Principles that should guide mental health policies in low-and middle-income countries

Princípios que deveriam nortear as políticas de saúde mental em países de baixa e média rendas

It is well known that about one quarter of the world population will develop some mental disorder over life. Mental illness is an important component in the global burden of disease, accounting for between 12% and 18% of the total burden according to the development level of global geographic regions. Ongoing demographic changes such as increasing longevity are associated with a mounting burden of mental illnesses. It is also well documented that mental health services have been insufficient to deal with current needs, which results in a treatment gap in most low- and middle-income countries (LMICs).[1] LMICs have the highest rates of suicide and 2.1% of the global mortality is directly attributed to neuropsychiatric disorders. Mental health problems place a substantial burden on individuals and their families in LMICs, affecting patients' life expectancy and patients' and family quality of life. Thus, it is paramount to scale up the provision of high-quality mental health services in these countries.[2]

The central question is: which fundamental values and human rights should influence decisions related to mental health care policies? A core principle supporting community-oriented mental health care is the notion that people should have equal access to services in their own locality and in the "least restrictive environment". At the same time, it is important to safeguard the self-determination and autonomy of people with mental illnesses as persons and as citizens.

These principles have been ratified by the United Nations (UN) Convention on the Rights of Persons with Disabilities (UNCRPD) and, more specifically, by the UN Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care, set forth in 1991. These international documents specify three important points which should be taken into consideration: 1) the right of the person to be treated without discrimination; 2) the presumption of legal capacity, unless incapacity can be clearly proven; and 3) the need to involve users and families in the development of policies which directly affect their lives.[3]

Changes in mental health policies, with some recognized inconsistencies between and within countries, can be divided into three periods: 1) the rise of the asylum, from around 1880 to 1955; 2) the decline of the asylum and the deinstitutionalization after the end of World War II; and 3) the reform of mental health services according to an evidence-based approach, balancing and integrating elements of both community and hospital services. The integration of community and hospital services is regarded as a "balanced care model", where most services are provided in community settings close to the populations served, with reduced hospital stays, usually at acute wards inside general hospitals. In LMICs that have the possibility to contemplate mental health in primary health care services, five categories of resources can be organized for the development of mental health care services: 1) outpatient clinics; 2) community mental health care teams; 3) acute inpatient services; 4) community-based residential care; and 5) work, occupational, and rehabilitation services. Community-oriented care should be characterized by the following assumptions: 1) focus on public health needs, i.e. priority to treat severe mental conditions; 2) development of local and accessible services; 3) engagement of users and their families in the planning and delivery of mental health care services; 4) promotion of self-help and empowerment for individuals and families; 5) provision of a setting for mutual assistance and/or peer support for service users; 6) development of stepped care options for referral to specialists and/or hospitalization if necessary; 7) provision of back-up supervision and support by specialized mental health services; 8) link with NGOs, particularly those involved in rehabilitation; and 9) arrangements for the system to work in a reference/counter-reference manner within a specific geographic area.

The World Psychiatric Association (WPA), under the leadership of Prof. Mario Maj, has appointed a WPA Task Force, led by one of the authors (GT), to produce commissioned guidelines on the steps, obstacles, and mistakes to be avoided in the implementation of community-based mental health care.[4] The report presented by the task force raises several major mistakes to be avoided in the development of community-based mental health care. First, there is no mental health planning without a strong participation of psychiatrists in the process of change, together with all the stakeholders involved in the project. Second, the planning should be accompanied by a rational succession of events, so as to avoid the closure of hospital beds before a solid community-based care is in place. No mental health system can work without a provision of sufficient acute ward beds to support people in crisis. At last,

another common mistake is to link reform to a particular political interest, which can expose the accomplishments of a given reform to political succession issues.

In conclusion, the main principles to guide mental health policies in LMICs should be based on public health needs,[5] taking into consideration the protection of human rights as ratified by the relevant UN conventions, and should be designed on the grounds of cost-effective and evidence-based mental health systems. There are many lessons to be learned from previous positive and negative experiences in developing community-based mental health care systems. It is now time for mental health professionals to gather and reach a consensus to advocate for high quality mental health services to provide care for the many millions of underserved people living in low- and middle-income countries.

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Note: Universidade de São Paulo; FAPESP = Fundação de Amparo à Pesquisa do Estado de São Paulo; CNPq = Conselho Nacional de Desenvolvimento Científico e Tecnológico; ESRC = Economic and Social Research Council; NIH = National Institute for Health; NIHR = National Institute for Health Research; WPA = World Psychiatric Association.
For more information, see Instructions for Authors.

References
1. Kohn R, Saxena S, Levav I, Saraceno B. The treatment gap in mental health care. *Bull World Health Organ.* 2004;82(11):858-66.
2. Jacob KS, Sharan P, Mirza I, Garrido-Cumbrera M, Seedat S, Mari JJ, Sreenivas V, Saxena S. Mental health systems in countries: where are we now? *Lancet.* 2007;370(9592):1061-77.
3. United Nations. *UN Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care*. Adopted by UN General Assembly Resolution 46/119 of 18 February 1992. New York: United Nations; 1992.
4. Thornicroft G, Alem A, Santos RA, Barley E, Drake R, Gregorio G, Hanlon C, Ito H, Latimer E, Law A, Mari JJ, McGeorge P, Padmavati R, Razzouk D, Semrau M, Setoya Y, Thara R, Wondimagegn D. WPA guidelines on steps, obstacles and mistakes to avoid in the implementation of community mental health care. *World Psychiatry.* 2010;9(2):67-77.
5. de Jesus MJ, Razzouk D, Thara R, Eaton J, Thornicroft G. Packages of care for schizophrenia in low- and middle-income countries. *PLoS Med.* 2009;6(10):e1000165.