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Quality in Delivery of Mental Health Services

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1. Introduction

Quality in health care is an important contemporary topic because of rising consumer expectations of health care amidst constrained health care budgets. Historically mental health services have been the poor cousin of health care services generally, and acute health care services specifically. At this time when quality in health care is occupying more space in the health care literature, it is opportune to review what inroads have been made as far as quality in delivery of mental health services.

This chapter will examine the movement towards quality management in health care and explore the divide between quality in general health care and quality in mental health care. After this, what is considered quality in delivery of mental health services is discussed and finally the challenges to quality in delivery of mental health services and methods to overcome these challenges are analysed.

2. The significance of mental illness and the costs of mental health services

The Australian national survey of mental health and wellbeing [1] estimated that 45% of Australians aged between 16-85 years, that is, approximately seven million people, experienced a mental disorder over the course of their lifetimes, while 20% experienced symptoms of a mental disorder over the the twelve months prior to the survey. Anxiety, affective and substance disorders were experienced by fourteen per cent, six per cent and five per cent of the population respectively [2].

Mental disorders are ranked third after cancer and cardiovascular in the major morbility and mortality disease burden groupings and mental disorders account for thirteen per cent

of the total disease burden in Australia [3]. Generally the disease burden for mental illness is non-fatal with only 718 deaths in 2008, excluding suicide and dementia, due to mental illness as a result of substance abuse involving alcohol and heroin [4]. The most mental illness burden is attributable to anxiety, depression, alcohol abuse and personality disorders.

Mental health services are complex and the Australian government has divided them into groupings based on point of contact for treatment [5]. Mental health services consist of mental health-related care in general practice, in emergency departments, community mental health-related care and hospital outpatient services, ambulatory equivalent mental health-related admitted patient care, Medicare–subsidised psychiatrist and allied health services, admitted patient mental health-related care, residential mental health care, mental health-related supported accommodation assitance program services, support services for people with a psychiatric disability, and specialised mental health care facilities. These groupings are arranged from simple to more highly specialised treatment and accommodation arrangements and usually reflect the increasing seriousness of the impact of the mental health-related problem on the individual, family and society.

Australia spent $5.8 billion on mental health-related services during 2008-2009 [6] and this equated to an avergae annual increase of 4.8% on expenditures over the previous four years. The total health care expenditure in the same peiod was $112.8 billion with health taking up 9.0% of Australia's Gross Domestic Product (GDP). If mental disease accounts for thirteen per cent of the burden of disease [3], then it is clear that mental health services are not getting a proportional allocation of Australian government health funds.

The United States spends far more proportionally on health care than most Western countries, spending 16 % of GDP in 2008-2009 amounting to $2.5 trillion [7]. Mental health care costs contribute to about 100million in 2003 which amounted to 6.2% to these health care costs [8]. Apart from these direct costs the indirect costs of mental illness are incurred through reduced labour supply, public income support payments, reduced educational attainment and costs associated with other consequences such as incarceration or homelessness. In fact serious mental illness is associated with the annual loss of earnings totally $193.2 billion [9].

In 2007-2009, an average annual 3.2 million or 8.6% of young adults aged 18-26years had some health ecpenses for mental disorders. Direct medical spending to treat mental health disorders in young adults totally $6.5 billion as a average annual cost [10]. According to the latest US Agency for Healthcare Research and Quality [11] treating America's youth for mental disorders is the most expensive children's medical condition, costing almost 9 billion dollars in 2006.

Mental ill health is the largest single cause of disability in the UK accounting for 23% of the overal burden of disease, compared to 16% each for cancer and cardiovascular disease [12]. In 2010-2011, The United Kingdom spent £118.58billion on health care which was approximately 8.7% of GDP [13], whereas the cost to the NHS for mental health problems and social care costs was over £21 billion a year. The economic and social costs of mental health problems is estimated at £102.5 billion in 2009-2010 [12]. However the majority of the impact of

mental illness falls on patients and their families and amounts to costing about £53.6 billion a year. Mental health conditions tend to affect people early in life with 50% of cases occuring before 14 years.

