Mental health is a general term used to refer, not only to the absence of the mental disorders but also to the ability of the individual to negotiate the daily challenges and social interactions of life without experiencing cognitive, emotional or behavioural dysfunction. Mental health and mental disorders can be affected by numerous factors ranging from biologic to genetic vulnerabilities, acute or chronic dysfunction, to environmental conditions and stresses. Recent research on the level of incapacity associated with mental disorders emphasises just how debilitating they can be. For example, the number of bed days and other disability associated with depression is comparable to or greater than that with eight major chronic medical conditions. Early identification, specific treatment and rehabilitation measures can significantly reduce the duration and level of disability associated with mental disorders, as well as decrease the likelihood of re-emergence of symptoms. Unfortunately, a very large population of individuals with mental disorders, including majority of those with depression, do not receive treatment. Though specific early identification, treatment and rehabilitation measures are available to reduce the levels of dysfunction in children and adolescents, majority of them do not receive appropriate services.

Many areas of biological research are rapidly advancing and providing exciting and encouraging results. Imaging technology has been applied in many mental disorders and has begun to elucidate structural and functional abnormalities. The rapid advances in our understanding of the biological correlates and causes of mental disorders is a positive sign for the development of prevention strategies in the future.

Psycho-pharmacological interventions have proven to be highly effective in the treatment of mental disorders and are in widespread use today. Psycho-social interventions can also improve the psychological well being during stressful life conditions. While programs to improve the developmental outcomes and reduce the effects of stressful life situations and experiences can lead to improvements in mental well being, an increased emphasis is needed to establish the effectiveness of interventions in understanding how they increase the quality of life of an individual.

MENTAL HEALTH SERVICES RESEARCH: DIRECTIONS

With impressive developments in molecular biology, the neurosciences, and imaging technology, psychiatry has moved toward a more biological and medical emphasis. Although these fields hold great promise, efforts must proceed in a balanced way to provide high quality management for those currently ill while seeking more powerful technologies for the future. The history of mental health can attest to how endorsement of organic viewpoints and the professionalism in psychiatry when it had little specific to offer in any immediate form, undermined constructive and humane efforts for patient management and rehabilitation. Hopefully, we will retain a broad perspective in the management of illnesses concomitant with the pursuit of increased biological understanding.

As psychiatry has moved away from the psychoanalytic formulation, it has focussed more attention on more careful classification and differential diagnosis, which contribute to clearer communication and consequent increase in the specificity of treat-
V. S. P. BASHYAM

Classificatory systems like ICD-10 and DSM-IV despite lacking a theoretical basis and depending on an arbitrary system of classification, have improved the overall clarity and uniformity of psychiatric practice, but it will be wrong to treat arbitrary classifications as realities. Much of the dogma of earlier periods that interfered with objective inquiry have been replaced by sophisticated conceptions of etiology and course, which demonstrate our limitations in the area of knowledge about the aetiology of many of the mental disorders.

Longitudinal study of schizophrenia completed in different countries, have demonstrated that the perception of the condition as one with a course of continuing deterioration and a pessimistic future is exaggerated. Long term studies demonstrate that there are a variety of possible outcomes ranging from patients having a single episode and returning to the pre-morbid level of functioning and returning to a reasonable functioning even after multiple episodes. Some studies have shown that the patients improve after being ill and disabled for 30 to 40 years.

It is not clear why clinicians have commonly perceived schizophrenia as a hopeless condition. It is to be accepted that a sub-set of patients with schizophrenia who are treatment failures return to the chronic care centres and occupy the beds for a number of years with continuing deterioration, and these may have influenced the conventional thinking about schizophrenia being a chronic illness with a downhill course. In some clinician's books a single episode with improvement may not qualify for a diagnosis of schizophrenia, and they wait for multiple episodes before making a diagnosis. This philosophy results in a classificatory system that implicitly includes bad prognosis as a criteria for diagnosis.

In the late 1960s WHO, using a standardised criteria for diagnosis carried out a collaborative study of 1202 patients selected from 9 countries (IPSS). One of the remarkable findings was a less favourable outcome in developed countries as compared to the developing nations. Some observers explained these differences in terms of family and social networks, labeling processes, and process of inclusion and exclusion criteria and exclusion of the disabled. Others were more skeptical and argued that patients from varying nations were not comparable.

Then in a second study, efforts were made to obtain a representative sample of new schizophrenic patients from ten countries. Sartorius et al monitored the defined population over a two year period to identify first contact with a helping agency because of psychotic symptoms, and they carefully identified patients in different cultures from the same criteria. Subsequent analysis showed that the symptom profile of schizophrenic patients in varying samples were similar. Again the investigators found that the outcomes were more favourable in the developing countries. In such countries 56% of the patients with schizophrenia had a much milder course over a two year period, whereas only 39% in the developed countries had a comparable outcome. The reasons remain highly speculative for this phenomena.

