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Review Article

Review and Analysis of mental health reforms in several countries: Implementation, comparison and future challenges

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Abstract

Mental health disorders affect people in all societies. In the past thirty years, countries have launched mental health program reforms to care for people affected by mental disorders, mental well-being and protection of human rights. This review presents a wide range of mental health reforms conducted in different countries, compares barriers, present trends for the future and highlight what can be learned from them. A literature review using Pubmed, Ebsco, world bank.org, OECD, Statistic Times and the WHO Mental Health Atlases for 2001, 2005, 2011, and 2017 databases was conducted. The results are presented in tables highlighting key elements comparing demographic information, healthcare professionals working in the mental health sector, policies, legislation and site of treatment in 19 countries. Crucial information is presented in four main themes: Legislation and Regulations; Mental health policies, plans and programs; Eliminating the custodial approach and stigma; and Deinstitutionalization/priority on community care and networks of care. Most mental health reforms began with deinstitutionalization without fully considering the infrastructure needed for community care, financing and the number of healthcare workers in the mental health sector. When initiating mental health reform policy makers should consider legislation, financial ability and establishing intermediate community services to facilitate rehabilitation.

Introduction

The leading cause of health-related disabilities worldwide, are mental health disorders [1]. More than 25 percent of the world population will experience mental and behavioral disorders. Mental disorders know no boundaries and affect individuals in all societies. In 2001, the World Health Report directed its focus to the neglect that mental health services have endured for decades. Mental health is imperative to the welfare of individuals, cultures and countries [1].

Over the past 30 years, several counties have launched mental health reforms with the goal of improving their mental health systems. The reform process in each country varies slightly, but most have focused on treating mental disorders within the primary care system, confirming that psychotropic drugs are accessible; moving from mental health hospitals to facilities within the community supported by psychiatric beds in general hospitals and home care; promoting campaigns for public awareness to defeat stigma and bigotry; including communities, families and consumers in the process of making decisions in regard to services and policies; initiating national policies, legislation and programs; educating mental health providers, and connecting mental health with other social sectors [2].

This article presents mental health reforms that were conducted in different countries around the world, compares barriers, presents trends for the future and highlights what can be learned from them.

Specifically, we conducted a review to address the core

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components of the main study objective and build on the literature review. The review objectives were to:

- Search for peer-reviewed journal articles and studies conducted by health organizations that address the research goals
- Assess the type and quality of the literature
- Assemble a body of knowledge on mental health reforms

Method

A review of the literature was conducted using Pubmed, Ebsco, world bank.org, OECD, Statistic Times and the WHO Mental Health Atlases for 2001, 2005, 2011, and 2017 databases. We initially searched the databases for titles or abstracts containing the following string "(mental health), (reform) AND (deinstitutionalization)". The search criteria were limited to studies published in English from January 1, 1990 to January 1, 2019. The reference lists of the studies included were searched by hand for additional relevant key terms. New key terms were identified "(legislation)", "(policies)" and the above databases were searched again and all relevant papers were added. All studies providing reviews on mental health reform, deinstitutionalization, legislation and national mental health plans were included. Exclusion criteria were studies concerning children (to age 18 years), commentaries and countries lacking data in English. Following review of abstracts and full-texts by the authors, they met with leading senior officials in the Israeli mental health system to discuss the available data.

The 19 countries that undertook mental health reforms were grouped according to geographical distribution: North and Central America (United States, Canada and Brazil), Australia, several countries in Europe (United Kingdom, The Netherlands, Sweden, Belgium, Spain, France, Germany, Italy, Greece), Asia (China, Japan and Russia), the Middle East (Israel and Saudi Arabia) and South Africa.

The information collected was then divided into four main themes. We sorted countries according to themes based on similarities in their reasons for initiating mental health reforms and they processes they undertook.

Our inspiration for the first two themes was derived from the WHO's Mental Health Atlas [3]. The following two themes were created based on important factors in our review of each country's mental health reform.

Each theme emphasizes different aspects of the reform. This enabled us to research and compare mental health reforms in different countries. The themes are:

Legislation and regulations. Mental health legislation contributes to the protection of human and civil rights for those with mental health disorders and concerns itself with facilities that provide treatment, personnel, professional training and service structure. It is comprised of provisions for protecting individual patients, as well as compulsory admissions and restraint, when necessary, and discharge criteria, among others [3]. Examples of service structure include the number of clinics, type and number of professionals available in each clinic and which treatments will be available.

Mental health policies, plans and programs. Policies generate accountability by providing norms to assess performance. Many national mental health policies specifically promote deinstitutionalization, which requires individuals to receive care in the community [4].

Mental health policies determine the vision for how the mental health of the population will be treated in the future, describing the framework that will be implemented to manage mental disorders. A thorough mental health policy will include coordination of essential activities and services to ensure that individuals in need receive appropriate care. It will also be structured to prevent fragmentation and inefficiencies in the healthcare system [2].

Eliminating the custodial approach and stigma. In 2001, the World Health Report stated that custodial mental hospitals should be phased out. In their place would arise community care facilities supported by psychiatric beds in general hospitals. Such community-based services can provide earlier treatment, which will lead to better outcomes and quality of life than that provided by institutional care. It can also help lessen the stigma of treatment. The process of dealing with this health and human rights issue and instituting the process of closing large psychiatric hospitals is occurring worldwide [2].