3. Movement towards quality management in health care

Much of the work on quality in health services rests on the influential framework of Donabedian [14] which focused on three components: the structure of the services, the process of provider-client intervention, and the outcomes of the care. This is a comprehensive framework including public services and resources, providers, and consumers. However the movement towards quality management in health care only got traction some time after Donabedian's framework because of the public concern about the apalling low level of quality of health care.

Patient safety started in 1999, when the Institute of Medicine, an agency of the US Government, issued the report, called *To Err is Human*, [15] which stated the following:

- Between 44,000 and 98,000 Americans die each year from preventable medical errors in hospitals alone. That does not account for those who die from medical errors outside the hospital.

- It is the equivalent to the number of people who would die if a jumbo jet crashed every day, and all its passengers died.

- Medical errors cause more deaths than motor vehicle accidents, breast cancer or AIDS.

The report highlighted the reasons the reported deaths happened, calling for a shift from placing blame, to finding the reasons and fixing them. It further outlined a series of proactive recommendations for doing just that. The recommendations [15] from *To Err is human* were:

1. Establishing a national focus to create leadership research tools and protocols to enhance the knowledge base about safety.

2. Identifying and learning from errors through immediate and strong mandatory reporting efforts as well as the encouragement of voluntary efforts both with the aims of making sure the system continues to be made safer for patients

3. Raising standards and expectations for improvements in safety through the action of oversight organisations group purchasers and professional groups.

4. Creating safety systems inside health care organisations through the implementation of safe practices at the delivery level. This level is the ultimate target of all recommendations.

The health care system is complex and Australia has developed a National Health Performance Framework that has been modified since its inception in 1999. The safety of the health

care system has been defined by the National Health Performance Framework as the avoidance or reduction to acceptable limits of actual or potential harm from health care management or the environment in which health care is delivered. Similar definitions are in wide use in Australia. For instance, the former Australian Council for Safety and Quality in Health Care, replaced by the Australian Commission for Safety and Quality in Health Care, defined safety as the degree to which potential risk and unintended results are avoided or minimised. The WHO [16] developed a Conceptual Framework for the International Classification of Patient Safety in 2009 so that all health systems are talking the same language about patient safety.

Quality is a multi-faceted concept which can be defined in different ways. At a broad level, quality reflects the extent to which health care service or product produces a desired outcome [17]. At a more detailed level, the National Health Performance Framework views quality as a guiding principle in assessing how well the health system is performing in its mission to improve the health of Australians. The Framework's dimensions for the assessment of health system performance include effective, responsive, continuous, sustainable, efficiency, accessible and safety, all considered relevant to the quality of health care services. In its report Charting the Safety and Quality of Healthcare in Australia [18], the former Australian Council for Safety and Quality in Health Care presented information relating to the dimensions of effectiveness, appropriateness, accessibility and responsiveness as relevant to the quality of health care in Australia. Complementing the information on those dimensions was information on safety, and also on equity, or the degree to which all Australians could benefit equally from health care service provision.

Improvements in quality and safety in health care are important because of rising cost of health care and an increasing concern of poor value for money. In spite of the money and effort spent on health care, poor quality and variations in practice, medical errors, injuries and lack of accountability abound [19]. It is a dilemma to know where to begin because performance of health systems and quality of health care are often used interchangeably although there are differences. Nolte [20] differentiates between quality and performance by referring to the definition of 'quality' proposed by the US Institute of Medicine which is the 'degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge' (1992) and definition of 'performance' suggested by Girard and Minvielle [21] as a broader, multidimensional concept that also includes dimensions of equity and efficiency.

In Australia there are National Standards for Mental Health Services [22] designed for implementation in public, private and NGO mental health services. The Australian Council of Healthcare Standards [23] is an independent not-for profit organisation. The Council reviews health care organisations and mental health services for perfomance, assessment and accreditation. It aims to provide a framework through the Evaluation and Quality Improvement Program (EQuIP) to deliver consumer centered services focussing on the continuum of care by providing systematic external peer review. The Council reviews mental health services against the National Standards for Mental Health Services and EQuIP.

