f) the cost-effectiveness of such treatments is frequently unknown.

Indeed, official statements of mental health policy, for example in national mental health plans, rarely even acknowledge the existence of the non-state funded health care providers and sectors. In our view, therefore, a great deal now needs to be done to clarify these issues and to find effective methods to bring non-Western health care staff into a wider and integrated mental health care system[139-141]. More and more detailed work is needed to identify the relative strengths of these various approaches, and how Western and non-Western tradition practitioners can form providers' networks, including cross-referral patterns, for the benefit of patients.

Proposal 8. Health care practitioners (of Western and non-Western traditions) should take practical steps to see each other as partners in an integrated system that increases the total amount of mental health care available, while ensuring that only effective and acceptable treatments are provided.

Many reports from service users and service user advocacy groups highlight that therapeutic pessimism from health care staff, whether hospital or community based, can itself be a factor promoting worse clinical outcome[142]. The social movement related to recovery has identified this feature of mental health staff, in particular, as hindering clinical progress[143].

Proposal 9. Mental health services should develop dedicated programs for recovery: this implies that staff understand an individual's personal recovery goals and fully support their achievement.

Mental health has recently been given a greater relative importance by the United Nations, as it has been clearly referred to within the Sustainable Development Goals (SDGs), and their related targets and indicators[144-148] (see Table 2). In the period until 2030, the development of global mental health will be advanced by embedding mental health initiatives, as far as possible, into wider SDG-related investments, so as to improve mental health both directly and indirectly.

Proposal 10. Developments to improve mental health will be enhanced by: a) increasing mental health care delivery; b) strengthening health systems (particularly providing integrated care for people with long-term conditions); c) investing in platforms to deliver population-level and community-level interventions; and d) embedding evidence-based measures into global SDG-related activities that will promote mental health and prevent mental illness.

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