Deinstitutionalization/priority on community care and networks of care. A major focus of national mental health policies concerns deinstitutionalization. The United Nations [5] and the WHO [2] have stated that mental health care should be moved to community-based treatment facilities.

Networks of community facilities, including mental health centers, psychiatric units in general hospitals, day centers and residential facilities) will increase access to services [2]. Implementing networks of community services, where most individuals with mental disorders can be treated, including those in low- and middle-income countries is an essential component of increased accessibility [6].

The literature on healthcare reform from 1990 to 2019 is vast. A historical review of each reform traces differences in the process that occurred in each country, some going back to the late 1970s. We created tables of results, summarizing data highlighting, key similarities and differences in each country. Some countries lack published information in articles and mental health atlases and for that reason not available (NA) appears in the tables.

Results

The attached tables present key elements comparing countries around the world regarding demographic information, healthcare professionals working in the mental health sector, policies, legislation and site of treatment.

Table 1 includes each country's demographic, economic, financial information and type of healthcare system. Healthcare systems and mental health care funding vary.

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Table 1: Demographic Information by Country.

Country	GDP 2017	% GDP for health expenditure 2016 Data DALY'S* 2017 Data	Government mental health expenditures as % of total health expenditures	Income level	Health expenditures per capita 2016 Data		Population 2019 Data	Health care system	Mental health care funding	How most people with mental disorders pay for services
					Public	Private				
United States	$19.39 trillion	17.2% 4,128.45	Less than 0.05	High	$4860	$5032	328,215,096	Private/ Public Health Insurance	Private insurance, tax based, out of pocket expenditure by the patient or family	Pay at least 20% toward the cost of mental health services/ psychotropic medicines
Canada	$1.653 trillion	10.6%	NA	High	$3341	$1412	37,155,611	Health Insurance	Tax based, out of pocket expenditure by patient or family; private and social insurance	NA
Brazil	$2.056 trillion	6.2% 3,592.74	1.02%	Upper-middle	$549	$445	211,814,121	SUS Unified Health System	Tax based, social insurance, private insurance and out of pocket by patient or family	No cost (fully insured)
Australia	$1.323 trillion	10.4% 4,037.92	NA	High	$3190	$1270	8,758,439	Health Insurance	Tax based, private insurances and out of pocket by patient or family	No cost (fully insured)
United Kingdom	$2.622 trillion	9.7%	NA	High	$3320	$872	66,814,991	National Health Services	Welfare	No cost (fully insured)
The Netherlands	$826.2 billion	10.5%	NA	High	$4354	$1032	17,114,750	Health Insurance	Health Insurance	NA
Sweden	$538 billion	11.0% 3,806.48	NA	High	$4603	$884	10,026,659	National Health Services	Health Insurance, Welfare, Private	No cost (fully insured)
Belgium	$492.7 billion	10.4% 3,310.07	NA	High	$3740	$1100	11,539,635	Health Insurance	Taxes, Health Insurance	No cost (fully insured)
Spain	$1.311 trillion	9.0% 2,658.78	NA	High	$2293	$955	46,439,524	National Health Services	Health Insurance, Welfare, Private	No cost (fully insured)
France	$2.583 trillion	11.0% 3,700.67	15%	High	$3626	$974	65,387,004	National Health Insurance	Health Insurance, Welfare	No cost (fully insured)
Germany	$3.677 trillion	11.3% 3,603.56	11.27%	High	$4695	$856	82,389,429	Health Insurance	Welfare, Health Insurance, Retirement pension plans	No cost (fully insured)
Italy	$1.935 trillion	8.9% 2,765.89	3.50%	High	$2545	$847	59,246,882	National Health Services	Welfare	No cost (fully insured)
Greece	$200.3 billion	8.3% 3,417.48	NA	High	$1296	$927	11,134,029	National Health Insurance	National health insurance, private insurance	No cost (fully insured)
Russia	$1.578 trillion	5.6% 5,591.18	NA	Upper-middle	$825	$526	143,919,671	National Health Services	Taxes	No cost (fully insured)
Saudi Arabia	$683.8 billion	4.7% (2014) 2,916.55	4.0%	High	$18359 Private and public		33,910,146	National Health Services	National health insurance	Persons pay at least 20% towards the cost of mental health services / psychotropic medicines
South Africa	$349.4 billion	7.44% 3,191.01	3.0%	Upper-middle	$554	$595	577,796,62	Private/ Public Health Insurance	Private insurance, tax based, out of pocket expenditure by the patient or family	No cost (fully insured)
Israel	$350.9 billion	6.80% 2,756.59	3.37%	High	$1702	$1120	8,064,547	National Health Insurance	Special income-related health tax combined with general government revenues	No cost (fully insured)
China	$12.24 trillion	5.5% NA	NA	Upper-middle	$409	$324	1,418,173,743	National health Insurance	Health care is paid by employer and employee	NA
Japan	$4.872 trillion	7.15% 2,240.63	NA	High	$3801	$718	126,529,100	Universal public healthcare	Public insurance (30% coinsurance for services), private insurance	Persons pay at least 20% of the cost of mental health services/ psychotropic medicines

Note. *DALY, Disability-adjusted life years per 100,000; NA, Not available. Information contained in this table was taken from the following sources: World Health Organization, 2019; "StatisticsTimes.com | Collection of Statistics and charts," n.d.; "World Bank Group - International Development, Poverty, & Sustainability," n.d. ; "WHO | Mental Health Atlas 2011," n.d. ; "WHO | ATLAS country profiles on mental health resources 2001," n.d.