The Standards within the National Standards for Mental Health Services [22] are:

1. Rights and Responsibilities

2. Safety

3. Consumer and Carer participation

4. Diversity Responsiveness

5. Promotion and Prevention

6. Consumers

7. Carers

8. Governance Leaderships and Management

9. Integration

10. Delivery of Care

Accreditation by meeting standards is a minimum requirement for mental healath services and healthcare generally. Accreditation is a static achievement that needs to be renewed every few years. In Australia 93% of public (that is 637 hospitals) and private hospitals (that is, 543 hospitals) are accreditated with either the Australian Council of Healthcare Standards, Business Excellence Australia, Quality Improvement Council or the certification of the International Organisaiton for Standardisation's 9000 quality family [24]. Funding sources demand that health care facilities are accreditated. Being an accrediated hospital has not stopped significant problems in patient care.

The drive towards improvements in health care is faced with many challenges, such as countless providers and patients, institutions and communities, and incremental policies driven by experience and evidence rather than theory and ideology. Health system performance measurement and reporting are part of a global move for accountability and transparency in health services and consumer engagement and contribute to the continuous quality improvement cycle [25]. Quality improvements can occur without measurements, for example clinical guidelines, peer review, videoing consultations, and patient interviews, however, measurement is important to quality improvement.

Kohn, Corrigan, and Donaldson [26] consider health care to be a highly complex and tightly coupled system which are the types of systems that are more prone to accidents. In complex systems one component of the system may interact with multiple of the components of the system in sometimes unexpected and invisible ways. Complex systems are both specialised and interdependent. Coupling is a dynamic term that means there is no slack or buffer between two items. Large systems that are tightly coupled have more time dependent processes and sequences that are more fixed. Tight coupling contributes to more accidents because things unravel quickly and prevent errors from being intercepted or prevent speedy recovery from an event.

Latent errors or system failures, according to [26] pose the greatest threat to safety in a complex system because they lead to operator errors. They are failures built into the system and present long before the active error. Latent errors are difficult for people working in the sys-

tem to see because they may be hidden in computers or layers of management and people become accustomed to working around the problems.

Such is the difficulty of getting health care right, [17] regard health care as characterised by islands of excellence in a sea of mediocrity. So there has been a steady increase in emphasis on continuous improvement of health care rather than leaving safety and quality to a static achievement of accreditation once every three or four years.

The approach to improvement in quality has been systemic and systematic, with the consumer perspective. Runciman, Merry, and Walton [17] have seven dimensions of quality in health care that involve:

1. Access

2. Efficacy and effectiveness

3. Efficiency

4. Safety

5. Timeliness

6. Acceptability

7. Appropriateness

These 7 dimensions operate at world international; state/national; organisational; team; clinicians; and patient levels.

Within health care there has been changes about safety and quality and managing problems that arise. Vincent [27] summarised these in a table:.

Past	Future
Fear of reprisal common	Generally blame free reporting
Individual scapegoat	Individuals held to account where justified
Disparate Adverse Errors databases	All database coordinated
Staff do not always hear the outcome of investigation	Regular feedback to frontline staff
Individual training dominant	Team based training more common
Attention focuses on individual error	Systems approach to hazards and prevention
Short term Fixing of problems	Emphasis on sustained risk management
Many Adverse Drug Events (ADE) regarded as one offs	Potential for replication of similar ADE recognised
Lessons from adverse events seen as primarily for the team concerned	Recognition that lessons may be relevant to others
Individual learning	Team based learning and developing of non-technical skills

Table 1. Changes in Approach to Safety and Quality in Healthcare

Indicators are explicitly defined and measurable items referring to structures processes and outcomes of care [28]. Developing and applying quality indicators is not easy. There are three types of indicators. Activity indicators measure how frequently an event happens. Quality indicators infer a judgement about the quality of care provided. Performance indicators are statistical devices for monitoring performance without any necessary inference about quality. Indicators do not provide answers but they are indicative of problems or may indicate good quality care.

Continuous improvement is a planned way of improving care for patients and carers step by step over time. The reflective cycle for continuous improvement follows the Plan-Do-Study-Act model of improvement of Langley, Nolan and Nolan [29]. Ferlie and Shortell [30] in discussing quality improvement in healthcare in the UK and the US, said that there are four essential core properties that must operate at individual, group/team, organisational and larger system level. These four essential core properties are: 1) leadership at all levels; 2) a pervasive culture that supports learning throughout the care process; 3) an emphasis on effective teams; and 4) greater use of information technologies for both continuous improvement work and external accountability.

