CHAPTER 41

Overcoming impediments to community mental health in low- and middle-income countries

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Introduction

As discussed in Chapter 6 by Wang and colleagues, the prevalence of mental disorders across the world—and across low- and middle-income countries (LAMIC)—is high. The median rate across the world of having at least one mental disorder in the last year is 10% (WHO WMHS Consortium, 2004). The impact of these disorders on disability, other aspects of health, and development is substantial. Yet, the vast majority of people with a mental disorder are not in contact with services that offer mental health care (Wang et al., Chapter 6, this volume), Importantly, the association between severe mental disorder and human rights violations is strong (WHO, 2001). Even among people with severe mental disorders, few people receive adequate, humane care (WHO, 2001) and discrimination is pervasive (Thornicroft, 2006). It is clear that there is an urgent need to act.

The World Health Organization (WHO, 2003) developed a mental health policy and planning package to help countries to develop services that provide access to adequate care for people with mental disorder. This package was preceded and followed by evidence-informed and evidence-based advocacy through major publications—such as *World Health Report 2001* on mental health (WHO, 2001), the *World Mental Health Report* (Desjarlais et al., 1995), *Neurological, Psychiatric, and Developmental Disorders* (Institute of Medicine, 2001), *Disease Control Priorities related to Mental Neurological, Developmental and Substance Abuse Disorders* (WHO and Disease Control Priorities Project, 2006), the 2007 *Lancet* Series on Global Mental Health, and the 2008 mental health Gap Action Plan (WHO, 2008). Although most research evidence on interventions comes from specialized care settings in high-income countries, fortunately there are good indications that much of this evidence generalizes to LAMIC (Patel, 2007).

A naïve observer would perhaps expect that with this amount of burden, human rights violations, high-level advocacy, technical guidance, and evidence for interventions, that mental health service development in LAMIC is flourishing. Indeed, it should be. Although it is true that some countries have made major strides, the reality however has been that mental health service development in most LAMIC has been a challenge. This chapter will address some key impediments in developing mental health services in LAMIC and will offer strategies to address these impediments.

Financial resources

As in other areas of health (Laxminarayan et al., 2006), to implement evidence-based policy and practice, financial resources are needed. Resources allocated towards mental health care are insufficient or are ineffectively distributed in (LAMIC) (Saxena et al., 2007). There are many explanations for the low levels of financing for mental health. None of these reasons are independent of one other; rather, they interact and together form a formidable block to the allocation of appropriate funds, whether by foreign donors, ministries of health or ministries of finance. In this section we will describe a variety of reasons for the lack of funding.

In most countries there is a lack of strong, coordinated, and consistent lobbying and political pressure to increase resources for mental health services. Without strong advocacy, mental health will not be high on the public health agenda and political will and funds will remain inadequate

This lack of strong advocacy stems from discrepancies about both the intended purpose of advocacy and the differing targets of advocacy. There appear to be two, implicitly stated disagreements regarding the purpose of global mental health advocacy. First, a disagreement on whom to help—some advocates suggest that the goal is to help the severely mentally ill, while others advocate for support for mild mental health problems. Second, among those who agree on which group to focus their advocacy, there is disagreement on how this should be done—some advocates focus on more a medical model, while others call for a combined medical and social model.

To scale up community mental health services, it is extremely helpful to develop a consensus in advocacy messages among the national mental health community (e.g. service providers, professional associations, senior government leaders in mental health, academics, and national policy-makers), as fragmentation at this level has prevented action in many settings.

Lobbying efforts towards policy and legislation is important but focusing on legislation and policy alone is insufficient. In reality, successful advocacy is also needed to ensure that these are funded, implemented, and translated into services. Coordinated advocacy groups need to continue their work through and beyond the legislative/policy process.

Mental health financing in countries—which is usually extremely low (see Chisholm and Knapp, Chapter 33, this volume)—may be more likely to be increased if there was more advocacy from service users, families, and service providers, including non-governmental organizations (NGOs). People with disorders and their families can be a powerful constituency to press for better mental health care with sufficient funding at local levels. Service-providing NGOs, with close community connections, often serve as advocates and coordinating centres for local advocacy. Such local advocacy will go furthest when in concert with appropriately coordinated national-level advocacy.

Part of the reason for the frequent political (and thus financial) inaction on mental health may unfortunately be attributed to the low level of interest from the public in issues of mental health. Stigma and discrimination pose a challenge to mobilizing the community to be involved in advocacy, perhaps making it especially important that people who receive mental health care are involved in lobbying.