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Availability of mental health services varies according to income group in many countries. Those with high-incomes usually have better access, availability and options for specialized care, in comparison to patients in low- and middle-income countries. Care models differ accordingly, as well [7]. According to the WHO, every US dollar invested in improving treatment for common mental illnesses, such as depression and anxiety results in a return of $4 in better health and ability to work [8]. This should be considered when allocating funds for mental health care.

Mental disorders account for 13% of the global burden of disease, this number is expected to rise to almost 15% by 2030. Although the socioeconomic consequences are well-established, less than 1% of individuals in low-income countries with common mental disorders receive sufficient care and only 10% in middle-income countries, such as China. As many as 50% receive adequate care in most high-income countries [9].

As seen in Table 2, countries vary in the number of professionals working in the mental health sector. Provision of mental health care is based on the professionals in the field. Their numbers need to increase and they need additional training to ensure sufficient staff is available to provide specialized care and support the primary health care programs. Numerous developing countries lack sufficient numbers of these specialists to staff mental health services. Initial mental health care is best provided in the primary care setting, although specialists who can provide a broader range of services are lacking. A team of mental healthcare specialists would ideally include psychiatrists, psychologists, psychiatric nurses and social workers, and occupational therapists, who are able to collaborate to provide well-rounded care and help integrate patients in the community [2]. Moving to a primary healthcare base, requires staff who are trained in detecting and treating mental health disorders. Comprehensive training would require attention to primary health care workers who might be uncomfortable dealing with mental disorders. Thus, in addition to providing new skills, training should also encompass the potential reluctance of primary healthcare providers to work with individuals with mental health disorders [1].

Mental health legislation constitutes the legal provisions for protecting the basic human and civil rights of individuals with mental health disorders. Mental health legislation is the cornerstone of mental health reforms, planning policies and mental health programs [10]. As can be seen in Table 3, most countries have dedicated, stand-alone mental health legislation, and those who do not, address legal provisions concerning mental health care in other laws. The WHO [2] proposed a set of essential drugs for treating and managing mental and behavioral disorders. Most countries have a national therapeutic drug policy that provides mental health patients with pharmacological treatment [11].

The type of treatment facility in each country is affected by mental health policy, legislation, demographics, financial abilities, work force and infrastructure. As seen in Table 4, some countries have been able to provide community sites for long-term residential care, where others provide care in psychiatric hospitals or psychiatric units in general hospitals.

Table 2: Health Professionals Working in the Mental Health Sector (Rate Per 100,000 Population).

Country	Psychiatrists	Mental health nurses	Psychologists	Social workers	Occupational therapists	Other paid mental health workers
United States	10.54	4.28	29.86	60.34	40.76	78.14
Canada	12.61	65.0	46.56	NA	2.89	NA
Brazil	3.16	34.95	12.37	6.61	2.86	243.03
Australia	13.53	90.58	103.04	NA	7.65	0.02
United Kingdom[a]	11	104	9	58	NA	NA
The Netherlands[a]	18.77	132.26	15.05	NA	NA	87.52
Sweden	19.12	50.57	NA	NA	NA	NA
Belgium	20.06	125.69	10.46	17.43	NA	NA
Spain	9.69	2.87	NA	0.11	0.28	2.46
France	20.91	98.02	48.70	NA	1.39	NA
Germany	13.20	NA	49.55	NA	56.43	NA
Italy	5.98	23.49	3.80	2.59	2.94	11.54
Greece	5.80	12.75	8.78	3.46	1.83	37.02
Russia	8.84	NA	4.64	2.40	NA	NA
Saudi Arabia	1.34	10.66	2.03	3.95	NA	NA
South Africa	**1.52**	9.72	0.31	0.39	0.12	0.27
Israel	9.87	NA	88.09	NA	38.11	NA
China	2.20	5.46	NA	NA	NA	1.13
Japan	11.87	83.81	3.04	8.33	7.24	31.63

Note: Information contained in this table was taken from the following source: World Health Organization, 2019, except for[a] "WHO | Mental Health Atlas 2005," 2014; NA, Not available

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Table 3: Policy and Legislation.

