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ABSTRACT Mental health services in the Eastern Mediterranean Region are predominantly centralized and institutionalized, relying on scarce specialist manpower. This creates a major treatment gap for patients with common and disabling mental disorders and places an unnecessary burden on the individual, their family and society. Six steps for reorganization of mental health services in the Region can be outlined: (1) integrate delivery of interventions for

priority mental disorders into primary health care and existing priority programmes; (2) systematically strengthen the capacity of non-specialized health personnel for providing mental health care; (3) scale up community-based services (community outreach teams for defined catchment, supported residential facilities, supported employment and family support); (4) establish mental health services in general hospitals for outpatient and acute inpatient care; (5) progressively reduce the number of long-stay beds in mental hospitals through restricting new admissions; and (6) provide transitional/bridge funding over a period of time to scale up community-based services and downsize mental institutions in parallel.

Réorganisation des services de santé mentale : des modèles de soins institutionnels aux modèles communautaires

RÉSUMÉ Les services de santé mentale dans la Région de la Méditerranée orientale sont essentiellement centralisés et institutionnalisés. Ils reposent sur un personnel spécialisé qui est rare. Cette situation crée un large fossé thérapeutique pour les patients atteints de troubles mentaux courants et handicapants, et fait porter une charge inutile pour l'individu, sa famille et la société. Six étapes pour la réorganisation des services de santé mentale dans la Région peuvent être présentées de la manière suivante : 1) intégrer l'offre des interventions pour les troubles de santé mentale prioritaires dans les programmes de soins de santé primaires et les programmes prioritaires existants ; 2) renforcer systématiquement les capacités du personnel de santé non spécialisé à fournir des soins de santé mentale ; 3) intensifier les services communautaires (équipes communautaires de proximité pour une zone de desserte définie, établissements résidentiels bénéficiant d'assistance aide à l'emploi et soutien apporté à la famille) ; 4) établir des services de soins de santé mentale dans des hôpitaux généraux pour les soins externes et les soins aigus chez le patient hospitalisé ; 5) réduire progressivement le nombre de lits de long séjour dans les hôpitaux de soins de santé mentale en diminuant le nombre des nouvelles admissions ; 6) fournir un financement de transition/provisoire pendant une certaine durée pour intensifier les services communautaires et parallèlement réduire la taille des institutions de santé mentale .

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The case for reorganizing mental health services: the optimal mix of services

Mental disorders are common and disabling. About 1 person in every 10 worldwide is suffering

from a mental disorder, and 1 in 4 families has a family member with a mental disorder (1). Rates of mental disorder are even higher in countries affected by complex emergencies. The vast majority of people with a mental disorder do not receive treatment. The treatment gap, i.e. the proportion of people who require care but do not receive treatment, has been estimated to be more than 90% in the Eastern Mediterranean Region (EMR). The limited resources that are available for mental health care in these countries are often deployed inefficiently in maintaining large psychiatric hospitals that are inaccessible to the majority of the population, may result in poor clinical and social outcomes and have even been associated with human rights violations.

Yet effective pharmacological and psychosocial treatments are available for depression, schizophrenia, epilepsy, alcohol and substance abuse and these treatments can be successfully applied in integrated, community-based mental health services in low-income countries (1,2). Hence there is a compelling case for reorganizing services into a decentralized, integrated community-based model of delivery for mental health care.

The major demographic changes which are taking place in almost all the countries of the EMR should be carefully considered when planning the scaling-up and reorganization of mental health services. The child and adolescent population is growing fast and this phenomenon should drive public health policy-makers when they plan mental health care and services, to avoid the risk of focusing exclusively on services for the adult population. In addition, the massive migration from rural to urban areas which is ongoing should also significantly influence not only the location of services but also the ability of services to address the new and specific needs of populations who are recently urbanized and often live in critically underserved environments.

Achieving reorganization: catalysts for change

Despite previous attempts to improve mental health services, decentralization and integration in the EMR is patchy, services are inadequately funded and resources remain centralized in mental hospitals (Figure 1). Successful initiatives in the Region have identified and taken advantage of opportunities to catalyse change:

Crisis can be a catalyst for change. Emergency situations provide the opportunity for review and adoption of new approaches, as exemplified by developments in Afghanistan, Iraq, Jordan and Somalia.

The community itself can provide crucial impetus and direction for the reorganization of

services. This invaluable resource needs to be facilitated by fostering the development of family/carer and user groups. Box 1 is a case study from Morocco illustrating the how family associations can play a role in mental health care in the community.

External donor pressure can be the driver to ensure that models of service delivery are effective and efficient and that they meet standards of quality and human rights.

Adoption of mental health policy and legislation incorporating internationally accepted human rights conventions can drive service reorganization since it requires a service model that can successfully meet the requirements of the legal framework. The right to community-based services is expressly recognized in Article 19 of the United Nations Convention on the Rights of Persons with Disabilities.

Momentum generated by the development of delivery platforms for priority programmes, e.g. HIV/AIDS, maternal and child health and noncommunicable diseases, can sometimes provide opportunities for reorganizing the service delivery model for mental health.

What needs to be done?