Many of the disabilities associated with long term illnesses can be contained by a good community management. In a review, Keisler and Sibulkin identify 14 experimental studies, most with random assignment, that compare community care with hospital treatment, where such alternative strategies compare favourably to hospital care across a wide range of patient populations and differing treatment methods. The optimal and most cost effective level of staffing for such programmes is still uncertain. It is quite likely to depend on the array of community resources already in place, the mix of the patients and the complex of the community. Many of the newly developed community care programmes are pragmatic and are oriented to the needs of the patients, for basic living skills and social support.

Given the success of some community programmes, one wonders why they have not been replicated in other settings in different countries in the past decades? The structure of financing and the lack of incentives are most commonly cited reasons and are certainly of importance. Financing provides the framework, but the success of community care also depends on the professional leadership, inter-agency communication and co-operation along with a supportive community environment.

There are no substantial professional rewards for community care efforts and managing a case of schizophrenia brings neither a high income nor prestige among one's colleagues. In addition, there is a good potential for blame when a patient becomes
MENTAL HEALTH SERVICES: IMPLEMENTATION AND EVALUATION

troublesome. For many professionals resistance and inertia is a comfortable stance. Over the years the effective institutionalisation of community care depends on its effective integration with professional training and recruitment.

LEGAL CONTEXT OF MENTAL HEALTH CARE

Since the 1990's, public interest litigation proponents devoted their energies to the mental health arena. Mental health lawyers had great expectations about the potentials of the legal reform. The hope that litigation could fundamentally shape the system of mental health services seems naive in retrospect. By directing attention to particular deficiencies, lawyers could induce service improvements but at the cost of neglecting other problems and discharging the patient from the protection of service systems. The degree to which the courts can direct state allocation of funds among competing priorities remains unclear.

Inspite of the enactment of the new Mental Health Act, many of the states have not translated the act into working rules in their respective states. The process of defining health needs is largely political. The ability to draw attention to the need, and evoke sympathy for patients and their families, depends substantially on the enthusiasm and the support mobilisation skills of the advocacy groups. Traditionally mental health advocacy has been weak for a variety of reasons. With mental health an almost exclusive public responsibility of individual states, it has been difficult to form a strong regional and national constituency. Moreover, the severely mentally ill have neither the personal resources nor the credibility to compete successfully with other interest groups and lobbies. Their families often avoid public identification with the cause, because of the perceived stigma, which prevents them from vigorous public participation also. There is an urgent need for sustained advocacy of mental health care like other health lobbies.

There are many contentious issues that cause concern for such kind of advocacy. They include:

1) Community care vs. revitalising the public institutions
2) Biological vs. social psychiatry
3) Drugs vs. psychotherapy
4) Psychology vs. psychiatry

and so on.

Many of the controversies are important and relate to the core issues of care, but our internal bickering and a running fight with the consumer advocates have diminished the effectiveness of our advocacy of the cause. Efforts have to be made to develop coalitions among competing mental health interests. A viable co-operative effort has not emerged in our country. It is high time the advocates of mental health interests, whether they are consumer protection groups or professional groups or voluntary organisations in the field of mental health came together to form a common front to present a united stance on the issues of mental health. It is to be accepted that it will be a herculean task to satisfy all the diverse groups interested in mental health delivery, but an effort must be made if this neglected sector has some say in the making of the policies and a just share of the funds for the health delivery system.

Although public mental health delivery services are significantly underfunded and neglected, at least the allocated funds should be used effectively by correcting the disorganisation of the service systems, streamlining the processes and establishing clear priorities used on the seriously and chronically mentally ill, for they are the most forsaken of the forsaken. Building a new and an integrated system requires a new financing and organisational strategies, such as the development of strong local mental health authorities and continuous team for case management arrangements.

EVALUATING THE EFFECTIVENESS OF MENTAL HEALTH CARE SYSTEMS

THE NEED FOR MEASURING

Mental health service delivery systems are complex and the complexity increases with the number and types of treatment modalities and service providers and their settings. There is a national need for better information on the properties of these systems. Reliable and valid measures of key mental health local delivery systems elements do not exist. A need exists for measures of service coverage, qual-
ity, comprehensiveness and system co-ordination or integration. Such an instrument should be simple and adaptable to a range of settings. These measures would contribute to knowledge of the consequences of inter-organisational relations and could help state and local officers to improve service delivery.

QUALITY OF CARE : HOW CAN IT BE ASSESSED?

Before we set out to assess quality we will have to choose whether we will adopt a maximal or optimal satisfaction of quality; if the latter, whether we shall accept what is the optimum for each patient or what has been defined as socially optimal ? We need to answer certain questions. Who is being assessed ? What are the activities being assessed ? How are these activities proposed to be conducted ? What are they meant to accomplish ? When we agree on the answers to these questions, we are ready to look for measures that will give us the necessary information about quality.