Country	Government policy on mental health care	National mental health program/plan	National therapeutic drug policy	Legislation
United States	2010, revised in 2014 Mental health is mentioned in the general health policy.	2011, revised in 2016 The mental health plan includes timelines for implementation. Shift of services and resources from mental hospitals to community mental health facilities. Integrating mental health services into primary care.	Absent	Dedicated mental health legislation was initiated or most recently revised in 1992. Legal provisions concerning mental health are not covered in other laws. A stand-alone law for mental health does not exist.
Canada	1988, Mental health is mentioned in the general health policy.	2009, The mental health plan includes timelines for implementation. Funding allocation for implementing at least half of the items in the plan. Shift of services and resources from mental hospitals to community mental health facilities.	Absent	Each province can frame its own laws. All people in Canada are entitled to Charter of Rights and Freedom._
Brazil	1991, revised in 2011 components of the policy- APPTR.	1991, revised in 2011. The mental health plan includes funding for implementing at least half of the items in the plan. Shift of services and resources from mental hospitals to community mental health facilities. Integrating mental health services into primary care.	1978	2001, Dedicated standalone law for mental health focuses on human rights (conforms to International Human Rights laws), regulating involuntary treatment, regulating mental health services, admission and discharge procedures, housing, accommodation and employment facilities for patients.
Australia	1992, a stand-alone mental health policy was formulated in 2009 and revised in 2015.	Current National Mental Health Plan has four priority themes: mental health promotion and prevention of mental illness; increasing service responsiveness; strengthening quality; and fostering research, innovation and sustainability._	1991	Dedicated, standalone mental health legislation and legal provisions concerning mental health are also covered in other laws. The years vary because legislation in Australia is the responsibility of the 8 state and territorial governments
United Kingdom	1998, components of the policy- APPTR.	National Service Framework for Mental Health, 1999 and the NHS Plan, 2000 which has 3 major priorities: access to crisis resolution/home treatment teams, first episode psychosis will have access to intensive treatment for the first 3 years from early intervention teams, people with intensive needs will have access to assertive outreach teams._	1979	The Mental Health Act 1983, revised in 2007 is the main piece of legislation that covers the assessment, treatment and rights of people with a mental health disorder.
The Netherlands	1999, components of the policy- APPTR.	1999, describes the ideal mental health care sector and how to reach (or come close to) that ideal. Its principles include demand-driven care, effectively and transparently-organized care, deinstitutionalization, further development of locally organized mental health care and a logically configured professional structure.	Present, year of formulation NA	Dedicated mental health legislation was initiated or most recently revised in 2006. Legal provisions concerning mental health are also covered in other laws. 1994, The Psychiatric Hospitals Act, which protects patients' rights in cases of committal and compulsory treatment.
Sweden	2010, revised in 2016.	Revised in 2016, The mental health plan includes timelines for implementation. Funding allocation for implementing at least half of the items in the plan. Shift services and resources from mental hospitals to community mental health facilities. Integrate mental health services into primary care.	Absent	There is no standalone mental health law. Dedicated mental health legislation was initiated or most recently revised in 2016. Legal provisions concerning mental health are also covered in other laws such as the Assistance Compensation Act._
Belgium	1988, revised in 2010. The decentralized authorities (Flanders and Wallonia) have developed their mental health policies and are largely responsible for implementing their own mental health action plan.	2010, revised in 2014. The mental health plan includes timelines for implementation. Funding allocation for implementing at least half of the items in the plan. Shift services and resources from mental hospitals to community mental health facilities. Integrate mental health services into primary care.	Present, year of formulation NA	2014, Dedicated, standalone law for mental health legislation. Legal provisions concerning mental health are not covered in other laws.
Spain	1985, revised in 2015, components of the policy- APPTR.	2008, The mental health plan includes timelines for implementing the plan. Shift services and resources from mental hospitals to community mental health facilities._	1994	Dedicated, standalone mental health legislation does not exist. However, legal provisions concerning mental health are covered in other laws.
France	1960, revised in 2011, components of the policy- APPTR.	1985 revised in 2005. The mental health plan includes timelines for implementation. Funding allocation for implementing at least half of the items in the plan. Shift services and resources from mental hospitals to community mental health facilities. Integrate mental health services into primary care.	Present, year of formulation NA	1986, Dedicated mental health legislation, it was revised in 2010. Legal provisions concerning mental health are also covered in other laws. There is no stand-alone mental health law. Look for new article._
Germany	1975, revised in 2009, components of the policy- APPTR.	2009, The mental health plan includes timelines for implementation. Funding allocation for at least half of the items in the plan.	Details about the national therapeutic drug policy/ essential list of drugs are NA	Dedicated, standalone mental health legislation was revised in 2010. Legal provisions concerning mental health are also covered in other laws.

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Italy	1994, revised in 2013, components of the policy-APPTR.	1999 revised in 2013. The mental health plan includes integration of mental health services into primary care.	Details about the national therapeutic drug policy/ essential list of drugs are NA	Dedicated, standalone mental health law since 1978 known as the Historic Reform Law. It was revised in 2008. Legal provisions concerning mental health are also covered in other laws.
Greece	1983, revised in 2016, components of the policy-APPTR.	2010, revised in 2016. The mental health plan includes shifting services and resources from mental hospitals to community mental health facilities.	1998	Dedicated, standalone mental health legislation was revised in 1999.[4,21] Legal provisions concerning mental health are also covered in other laws. Law 2716/99 is exclusively for mental health and legislates a wide range of community services and refers to sectorization, protection of rights, psychosocial rehabilitation and social inclusion.
Russia	1992, revised in 2016, components are promotion, prevention, treatment and rehabilitation.	The mental health plan includes timelines for implementing the plan, shifting services and resources from mental hospitals to community mental health facilities and integrating mental health services into primary care.	1993	1992, Dedicated, standalone mental health legislation was revised, in 2016. Legal provisions concerning mental health are also covered in other laws.
Saudi Arabia	1989, revised in 2011, components of the policy-APPTR.	Formulated in 1989 and revised, in 2007. The mental health plan includes timelines for implementation. Funding allocation for implementing at least half of the items in the plan. Shift services and resources from mental hospitals to community mental health facilities. Integrate mental health services into primary care.	1988	2006, Dedicated, standalone mental health legislation was revised in 2016. Legal provisions concerning mental health are also covered in other laws.
South Africa	1997, revised in 2013, components of the policy-APPTR.	exists and was approved in 2009 and revised in 2013. The mental health plan includes timelines for implementation. Funding allocation for implementing at least half of the items in the plan. Shift services and resources from mental hospitals to community mental health facilities. Integrate mental health services into primary care.	1998	Dedicated, standalone mental health legislation was revised in 2002. Legal provisions concerning mental health are also covered in other laws.
Israel	1991, revised in 2012, components of the policy-APPTR.	The mental health plan includes timelines for implementation. Funding allocation for implementing at least half of the items in the mental health plan. Shift services and resources from mental hospitals to community mental health facilities. Integrate mental health services into primary care.	1994	1991, revised in 2014 Dedicated, standalone mental health legislation. Legal provisions concerning mental health are also covered in other laws.
China	1987, revised in 2015, components of the policy are prevention, treatment and rehabilitation.	Formulated in 1992 and revised in 2010, the mental health plan includes timelines for implementation. Funding allocation for implementing some items in the plan.	1995	Revised in 2013 Dedicated, standalone mental health legislation exists.
Japan	1950, revised in 2014, components of the policy-APPTR.	1950, revised in 1995 and 2009. The mental health plan includes timelines for implementation and shifting services and resources from mental hospitals to community mental health facilities.	Absent	Enacted in 1950 and reviewed every 5 years. It was modified to the Mental Health and Welfare Law of 1995, wherein it provided the legal basis to perform adequate treatment (including voluntary) and prevent abuse, and supported adopting community care. Dedicated, standalone mental health legislation was revised in 2016. Legal provisions concerning mental health are also covered in other laws.