3.1. Consumers and health care

Consumers' expectations of health care are certainly different from those of health care providers. As far as quality in health care is concerned [31] study found that consumers described quality in health care in terms of access to care, having competent and skilled providers, and recieving the proper treatment. From nurses consumers in the same study wanted caring behaviour, competence and skill, good communication and discussion about their condition.

Engagement with consumers in health care can occur at three levels [32]. Informed choice is the role that is most actively promoted for consumers and within that sphere shared decision making is promoted to a lesser extent. The two other levels of engagement are less often encouraged and supported. These levels deal with consumers as active participants in their care (co-producer role) and consumers evaluating the care they recieve (evaluator role).

Although speaking of health care reform in the United States, [33] take the importance of consumer engagement further and state that 'engaging consumers is an essential component to health care reform'. Consumers of higher education, higher incomes, no health insurance and good self reported health have higher levels of engagement with their health care. Interestingly, people with depression have lower levels of consumer engagement in thie health care. Hibbard and Cunningham's research shows that consumers that are more involved in their health care have lower levels of unmet needs and recieve greater support from health care providers.

The value of consumers to the drive for quality in health care is part of incorporating the end user into the design and delivery of health services. Health services however are not like industrial complexes. [34] compares the quality improvement strategies in reshaping Toyota with quality attempts in health care. The problems for health care lie in providers

not being able to anticipate that quality improvements will result in higher prices, increased volume or decreased costs.

[35] take the point about consumer involvement in quality in health care further and delineate five principles to improve the effectiveness and impact of public reporting in health care quality. These principles are:

1. Consumers must be convinced that health care quality problems are real that they have serious consequences and that quality can and should be improved.

2. Quality reporting must be standardised and universal

3. Consumers are given quality information that is relevnt and easy to use

4. Dissemination of quality information is improved

5. Purchasers reward quality improvements and providers create the information and organisational infrastructure to achieve them

Certainly, [36] were cautious about consumer led quality improvements in health care. These authors stressed that greater clarity has to be obtained about what consumer satisfaction with the health system (not just health treatments) is all about.

The UK has moved forward with consumer engagment in healthcare with the Care Quality Commission forming in 2009 as the independent regulator of health and adult social care in England. It replaced the Healthcare Commission, Commission of Social Care and the Mental Health Act Commission. Every year the Commission conducts patient surveys on the NHS Trusts throughout England. The survey is based on the Picker Patient Experience Questionnaire that has been validated across five countries in, Germany, Sweden, Switzerland and, Germany as well as the UK [37]. The dimensions of patients' experience in the Picker adult in-patient questionnaire are:

• Information and education

• Coordination of care

• Physical comfort

• Emotional support

• Respect fro patient preference

• Involvement of family and friends

• Continuity and transition

• Overall impression

The commission's patients survey compares the responses with previous years results and these reports are given back to the specific Trusts with comparison data from other Trusts. Trusts are expected to improve their performace because the Commission is the regulator and has a Judgement Framework and an Enforcement Policy.

Consumer input to improving mental health services has been recognised in the US with the development of the Consumer-Orientated Mental Health Report Card which is organised around prevention, access, appropriateness, and outcomes with consumer satisfaction included under each area and each of these areas is associated with indicators. The Mental Health Statistics Improvement Program [38] has taken the Consumer Orientated Mental Health Report Card and it has been adapted for use with inpatients, youths and families and translated into French and Spanish.

In an era when there is sustained political rhetoric in favour of consumers involvement in health care [39] the media's interest in critical contributions is limited, preferring to sensationalise issues as part of the production of news [40]. However the media does have a legitimate role to play in health policy and health services within democratic societies.

The media is significant in the relationship between health decision makers and patients, providing a communication channel influencing the demand and supply of medical treatments sometimes reagardless of evidence of effectivenss, providing a voice for whistleblowers and a platform for patient safety disasters to be exposed. In reporting medical errors the media often takes the simple approach of blaming those doctors who fail to live up to some imaged medical paragon [41], and missing the failures of the poorly developed and managed health systems that allow these mistakes to occur.