The information from which inferences can be drawn about the quality of care can be classified under 3 categories- structure, process and outcome. Structure denotes the attributes of the settings in which care occurs. This includes the attributes of material resources (such as facilities, equipments etc.), of human resources (number of qualified personnel etc.) and of organisational structure (methods of peer review). Process denotes what is actually done in giving and receiving care. It includes the patient's activities in seeking care and as well as the practitioner's activities in making a diagnosis or implementing treatment. Outcome denotes the effects of care on the health status of patients and populations. Improvements in the patient's knowledge and salutary changes in the patients behaviour are included under a broad definition of health status and so in the degree of patients satisfaction with care.

Because a multitude of factors influence the outcome, it is not possible to know for certain, even after extensive adjustments for differences in case mix are made, the extent to which an observed outcome is attributable to an antecedent process of care. Confirmation is needed by a direct assessment of the process itself.

The assessments of outcomes under rigorously controlled circumstances is, of course the method by which the goodness of alternative strategies of care is established. But quality assessment is neither clinical research nor technology assessment. It is almost never carried out under rigorous controls that a research requires. It is primarily an administrative device, used to monitor performance to determine whether it continues to remain within acceptable boundaries.

Beyond causal validity, which is the essential requirement, one is guided by attributes such as relevance to the objectives of care, sensitivity, objectivity, timelessness and cost. As a general rule it is best to include in any system of assessment elements of structure, process and outcome. These allow a supplementation of weakness in one approach by strength in another. It helps one interpret the findings, and if the findings do not seem to make sense, it leads to reassessment of the data itself.

It may be useful to say a few words about patient satisfaction as a measure of quality of care. Patient satisfaction may be considered to be one of the desired outcomes of care even an element in the health status itself. An expression of satisfaction or dissatisfaction is also the patient's judgement on the quality of care in all it's aspects, but particularly as concerns the interpersonal process. By questioning the patients one can obtain information about overall satisfaction and also about satisfaction with the specific attributes of interpersonal relationships, specific components of technical care and outcomes of care. In doing so, it should be remembered that unless special precautions are taken patients may be reluctant to reveal their opinions, for fear of alienating their attendants. Therefore, to add to the evidence at hand, information can also be sought about behaviours that indirectly suggest dissatisfaction.

ISSUES IN THE EVALUATION OF HUMAN SERVICE DELIVERY

Evaluation of human service delivery systems are difficult to accomplish to the satisfaction of either administrators or evaluators. Assuming human services programmes have definite, non-contradictory and measurable goals, then there are three points at which the treatment involved can be and should be evaluated.
MENTAL HEALTH SERVICES: IMPLEMENTATION AND EVALUATION

1) Is the treatment effective?
2) Can the treatment be delivered?
3) Is treatment being delivered?

Considerable efforts have gone into the measurement of human services delivery systems through interviews with clients. Client interviews are quite useful.

A treatment that is not being delivered or is being delivered in a defective way obviously cannot be effective, although correct delivery is not a guarantee of effectiveness.

A monitoring system is useful not only for evaluation but also for correcting administrative faults. A human service system administrator who does not know whether his program is operating as designed is obviously an inefficient administrator who has to operate largely in the dark.

I like to point out that the critical feature of human services is that they are highly operator dependent and difficult to standardize. Hence it is always problematic whether a treatment is being delivered as designed, whether the mode of delivery is adding some unintended treatment to the basic one, and finally whether a treatment can be delivered in a reasonable way at all by the typical human services organisations.

CONCLUSIONS

Compared to the previous decades, the past decade has been characterised by less rhetoric. We have seen greater appreciation of the tough realities of providing effective community based care to the seriously mentally ill persons. We understand better the complexities of organisation of service arrangements. Research technologies have advanced significantly, which promises great potential for the future. India has a fair pool of mental health professionals and they can form the basis of a highly effective mental health system. Mental health advocacy has been more active than before. Despite all these gains, all is not well in the mental health services. The public sector mental health delivery system suffers from significant underfunding. Building an integrated system requires new financing and organisational strategies. The focus should be on the seriously and persistently mentally ill and these patients should get necessary services.

I have sketched the steps to be taken in endeavouring to assess the quality of medical care. I hope it will be clear that there is a way, a path worn rather smooth by many who have gone before us. I trust it is equally clear that we have, as yet, much more to learn. We need to know a great deal more about the course of illness, with or without alternative methods of care. To compare the consequences of these methods, we need to have more precise measures of quantity and quality of life. Our criteria and standards need be more precise measures of quantity and quality of life. Our criteria and standards need be more flexibly adopted to the finer clinical peculiarities of each case. All these has to go on against the background of the most profound analysis of the responsibilities of the mental health professionals to the individual and the society.

V S. P. BASHYAM, M.D., D.P.M., Senior Professor & Head, Department of Psychiatry, Madras Medical College, Director, Institute of Mental Health, Chennai - 600 10 & Consultant, T.T.K. Hospital, Chennai.