Note. Information contained in this table was taken from the following sources: **United States,** WHO, 2011; WHO, 2016; WHO, 2019; **Canada,** WHO, 2013; WHO, 2016; WHO, 2019; **Brazil,** WHO, 2011; WHO, 2013; Fagundes Júnior, Desviat, & Silva, 2016; WHO, 2016; WHO, 2019; **Australia,** WHO, 2013; Shen & Snowden, 2014; WHO, 2016; WHO, 2019; **United Kingdom,** WHO, 2016; **Netherlands,** Shen & Faber, 2001; WHO, 2011; WHO, 2016; **Sweden,** Stefansson & Hansson, 2001; WHO, 2013; WHO, 2016; WHO, 2019; **Belgium**; Whiteford & Buckingham, 2005; WHO, 2013; Shen & Snowden, 2014; WHO, 2016; **Spain,** United Nations General Assembly, 1991; (Tse, Ran, Huang, & Zhu, 2013); WHO, 2013; WHO, 2016; WHO, 2019; **France,** WHO, 2013; WHO, 2016; WHO, 2019; **Germany,** WHO, 2011; WHO, 2013; WHO, 2016; WHO, 2019; **Italy,** Bauer, Kunze, Von Cranach, Fritze, & Becker, 2001; WHO, 2011, WHO, 2013; WHO, 2016; WHO, 2019; **Greece,** WHO, 2011; Giannakopoulos & Anagnostopoulos, 2016; Thornicroft, Deb, & Henderson, 2016; WHO, 2016; WHO, 2019; **Russia,** Poloshij & Saposhnikova, 2001; WHO, 2011, WHO, 2013; WHO, 2016; WHO, 2019; **Saudi Arabia,** WHO, 2011; Koenig, Al Zaben, Sehlo, Khalifa, & Al Ahwal, 2013; WHO, 2013; WHO, 2016; WHO, 2019; **South Africa,** WHO, 2011; WHO, 2013, WHO, 2016; WHO, 2019; **Israel,** WHO, 2011; WHO, 2013; WHO, 2016; WHO, 2019; **China,** WHO, 2013; Shen & Snowden, 2014; WHO, 2016; WHO, 2019; **Japan,** Tse et al., 2013; WHO, 2013; WHO, 2016; WHO, 2019
APPTR, advocacy, promotion, prevention, treatment and rehabilitation; NA, not available

The number of acute care beds for in-patients per 100,000 people varies greatly. China has the lowest number, at 9.95 and Belgium has the highest number at 174. The WHO has stressed the significance of providing mental health treatment in the community, close to where the patient lives [2].

Most in-patient psychiatric care is provided by psychiatric hospitals or psychiatric units in general hospitals (although the number of beds has decreased). The world trend in mental health reform is moving in the direction of new models of in-patient mental health care, positioned mainly in general hospitals, and most reforms are aimed at decreasing the number of psychiatric hospitals.

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Discussion

This article presents mental health reforms that were conducted in different countries around the world. It compares barriers, presents trends for the future and highlights what can be learned from them.

Theme 1: Legislation and Regulations.

As seen in Table 3, most countries have established mental health legislation. Italy, a pioneering country in mental health legislation began its mental health reform in 1978. It used legislation to abolish the practice of custodial psychiatry [12]. Italy has an independent body that assesses how well mental health legislation complies with international human rights, regularly inspects facilities and regionally reports annually [3]. Like Italy, many countries, including Saudi Arabia, Israel and Japan use dedicated legislation and annual inspections of compliance with mental health legislation and facility inspections [3]. Brazil, Australia, Belgium, Germany, Greece, Russia and South Africa have dedicated, stand-alone laws for mental health legislation and a dedicated authority or independent body to assess mental health legislation compliance with international human rights, which provides random inspections of facilities and partial enforcement of mental health legislation [3]. The United States, Spain, Sweden and France do not have stand-alone mental health legislation. Mental health is covered in other laws and assessment of compliance to mental health legislation is irregular or non-existent [3].