There have been situations in which the media has been involved in the ongoing exposure of major health system failures such as Dr Jayant Patel in Queensland [42], Sydney Morning Herald's coverage of the Cambelltown and Camden hospitals problems in 2004 [43], and The Guardian's report of Professor Bolsin's account of events at the Bristol Royal Infirmary in the 1990s [44]. Even the power of the press however, finds it hard to make much of an impression against the medical fraternity which is backed by the government. Most system failures take years to pass through the process of breakdown in patient safety, whistleblower, public exposure with the press, public inquiry and recommendations, to implementation of changes within the health system and system improvements to prevent the same problems occuring again. Not only does this process take years there are many casualities on the way as patients suffer and whistleblowers lose their jobs and their reputation's suffer as was the case with Professor Bolsin.

In 2002 the World Health Assembly urged the WHO and Member states to pay the closest possible attention to patient safety and in 2004 launched the WHO patient safety program with Sir Liam Donaldson as the WHO envoy for patient safety. The WHO definition of patient safety is simply: the absence of preventable harm to a patient during the process of healthcare. WHO patient safety has initiated two patient safety campaigns involving hand washing and a safety checklist to improve compliance with surgey standards and decrese complications.

One initiative of the WHO Patient Safety is Patients For Patient Safety (PFPS) [45]. Patient For Patient Safety (PFPS) is a collective voice of patients and consumers concerned about patient safety issues. This active process involves patients and consumers as partners in healthcare and operates in countries and globally.

4. The global burden of mental disorders

The global burden of mental disorders is considerable. The [46] reports that as many as 450 million people suffer from a mental or behavioural disorder, nearly 1 million people commit suicide every year, four of the six leading causes of years lived with disability are due to neuropsychiatric disorders (depression, alcohol-use disorders, schizophrenia,and bipolar disorder) and those suffering from a mental illness are also victims of human rights violations, stigma and discrimination both inside and outside public institutions. The gap between the need for treatment for mental disorders and resources available is greater in developing countries than in developed countries. In developed countries between 44% and 70% of patients with mental disorders do not recieve treatment, whereas in developing countries the treatment gap is close to 90%.

Disadvantages are accumulative in health and mental functioning is fundamentally connected to physical and social functioning and health outcomes. Depression is often associated with chronic physical illness and requires comprehensive treatment to achieve the best physical outcomes. The family bears the burden of a family member with mental illness but the extent of this burden is hard to quantify. Sometimes the stigma associated with mental illness extends to the family and causes isolation and discrimination.

Reputable sources such as the [46] report situations of mental patients being chained as a form of treatment. The New York Times in 2009 reported examples of abuse during psychatric treatment in Kings County Hospital [47]. The political abuse of psychiatry which is the misuse of psychiatric diagnoses and treatment to obstruct the human rights of individuals is well documented in a recent review by [48].

The huge treatment gap in mental health in developing countries requires innovative thinking rather than repeating the clinic or hospital based patient management by specialist mental health professionals as occurs in Western countries. Vikram Patel [49], a psychiatrist from the London School of Hygiene and Tropical Medicine, said that mental health care in developing countries needs to shift treatment to appropriately trained and supervised lay people. The precise model of care for mental health in developing countries depends greatly on the local health system factors and in particular the state of the general health system and the political commitment to public health [50]. A great deal has to be done about mental health advocacy and raising the priority of mental health with donor agencies.

There is a complex interaction between poverty and mental disorders. Mental disoders are costly in terms of treatment and loss of productivity. Other factors such as low educational levels, poor housing and malnutrition contribute to common mental disorders. Povery contributes to mental disoders and mental disorders contribute to poverty. Similarly, work education, violence and trauma are linked in a vicious cycle to mental disorders [46].

Traditionally underserved groups include those who are geographically remote, those of disadvantaged socioeconomically minorities, people with disabilities, women and indigenous people, lesbian gay and bisexual people and the aged. Developing mental health services to meet the needs of these diverse and underserved groups has recieved increasing

attention both globally with the Nations for Mental Health [51] final report (2002) and nationally.