Public advocacy will make investment in mental health more politically palatable, though there is a challenge. In developing coordinated advocacy, the interests of different groups (service users, family members, and mental health specialists) may vary greatly within and between groups. For example, different users have been seen to work towards different objectives, ranging from 1) less or no psychiatric interventions to 2) more, humane community and socially oriented mental health services to 3) better access to new psychotropic medications. (Indeed, some user organizations are funded by industry while others insist on independence from industry.) Similarly, psychiatrists are not a monolithic group. Opposing advocacy from different stakeholders may result in inaction on the part of governments. Thus, it is necessary to develop a clear consensus and plan for action among the national mental health community. Disagreements on goals to be achieved among a community of mental health specialists limits funding and abilities for policy change. Any internal division among mental health experts and decision-makers is an obstacle to coordinated and effective advocacy.

A prominent explanation for the lack of mental health funding concerns the role of donors and the international community as agenda setters. For example, mental health does not appear in the Millennium Development Goals (MDGs; Miranda and Patel, 2005). Unfortunately, in several countries, exclusion of mental health from the MDGs has directly obstructed the financing of mental health services by international donors even in countries where national authorities made mental health a priority (e.g. Afghanistan, Rwanda). When international agencies and donors do not prioritize mental health, there is reduced incentive for national policy-makers to address this issue. Furthermore, ministry of health staff and funds are often directed towards implementing donor-supported programmes.

Communicable disease, especially HIV/AIDS, has been the funding priority for donors and national leaders, and this has been a barrier to securing funds for mental health services in sub-Saharan Africa. This challenge should be converted into opportunity by integrating mental health services into HIV/AIDS programmes (Freeman, 2000). Rather than compete with communicable disease, integrating mental health care into communicable disease health care programmes may be extremely helpful to funding care for the large percentage of people with mostly mild and moderate common mental disorders. Yet, it is unlikely to provide a solution to the problem of organizing care for people with chronic, severe mental disorders.

There seem to be common, but incorrect, beliefs that mental health interventions are ineffective, economically inefficient, and too costly. Perceptions of cost-ineffective services need to be addressed with evidence and political pressure. It should be noted that any discussion of cost-effectiveness depends greatly on the mental disorder being considered (WHO, 2006). The treatment of severe mental disorders may be relatively less cost-effective but they still may provide good value for money (Chisholm et al., 2008).

Critics of the discussion on cost-efficacy point to the human rights of the mentally ill. Because of the prevalence of human rights violations against people with mental disorders (even at times by the professionals who are supposed to care for them), there is a strong moral case for providing effective and humane mental health care (Patel et al., 2006).

Epidemiological data have highlighted the tremendous global burden of mental disease. It is unclear to what extent epidemiological data are helpful in putting mental health on the agenda. In fact, in many cases such data are easily misunderstood or not very informative (e.g. depression prevalence rates typically do not distinguish between mild and severe depression, which are very different public health issues). Moreover, in some circumstances rates of poor quality studies tend to be higher than rates of stronger studies (Steel et al., 2009) and policy makers may be put off by over-advocacy with rates that are not credible. Nonetheless, epidemiological data can have advocacy value if attention to new local evidence prompts health planners to invest in mental health.

Organization of services

The integration of mental health care into general health services occurs mainly in two forms: mental health care delivered by general health workers in primary care settings or through specific programmes addressing physical disease (HIV/AIDS, tuberculosis). Additionally, although not covered here, integration into general health care services could include, for example, liaison psychiatric services in general hospitals.

The term 'dedicated mental health care' is used for mental health care delivered by workers performing full-time mental health work through specific mental health services (e.g. outpatient psychiatry, inpatient care by mental health specialists at general hospitals, mental hospitals). One could also speak of a hybrid model of general care when a worker's time is fully dedicated to providing mental health care in a primary care clinical setting.

How different types of services are organized/configured/mixed within a mental health system tends to have an impact on the

effective treatment coverage of people with diverse mental disorders. A mixed model of care, in which mental health care is available at multiple levels of care, is, without doubt, the ideal, but reflection is needed on how services decision-makers should invest their available, limited resources for mental health care (WHO, 2003).

As described earlier in this book (Thornicroft et al., Chapter 12), resources and expertise for mental health care need to be geographically decentralized for people to have access to them, and a system needs to be created that makes treatment for acute and chronic mental illness and the corresponding social and rehabilitation services available at the community level. There is thus a need to move staff and financial resources into the community, and this is an enormous challenge. This requires allocation of funds to different regions and subregions of countries, and the funding should cover general mental health clinics covering a range of disorders, rather than vertical programmes for very specific pathologies.