Theme 2: Mental health policies, plans and programs. Most countries have initiated governmental policies regarding mental health care during the past 30 years. As seen in Table 3, the main components of these policies are advocacy, promotion, prevention, treatment and rehabilitation. Dedicated mental healthcare policies have been devised by most countries. The United States and Canada do not have stand-alone mental health policies; yet, it is categorically cited in the general health policies [13].

Countries participating in the WHO's Mental Health Atlas have similar mental health plans and programs in that they focus on timelines for implementing the report, allocating funds to implement at least half of the elements of the program, shifting services and resources from hospitals to the community facilities and integrating mental health services into primary care [13].

Several countries have highlighted different priorities in their national mental health plans. Australia's priority themes include promoting mental health, preventing mental illness, increasing the responsiveness of service, enhancing quality, nurturing research, innovation and sustainability [3].

The United Kingdom's National Mental Health Plan has three priorities: access to crisis resolution/home treatment teams, access to intensive treatment for the first three years will be provided to patients with a first episode if psychosis from early intervention teams, and patients with strong needs will have access to assertive outreach teams [3].

The Netherlands' fundamentals include demand-driven care, organized care that is effective and transparent, deinstitutionalization, additional development of mental healthcare at the local level and a logical professional organization [3].

Theme 3: Eliminating the custodial approach and stigma

A custodial approach perpetuates the stigma surrounding seeking treatment for mental health [2]. The current status of each country can be seen in Table 4. It includes the number of beds in psychiatric units contained within general hospital, community mental healthcare centers, sites of long-term residential care, etc.

United States. Throughout the 19th century, US mental health policy was focused on treating patients with the most severe and long-term problems. This led to the development of asylums, a state-run facility providing sanctuary, comprehensive therapies and human custodial care for individuals with impaired mental health. By the 1950s, the quality of care in the asylums deteriorated due to financial difficulties and a new shift towards psychoanalytic and pharmacologic therapies emerged. These changes opened the doors of the state asylums, and allowed patients the right to receive treatment in community-outpatient facilities [14].

Germany. The country's well-known reputation in the field of psychiatry declined drastically following the mass murders of about 200,000 people with mental illness during World War Two. Germany began to transition r from providing mental healthcare in large asylums to an approach based on therapy and rehabilitation in 1968, after public reactions to the state of mental health. An expert commission of psychiatrists from East and West Germany reported on the condition of mental health care. In-patient care was essentially provided by approximately 130 psychiatric hospitals, with an average of 1,200 beds each, with some containing up to 3,000. Most were in disrepair and 70% of admissions were compulsory. The trend in Germany is to decrease the size of psychiatric hospitals while constructing a parallel system of psychiatric units in general hospital [15].

1. *Italy.* Psychiatric reform was one of the most profound endeavors to remove the practice of custodial psychiatry by applying legislation. Psychiatric reform legislated in 1978 had four major objectives:Gradually close all psychiatric hospitals and prohibit any new admissions.

2. Establish small psychiatric wards (maximum 15 beds) in general hospitals.

3. Construct community-based mental health centers that would provide psychiatric care to specific geographic areas.

4. Define specific regulations and procedures for compulsory admissions.

In 2017, Italy had 8.96 acute beds in general hospital psychiatric units per 100,000 inhabitants; one of the lowest numbers of psychiatric beds in Europe [15].

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Table 4: Treatment Facilities.

Country	Acute in-patient beds per 100,000 population Data 2014 (WHO)	Number of mental hospitals (Atlas-17)	Number of beds in mental hospitals per 100,000 (Atlas-17)	Number of general hospital psychiatric units (Atlas-17)	Number of beds in general hospital psychiatric units per 100,000 (Atlas-17)	Long-term residential care	Acute in-patient care	Community mental healthcare centers
United States	11	605	18.66	1117	11.14	General hospital psychiatric units, private psychiatric hospitals, supported housing, group homes	General hospital psychiatric units, psychiatric hospitals, residential care facilities, forensic inpatient units	600 affiliated with hospitals
Canada	37	NA	NA	NA	NA	General hospital psychiatric units, psychiatric hospitals, housing for long stay residential treatment	General hospital psychiatric units, psychiatric hospitals	Number of facilities NA
Brazil	27.7	146	9.79	236	0.56	General hospitals, psychiatric hospitals, community residential facilities, family care at home,	General hospital psychiatric units, psychiatric hospitals, residential care facilities, forensic inpatient units	615 attached to a hospital 2232 nonhospital community facilities
Australia	62	17	7.21	143	21.76	General hospital psychiatric units, psychiatric hospitals, Residential mental health care	General hospital psychiatric units, psychiatric hospitals, residential care facilities, forensic inpatient units	Number of facilities NA
United Kingdom	46	NA	NA	NA	NA	General hospital psychiatric units, psychiatric hospitals, hostels, group homes, supported housing	General hospital psychiatric units, some psychiatric hospitals	Number of facilities NA
The Netherlands	139	NA	NA	NA	NA	Psychiatric hospitals, staffed group homes at psychiatric hospitals in the community	Psychiatric hospitals are more common than General hospital psychiatric units	Number of facilities NA
Sweden	45	NA	31.10	NA	NA	General hospital psychiatric units, nursing homes	General hospital psychiatric units	Number of facilities NA
Belgium	174	53	98.88	63	22.71	General hospital psychiatric units, psychiatric hospitals,	General hospital psychiatric units, psychiatric hospitals	Number of facilities NA
Spain	36	85	28.15	477	14.31	Psychiatric hospitals, nursing homes, supported housing, family	Psychiatric hospitals and General hospital psychiatric units	358 affiliated with hospitals 589 non-hospital community facilities
France	90	NA	6.98	NA	22.34	General hospital psychiatric units, psychiatric hospitals, community residential facilities	General hospital psychiatric units, some psychiatric hospitals, private hospitals	Number of facilities NA
Germany	128	274	55.70	401	80.64	General hospital psychiatric units, psychiatric hospitals, community residential facilities	Psychiatric hospitals and General hospital psychiatric units	63 affiliated with hospitals Number of nonhospital community facilities NA
Italy	10	0	0	354	8.96	General hospital psychiatric units, community residential facilities	General hospital psychiatric units	317 affiliated with hospitals 1,114 nonhospital community facilities
Greece	71	3	10.65	37	5.70	General hospital psychiatric units, psychiatric hospitals, community residential facilities	General hospital psychiatric units, psychiatric hospitals, residential care facilities, forensic inpatient units	63 affiliated with hospitals 34 nonhospital community facilities
Russia	101	195	93.03	NA	NA	Psychiatric hospitals, nursing homes, family	Psychiatric hospitals	3,356 affiliated with hospitals NA number of nonhospital community facilities