The important issue about meeting the mental health needs of traditionally underserved groups is that no one approach is going to satisfy the needs of these widely diverse populations. However as research is acculmulating about health needs for these populations then strategies can be developed to promote mental health, prevent mental illness and provide treatments for early recovery and prevention of long term disability.

5. Quality in delivery of mental health services

Health services that deal with mental illness have not be subjected to the same scrutiny as have health services that deal with physical illness. There are many reasons for this, not the least of which is the social stigma associated with mental illness. Patients in general health services who experience poor care have avenues to complain and have their complaints dealt with so that services can be improved. Patients in mental hospitals have the burden of social stigma to negotiate before complaining about poor care. Also, many general health services struggle to provide culturally competent services. For sufferers of mental illness the cultural differences between providers and mental health consumers can be a barrier to treatment and recovery.

In 2002 President Bush in the United States set up the New Freedom Commission on Mental Health because the health system should treat people with mental illness with the same urgecny as a physical illness. Bush identified three barriers to excelelnt care for those with mental illness: the stigma attached to mental illness, unfair limits that stems from inadequate health insurance, and a fragmented system for delivering services. The Commission [52] produced its report and tied its 19 recommendations to six goals: building greater understanding among Americans that mental health is essential to overall health; mental health care is consumer and family driven; eliminating disparities in the delivery of mental health services; early mental health screening assessment and referral to services is common practice; excellent mental health care is delivered and research is accellerated; and technology is used to access mental helth care and information.

Goal 1

Building greater understanding among Americans that mental health is essential to overall health;

Recommendations

1. Advance and implement a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention

2. Address mental heatlh with the same urgency as physical health

Goal 2

Mental health care is consumer and family driven;

Recommendations

1. Develop an individualised plan of care for every adult with the sersious mental illness and for every child with a serious emotional disturbance

2. Involve consumers and families fully in orienting the mental health system towards recovery

3. Align relevant federal programs to improve access and accountability for mental health services

4. Create a comprehensive state mental health plan

5. Protect and enhance the rights of people with mental illnesses

Goal 3

Eliminating disparities in the delivery of mental health services;

Recommendations

1. Improve access to high-quality care that is culturally competent

2. Imporve access to high-quality care in rural and geographically remote areas

Goal 4

Early mental health screening assessment and referral to sesrvices is common practice;

Recommendations

1. Promote the mental health of young children

2. Improve and expand school mental health programs

3. Screen for co-existing mental and substance use disorders and link with integrated treatment strategies

4. Screen for mental disorders in primary health care, across the life span, and connect to treatment and supports

Goal 5

Excellent mental health care is delivered and research is accellerated;

Recommendations

1. Accelerate research to promote recovery and resilience and ultimately to cure and prevent mental illness

2. Advance evidence based practices using dissemination and demonstration projects and create public-private partnerships to guide implementation

3. Improve and expand the workforce providing evidence-based mental health services

4. Develop the knowledge base in four understudied areas: disparities in mental health care; long term effects of medication, trauma and acute care

Goal 6

Technology is used to access mental helth care and information

Recommendations

1. Use health and information technology to improve access to and coordination of mental health care, especially in remote areas and underserved populations

2. Develop and implement integrated electronic health record and personal health information systems

The recommendations of the Commision may not have been fully implemented [53]. It has been, however, a line drawn in the sand stating that the system to provide services to treat mental illness was a shambles and that the mental health maze had to be transformed starting from community perceptions of mental health and eradicating stigma associated with mental illness treatment. The stigma of mental illness is pervasive. It limits people seeking care, influences the provider-client realtionship and impacts public funding of mental heatlh services.

Simpson and House [54] conducted a systematic review about involving users in the delivery and evaluation of mental health services. They found that the few comparative studies of users' involvement that have been published indicate that involving users as employees, trainers, or researchers has no negative effect on services and may be of benefit.

The priority towards a limited biomedical model of medical training rather than an expanded bio-psycho-social model greatly impedes recognition of mental illness in primary health care. The biomedical model of medical education is reflective of the philosophy of medicine [55] and is reflective also of the dominance of physical acute health care in public funding of health services and health research.