NGOs often play an irreplaceable role in providing community mental health services. However, in some countries NGOs have difficulties in establishing themselves and, even when established, some NGOs may create their own set of problems. In some locations existing NGOs may be unhelpful by grossly inflating reports on the level and quality of social services that they (the NGOs) provide to the mentally ill. This gives the message that there is no need for government to invest in mental health, as the NGO already has done all the work.

Like in high-income countries, developing community mental health care in LAMIC requires linking mental health more closely with other non-health sector services. Social services are part of, or complementary to, decentralized specialist mental health care, and this should be reflected in the structure of such services. Depending on the setting, linkages that reach beyond the social services sector to traditional and/or religious healers may be appropriate.

Much of the discussion of community involvement in mental health focuses on the crucial role of families and community organizations, especially in rehabilitation, and the need to spread resources and expertise beyond mental health hospitals. There is a need for the 'grassroots' creation and management of mental health programmes, emphasizing collaboration with community members and NGOs. Decentralization and deinstitutionalization—two conceptually distinct but often overlapping processes—open up many opportunities to involve communities and families in mental health care.

Substantial resistance to the decentralization of health resources arises in many countries that have attempted to spread resources to the periphery and to social programmes. Resistance to social services can be substantial, because it involves an understanding of mental disorders outside the medical model.

To assist with these challenges, technical support for LAMIC is needed to develop financing schemes for community-based approaches. It is important to understand the separate sectoral costs (e.g. health care, housing, employment) in attempting to create an integrated, multisectoral mental health programme (WHO, 2003). Problems in mental health financing also arise when mental health policy created at the national level requires financing at the subnational level, where decision-makers may not feel as responsible for implementing national-level policy. This has occurred in South Africa and Pakistan (WHO, 2007).

An important—although often difficult—step in decentralizing mental health resources is downsizing existing mental hospitals (WHO, 2001). Mental hospitals have poor coverage, tend to put people at elevated risk of human rights violations, and absorb a disproportionate amount of resources (WHO, 2001).

Worryingly, some of the most persistent barriers to the implementation of such community programmes appear to be the vested interests of psychiatrists and other hospital workers. These interests can be an obstacle to funding, deinstitutionalization, and the expansion of a mental health workforce. Concerns about job security have delayed moves to community-based care. The staff and leadership of psychiatric institutions are too often willing and able to exert influence that opposes the political will to reform mental health services. Thus, in pursuit of mental health service reform, psychiatrists should be seen as stakeholders, not just as providers.

Financial incentives and professional self-interest have led too many psychiatrists and mental health staff to resist deinstitutionalization and any restructuring of care to the community level, and to oppose expansion of the workforce and public health models of care. Downsizing hospitals can be an understandable threat to the economic and professional interests of those who work in hospitals. Financial and professional guarantees need to be thus put in place for hospital staff during the period of transformation.

In our experience and in that of a range of experts that we interviewed (Saraceno, 2007, opposition to downsizing hospitals in favour of community-based care most often comes from trade unions and hospital staff of various levels. It is thus important that the reform process incorporates these groups, so that they may be offered roles in the community-based secondary mental health system. It should be recognized that psychiatrists may also resist attempts to expand the mental health workforce to have non-psychiatrists or non-doctors provide management of mental disorders. Such resistance to changing mental health services is often taken up by professional associations, which make it difficult to cultivate the united political will to pursue reforms.

Despite much agreement among international mental health experts regarding deinstitutionalization (Saraceno, 2007), there often exist some controversy and debate in society—especially when it is implemented in a problematic manner. For example, more than 30 years ago, dehospitalization (often confused with the complex process of deinstitutionalization) has led many mentally ill persons living on the streets in North America in places where deinstitutionalization was done without the creation of community-based services. Mental health advocates should be clear that talking about closing a hospital leads to understandable resistance and any talk about closing hospitals should be accompanied with a well-communicated, strong plan about developing care in the community.