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Saudi Arabia	12.5	25	17.11	4	0.32	General hospital psychiatric units, psychiatric hospitals, community residential facilities	General hospital psychiatric units, psychiatric hospitals,	25 affiliated with hospitals 4 nonhospital community facilities
South Africa	18	64	16.56	40	4.33	General hospital psychiatric units, psychiatric hospitals, community residential facilities	General hospital psychiatric units, psychiatric hospitals,	61 affiliated with hospitals NA number of nonhospital community facilities
Israel	44	13	35.23	11	4.18	Private psychiatric hospitals, general hospital psychiatric units, family	General hospital psychiatric units, psychiatric hospitals,	Number of facilities NA
China	9.95	949	24.29	NA	NA	Private psychiatric hospitals, general hospital psychiatric units, family	Private psychiatric hospitals, general hospital psychiatric units	NA
Japan	281	10640	196.63	576	66.15	General hospital psychiatric units, psychiatric hospitals, community residential facilities	General hospital psychiatric units, psychiatric hospitals,	2,767 affiliated with hospitals 6,481 nonhospital community facilities

Note. Information contained in this table was taken from the following sources: World Health Organization, 2019; "WHO information gateway," n.d.
NA, Information not available. Data do not include outpatient facilities specifically for children and adolescents (including services for developmental disorders) and other outpatient facilities (e.g. mental health daycare or treatment facility)

Saudi Arabia. Among traditional Arabs, there is a stigma toward seeking mental health services. Many Muslim Arabs think that only "crazy people" seek mental health services and consider them ineffective. In addition, pursuing mental health services may negatively impact future marital prospects, and may lead husbands to divorce their wives or take another wife. Men also tend to resist searching for mental health services because seeking help from a psychiatrist can be seen as weakening their masculinity and reducing their sense of being the head of the family and the protector. Over the last 30 years, major strides have been made in the field of mental health. These can be seen in the number of psychiatric hospitals, which have increased nine-times, and psychiatrists ten-times. The numbers of psychiatric nurses, psychologists and social workers have increased as well. The establishment of community based mental health centers is well underway [16].

Israel. The mental health insurance reform was launched in July 2015, when responsibility for treating patients with mental illness was transferred from the government to the four nationally mandated health maintenance organizations. The previously existing pre-reform division between physical and mental health caused a significant disparity in service availability, expensive private care and stigma [17]. Structural changes, do not address stigma, but may lower the impact. Therefore, psychiatric services were moved to new locations where they were less visible and more accessible [18]. A main goal of the mental health reform was to link physical health and mental health and by doing so reduce stigma.

Japan. Mental illness has evoked great stigma. In the 1950s, most patients did not receive any care and were mainly confined at home. In the 1960s, many private psychiatric hospitals were developed and hence, patients were treated in hospitals and not in the community. The initial process of mental health reform in Japan is focusing on reducing the average length of stay and creating community care facilities [19].

Theme 4: Deinstitutionalization/priority on community care and networks of care.

Deinstitutionalization is a crucial element of national mental health policies. The United Nations [5] and WHO [2] have both stated that mental healthcare should be moved from hospitals to community-based treatment centers.

In the *United States*, there has been an increase in the number of emergency room visits due to the limited access to mental health care [14]. The development of community mental health care in the US has not reached the point where all mental health patients have access to care. The US differs greatly from other mental health reforms since community services are lacking and most people cannot afford what is available due to the cost of private insurance plans [14]. *Canada's* mental health care has moved from hospitals to the community, supporting primary mental health care. The reform improved primary care services by creating adult primary care teams to increase access to mental health services [1]. *Brazil* is in the process of deinstitutionalizing and incorporating psychosocial care centers and therapeutic homes for long-term patients [20]. *Australia*, thirty years of deinstitutionalization has reduced the number and size of stand-alone psychiatric hospitals, which have been replaced by acute beds in general hospitals and an array of community-based services [21]. In the *United Kingdom*, deinstitutionalization has been accomplished by closure of large asylums and the development of community-based services. Yet, there are still difficulties such as staff turnover, dissatisfaction of patients and caregivers with emergency services and social exclusion due to stigma [22]. In the *Netherlands*, mental health reform brought about deinstitutionalization and downsizing of psychiatric hospitals and introduced integration of ambulatory services, community mental health centers and sheltered housing [23]. Since the 1960s, *Sweden* has focused on closing large mental hospitals; yet, the establishment of alternative