In spite of the dominance of acute physical health care there have been some inroads made with mental health services as an area of academic interest. Although there are many journals that deal with mental health issues a smaller number deal specifically with mental health services. In 2006 the journal Mental Health Services Research combined with the journal of Administration and Policy in Mental Health under the editorship of Leonard Bickman to form Springer's Administration and Policy in Mental Health and Mental Health Services Research journal. Another Springer journal dealing with mental health services is the Journal of Behavioural Health Services and Research (JBHS&R).

6. Challenges to quality in delivery of mental health services and methods to overcome them

There is an argument that the escalating cost of mental health services reflects the need for these services. There is also the argument that the cost of mental health services reflects an

imbalance in budgetary allocation between treatment services and mental health promotion and mental illness prevention programmes. Knapp McDaid and Parsonage [56] presented an imposing economic argument for mental health prevention programs having a beneficial impact on the economic burden of mental illness over the long term. Fifteen interventions were modelled. These were a range of health interventions across the life span that had evidence of their effectiveness. Some of these interventions were: health visiting to reduce post natal depression, school based interventions to reduce bullying, school based social and emotional programmes to prevent conduct problems in childhood, early detection of psychosis, workplace screening for depression, population-level suicide awareness training and intervention, and tackling medically unexplained symptoms. The estimated economic pay-offs per £ of expenditure from each of the models varied, with the sector involved such as the NHS, other public sector bodies and non- public sector impacts and the timeline considered such as short term (in the first year) through to long term (year 6 and beyond). Early intervention for conduct disorders had a 7.89 return on inventment per £1 expenditure, suicide training course provided to all GPs had a 43.99 return and workplace health promotion programmes had a 9.69 return on investment.

Preventive mental health strategies targeting families, schools, and workplaces could be developed to promote healthy child development, resilience, personal achievement, healthy relationships, career satisfaction, work-life balance and healthy ageing. Secondary specialist care in mental health services is urban and needs to be expanded to meet the needs of traditionally underserviced consumers.

The major challenge to quality in delivery of mental health services is the adequate diagnosis and treatment of mental illness in the primary care sector of health care services. After analysing the results of the US National Comorbidity Survey Replication study, [57] found that most people with mental disorders in the United States remained either untreated or poorly treated. They recommended that interventions were needed that enhanced treatment initiation and quality.

The internet as a menal health intervention and prevention tool is being explored more as adults and youth integrate the internet into their daily lives. Obviously the use of the internet can eliminate the stigma associated with accessing a real world facility and therapist. Emental health service is defined as including 'all forms of electronic mental health services delivered over the internet, ranging from informational and educational products to direct services offered by professionals' [58].

Ybarra and Easton [59] provide an assessment of internet-based mental health interventions and were generally cautious but positive about their effectiveness. Transferring face to face mental health interventions to the internet presents challenges that have to be addressed. The health literacy level of the traditionally underserved populations which is usually lower than advantaged populations is an important issue that needs consideration, the marketing and presentation of mental health interventions will be in competition with the glitz of abundant websites, and the training of mental health professionals will have to change to encompass a different skill base that will be necessary for operating on the internet.

7. Conclusion

Mental health services lag behind general health services as far as seeking to develop a qual‐ ity management approach to the delivery of mental health services. The global burden of mental illness on individuals, families, communities and the public purse is enormous and is beginning to be recognised. Funding for mental health services is not proportional to the impact of mental illness. The disconnenct between the need for mental health services and the services available is related to the prioritisation of physical acute health over mental health. This prioritisation relfects cultural attitudes towards mental illness which generally encompass various forms of stigmatisation of mental illness and ostrasizing the people and sometimes the families of those who suffer mental illness.

There are some signs globally and nationally that reducing the stigma of mental illness will lessen the burden of mental illness. As part of a social justice approach, there are movements to be more inclusive towards the mental health needs of the traditionally underserved popu‐ lations. Prevention programs may have a beneficial impact on the economic burden of men‐ tal illness. The integration of the internet into the lives of so many people means that it may provide an opportunity for greater accessibility of more people to innovative mental health interventions.

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