Downsizing or closing mental hospitals is likely to result in failure if not accompanied with secondary care and community services. Indeed, the likely reason for Brazil's mental health reform's success is the increase of secondary level care that has co-occurred with the decrease of mental hospital beds. The need to downsize mental hospitals thus coexists with the need to develop community mental health services. Challenges to developing community mental health services may transform into challenges to downsizing mental hospitals. Decision-makers are sometimes unwilling to downsize and/or close mental hospitals—due to the political risk of facing vested interests. Deinstitutionalization is technically complex and cannot occur without adequate community mental health services in place. Thus, any downsizing of mental hospitals

should be concurrent with improving community-based inpatient care for the mentally ill. Additional funding will be needed during the transition to community care. Yet, as we discussed earlier, to raise funds unified advocacy is important and this advocacy will be weaker if public health planners and health staff disagree about the need to decentralize. The need for unified, ethical solution is urgent given the inhumane living conditions in many mental hospitals.

Integration of mental health care in primary health care (PHC) is essential to obtain good coverage. However, poorly executed integration of mental health into primary care leads to under-trained, unsupervised primary care workers who are not sufficiently competent in the care (identification and treatment and/or referral) they are supposed to provide. Even if technically competent in clinical management, they may not know how to manage their time in such a way to find time for mental health care during their day. Moreover, without appropriate training and supervision, overburdened primary care staff are at risk of increasing their reliance on pharmaceuticals, leading to narrow biomedical support even for people with subthreshold problems. Integrating mental health in PHC thus requires planning (WHO, 2007). Finally, in many LAMIC essential psychotropic medicines are often not continuously available at the PHC level—a barrier that hinders appropriate care for those people whose disorders can be effectively treated through medication.

Investment in community mental health services and supervision of PHC workers by mental health specialists is critical to the success of the primary care model. This observation is in line with the WHO (1978) Alma-Ata Declaration, which promoted a primary care model 'sustained by integrated, functional and mutually supportive referral systems' as an integral part of a country's health system.

Strengthening the workforce

A commitment to strengthening the mental health workforce by training staff in the community and by expanding the base of providers will require a new role for mental health professionals, one focused on training and supervision, and one that involves the mobilization of families and communities in care and rehabilitation.

Improving the structure of the mental health system in LAMIC depends fundamentally on the availability of an adequate mental health workforce. Mental health training needs to move beyond hospitals and universities and beyond theoretical sessions, to a continual process of supervision and mentorship in the community they serve. This applies to the training of psychiatrists, medical officers, and primary care providers, as well as paraprofessionals in mental health. International collaboration for training can be helpful as countries have much to learn from one other. Training through hands-on supervised clinical work is likely of greatest benefit (WHO, 2007). Training in psychiatric hospitals for undergraduate medical students is particularly unhelpful to teach them how to address mental health in primary care settings. It is suggested that training should take place regularly, in clinical settings in the community and under the dedicated supervision of mental health specialists, rather than through one-off workshops. Therefore, mental health support in the community may depend on a shift in the role of mental health experts from clinical care to one of supervision.

Providers in the general health care system—e.g. community health workers, PHC staff—should be further trained in mental health. Yet, when they are overburdened with other responsibilities, it can be helpful to find, train, and supervise new groups of workers altogether. Training dedicated community mental health workers can be extremely valuable, especially when their roles are recognized and endorsed by governments.

Furthermore, lay individuals in the community can be trained to appropriately refer persons for further care. As for other groups, such training requires adequate post-training supervision from professionals. In particular, it can be valuable to more formally involve families in providing care, and to empower them as advocates. Service users may be involved in care as well, e.g. there can be a role for users as staff in supported housing programmes. To best involve families in care, they need the support of trained personnel, who can provide support and guide the use of medications. Family care may be especially useful in rural areas, providing families are given appropriate support by trained mental health staff.

Involving families makes them stakeholders in mental health. The resulting advocacy can have an impact on policy. In addition to involving families, the involvement of service users in advocacy is likely to lead to increased funding for community mental health services to facilitate responsible deinstitutionalization and greater community integration, as we have discussed above. Thus involving families and users has value both from a human resource and an advocacy perspective.

The involvement of families is complemented by the involvement of the community, and is consistent with using participatory action approaches, which have been common in rural development and which are now also used by some mental health NGOs (Underhill, 2002). Such approaches are also increasingly common in psychosocial programmes in emergencies (IASC, 2007).

As touched upon earlier, making mental health care broadly available necessitates a supervisory role for mental health specialists. Psychiatrists need to focus their efforts on training other health workers. Developing a broader base of mental health care providers in general health services and in community-based mental services, depends on mentorship and community-based training. To restructure care the specialist must be motivated to switch to a training and supervisory role. This may require financial incentives.