The World Health Organization (WHO) has developed the Service Organization Pyramid Model for an Optimal Mix of Services for Mental Health (Figure 2). This model incorporates the recovery paradigm, which proposes that people with mental disorders are central to their own recovery and can manage their mental health problems themselves, supported by family, friends and community institutions. At successively higher levels of the pyramid the mental health needs of the individual require more intensive professional assistance with commensurate higher costs of care.

Integrate mental health care into primary health care

Although all countries in the Region have made some progress towards integrating mental health services into the primary health care system, there is considerable variation in the extent of integration (Figure 3). The case study in Box 2 looks at how the Islamic Republic of Iran has successfully integrated mental health services into all levels of care nationwide. Integration of mental health into primary care improves identification and treatment rates for priority mental disorders and promotes access and holistic care for comorbid physical and mental health problems (3). Even in countries where primary health care services are weak, this can be achieved if primary care workers are provided with training followed by sufficient support and supervision by secondary-level services. The WHO Mental Health Gap Action Programme

(mhGAP) provides resources to support the provision of front-line services for a range of priority conditions to be delivered through primary health care and other non-specialist settings.

Community-based services for mental health care delivery

Community-based services, such as mental health outpatient facilities and day-treatment facilities are underdeveloped in the EMR compared with the rest of the world, and the provision of community residential facilities is much lower than in European countries. There is a widespread clinical consensus that people receiving community-based mental health care have better health and mental health outcomes and better quality of life than those treated in institutional psychiatric settings (5). Community services can be scaled-up in resource-poor settings by using non-mental-health professionals (6–8). Box 3 shows a case study from Palestine. Adopting a whole community approach can compensate for health service manpower shortages and provide avenues to incorporate income generation and group management interventions (9).

Psychiatric units in general hospitals

Across the EMR the availability of psychiatric beds in general hospitals is about one-third of that found in the rest of the world. Two-thirds of psychiatric beds in the EMR are still located in mental hospitals, the remainder being almost equally divided between general hospitals (18%) and community residences (16%). There is a very wide variation between EMR countries in the extent to which psychiatric beds are located in community settings (Figure 1).

General hospital settings provide an accessible and acceptable location for 24-hour medical care and supervision of people with acute acerbations of mental disorders, in the same way that these facilities manage acute exacerbations of physical health disorders. Although there is a consensus that acute inpatient services are necessary both to diagnose and to treat patients, the number of beds needed is contingent on which other services exist locally and on local social, economic and cultural characteristics.

Scale-back and refocus psychiatric hospitals

Successful deinstitutionalization programmes involve investment in community-based services, development of human resources with an appropriate skill mix and parallel funding to manage the transition. The range and capacity of residential long-term care that will be needed in any particular area is dependent upon which other services are available or developed locally, and upon social and cultural factors, such as the amount of family care provided (10). When deinstitutionalization is carried out carefully for those who previously received long-term inpatient care, the outcomes are more favourable for most patients who are discharged into community care (11–13). Improvement of quality of care in psychiatric hospitals and processes

of deinstitutionalization should be encouraged, developed and monitored (14). Existing psychiatric hospitals in the EMR can respond to this need by developing as tertiary centres of excellence. However, it should be noted that in some countries the total number of psychiatric beds in psychiatric and general hospitals is very low and in those cases the effort should be directed towards increasing mental health beds in general hospitals in spite of the well-known resistance to this by professionals working in general hospitals. The WHO QualityRights Tool Kit is a useful resource to guide the process of examining the human rights situation in institutions and guiding collaborative reform (15). While reducing the numbers of patients residing in long-stay facilities will release resources to pay for the development of community-based mental health services, it needs to be stressed that parallel dual funding will still be required during the period of reorganization.

Integrate mental health into priority health service delivery platforms

An integrated approach to addressing mental health in the context of care for HIV, maternal and child health and noncommunicable diseases has been shown to be cost-effective and efficient (16–18). Maternal and child health programmes are population- and community-based and can provide a platform for equitable care, especially in rural and difficult-to-access communities (19,20) and offer the chance to treat the “whole patient”, which has beneficial effects not only for the individual but also for his/her family. Box 4 summarizes how mental health services have been integrated into maternal and child health services in Pakistan.

User and carer involvement

Increasing participation of service users and carers is one of the major advances made in mental health care in the last decades. The recovery movement has validated the active engagement of people in accepting and overcoming the challenges of disability associated with mental health problems (20). Facilities should support service user involvement in decision-making at all levels, including the running of the facility as well as their personal treatment and care plans. Users might be also included in contributing to designing research studies as it is the case in a few countries such as the United Kingdom. Community mental health services should support families coping with the problems associated with chronic mental disorder in a family member, for example by developing programmes designed to decrease family burden and improve psychological support.

Key recommendations for ministries of health

The key recommendations summarized in Table 1 address 6 strategic interventions for service reorganization for ministries of health. Service reorganization cannot be carried out in isolation and it must be underpinned by policy and legislative reforms, complemented by promotion and preventive interventions, and informed by information, evidence and research. Furthermore the active involvement of users and carers should be promoted in the planning and review of delivery of care and reorganization of services.

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