Public mental health leadership

Mental health leaders in LAMIC—such as directors of mental health in ministries of health—have responsibility for the complex tasks of increasing funding, making mental health care more broadly available, developing a system for secondary, primary, and community care and reforming hospitals, among other challenges. Such tasks require not only a familiarity with the needs and possible supports for diverse people with mental disorders, but also population-based, public health vision and skills. The skills for such leadership need to be developed, or sought from outside psychiatry, from the academic discipline of public health.

The rarity of public health-minded approaches in mental health care may be due in part to the nature of existing evidence-based interventions which are mostly at the individual level, and also to the training of mental health leaders that tends to have focused on clinical care only. The rarity of adequate public mental health leadership may also be due to a lack of incentives for psychiatrists to take a public health view, and also to a lack of authority for non-psychiatrists attempting to engage such a view.

Training courses for public mental health leaders are needed. Training leaders in public mental health may greatly improve mental health strategies in LAMIC countries. Promisingly, an International Master in Mental Health Policy and Services has commenced in Lisbon, in collaboration with WHO.

International assistance—laterally with other LAMIC or with international agencies—and incentives can play a crucial role in developing public mental health leadership. With concern that any programme should be adapted to local settings, it can be extremely helpful to have lateral, regional, and global cooperation for mentoring and for sharing models of success. International networks— such as Global Forum for Community Mental Health (http://www.gfcmh.com/)—can also play an important role.

Conclusion

Making mental health services available in the community in LAMIC is a must. Community mental health services, compared to institutionalized care, give greater coverage. Also, community care has a lower risk of human rights violations introduced by the care system. Yet, there are impediments to developing community services, as reviewed in this chapter. In particular, the interests of mental health care providers (and often family members as well) favours institutions. Also, there is the challenge that developing mental health care in the community involves start-up costs, which requires a substantial increase in resources, which are most easily raised when key stakeholders agree on how to move to community services.

The formation of national plans for mental health, developed in a participatory manner with service providers and users among other stakeholders, is an excellent vehicle for coordinating advocacy. Such plans are needed not only because good planning helps service development, but also because good plans are a helpful vehicle for fund-raising. By functioning as a coherent proposal for services, a national plan, endorsed by the minister of health, can facilitate sound financing from different levels of government and can be used as a proposal to international donors. Such plans can thus break the vicious cycle between lack of unified advocacy and lack of resources

This chapter also covers other barriers. With respect to human resources, diversifying the mental health workforce is key. Psychiatrists should increasingly move from direct service provision to training/supervising non-psychiatrists (e.g. PHC staff) in mental health care. This change in roles is essential to increase coverage in the community. Incentives—including financial incentives—for such change in roles need to be made available.

This chapter discussed the challenges related to integrating mental health care in PHC, which includes the need for supervision, but also the limited time that PHC providers have for mental health. Greater efforts need to be extended to work with PHC providers on time management for providing mental health care. For example, PHC providers may task-shift some of the work by involving community workers or, alternatively, they may dedicate specific, relatively quiet, times of the week to mental health care, during which they schedule appointments with appropriate amount of time for each patients (Jones et al., 2009). Making dedicated time for mental health care is justifiable given the high prevalence of mental health problems in PHC (Ustun and Sartorius, 1995).

Psychiatrists will continue to play key roles in many countries and, as mentioned earlier, they should lead the clinical supervision of mental health treatment in the health sector. Yet, this chapter provides reasons to doubt whether clinicians are best placed to lead mental health services development in countries unless they have a public health training and perspective to facilitate planning at the population level. There is a need for better access to public mental health leadership training for key decision-makers in LAMIC.

We end this chapter with two observations and a conclusion. The first observation is that integration of mental health into PHC in rural districts works best if secondary care is in place first so that secondary care mental health experts can supervise the integration into PHC. The second observation is that decentralization from tertiary care to community care works best if secondary care is in place first, in order to provide access to care to people who would otherwise go to tertiary care. Accordingly we conclude that countries should consider prioritizing developing mental health in secondary care (e.g. accessible outpatient mental health clinics staffed by multidisciplinary teams, small acute psychiatry wards in general hospital) to be followed by the important work of integrating mental health at the primary care level and decentralizing the tertiary care level.

Acknowledgements

This chapter is based on a written key informant survey with international experts conducted in 2006 to 2007 (WHO, 2007). In this chapter, we represent the entire body of lessons we learned from the study. We thank Jessica Mears for her valuable comments on an earlier draft of this chapter.

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