psychiatric treatment was rare. Although the policy of the national board was intended to reinforce outpatient services, there are still obstacles between social services and psychiatric services [24]. In contrast to most reforms, *Belgium's* mental health care delivery reform was built on establishing networks of mental health services designed to provide extensive care to all mental health adult service users. Networks of care provide five basic care functions: Prevention, early detection and primary care for mental health disorders, outreach and crisis intervention, a process of recovery and social rehabilitation, intensive residential treatment for acute cases and long-term care and housing facilities [25]. *Spain's* mental health reform produced a significant decrease in the total sum of beds and psychiatric hospitals. The number of psychiatric units in general hospitals increased and the development of new forms of community care have been developed [26]. Primary care teams in the field of mental health have established policies to identify and manage mental illness. Primary care in Spain has established itself as the main avenue of access to specialized psychiatric care. Following decentralization of mental health centers, intermediate community services, including day centers, sheltered accommodations, rehabilitation units, etc. were created [27]. According to research conducted in Spain, there is a need to develop median community services and programs for rehabilitation and resettlement in society [26]. In contrast, *France* shifted from psychiatry to mental health by decentralizing the mental health policy. A number of steps helped establish community-based psychiatry, such as a change in the medical approach, in that psychiatrists work with other specialists [28]. Hospital-based care is still very important and is identified with under development of community services and inadequate sheltered housing for the most disabled patients [29]. Pre-reform *Germany* had a 70% rate of compulsory admissions, with an average length of stay of almost a year. More than 80% of treatment took place in closed wards. Since the process of mental health reform, psychiatric hospitals have downsized 50% of their beds and one psychiatric hospital has been closed [15]. There has been a development of out-patient community integrated mental health care programmers and residential services as well as building of general hospital psychiatric units [30]. *Italy* is one of the pioneering countries for mental health reform. It is most well-known for the process of deinstitutionalization, when it passed legislation in 1978 banning psychiatric hospitals. Today there are only forensic psychiatric hospitals in Italy. All psychiatric beds are in specialized wards in general hospitals [12]. In *Greece*, the deinstitutionalization portion of the mental health reform focused on reducing the average number of hospitalizations by 40%, deinstitutionalizing psychiatric patients with chronic conditions, reducing admissions to mental hospitals, refurbishing and reforming mental hospitals and training mental health professionals. The reforms aspect of community care promoted mental health in the community by creating decentralized community networks of preventive, specialized treatment, community interventions against the stigma, and rehabilitation services [31]. In *Russia*, psychiatric hospitals provide treatment. Psychiatric outpatient care is provided by a system of psychiatric care dispensaries. Russia believes that due to pharmacotherapy, psychotherapy and social support, the need for psychiatric beds will decrease. Their goal is to slowly build general hospital psychiatric units [32]. In 1983, there were few beds to treat psychiatric patients in *Saudi Arabia*. Over time, the number of psychiatric hospital beds, general hospital psychiatric units and community health care centers have increased [16]. In *South Africa*, mental health services reforms include down-sizing psychiatric institutions and developing community-based services [33]. Israel has fewer psychiatric beds per capital in general hospitals compared to most developed countries. However, the trend, like other countries, is to allocate more beds in general hospitals. Consistent with international trends, psychiatric beds have been reduced in psychiatric hospitals. There has been an increase in community-based mental health services, as well as public mental health clinics and rehabilitation services involving hostels, independent housing, social clubs and others [17]. During the Cultural Revolution in *China* from 1966-1976, community mental health programs almost disappeared entirely. The economic reform in the 1980s encouraged hospitals to be profitable and part of the economy. Mental health facilities, that were financially dependent were either converted to small psychiatric hospitals or closed. In China, one may access tertiary psychiatric hospitals directly, bypassing the primary and secondary healthcare levels. Towards the end of the 1990s doubt began to rise in the minds of some psychiatrists concerning the justification for large hospital-based, profit-making models for mental health services. The Ministry of Health began reassessing the principles and approaches to mental health care. Through advocacy by senior ministry officials a national mental health plan was formulated and first initiated in 2002-2010 [34-41]. Like many other countries, *Japan* is slowly shifting care from hospitals (institutions) to communities, closer to the patient's home. The belief in Japan is that implementing deinstitutionalization gradually will have the advantage of continuing to learn from the experience of other countries [4].

Limitations

This review had several limitations that need to be addressed. Several countries lack sufficient publications in English; therefore, the bulk of data for those countries was obtained from the WHO's Mental Health Atlases. Most of the countries' publications presented a current snapshot on the state of mental health with insufficient information regarding estimates for future costs, scope of future service consumption, and changes that are needed to continue promoting and assimilating mental health. For these reasons, future research in this field is required.

Conclusions

According to the findings of this review, the foundation for all mental health reforms has been based upon the importance of community psychiatry. The following actions have been incorporated in all mental health reforms: Deinstitutionalization, developing community mental health services and integrating primary care in mental health.

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This review found that most mental health reforms began with the process of deinstitutionalization without fully taking into account infrastructure for community care, financing and the number of health professionals working in the mental health sector.

Based on our findings, a number of steps should be considered when initiating mental health reform.

1. To enact change in the field of mental health, legislation must be present or developed to ensure the provision of human rights. Governments must be part of the process to establish policies and to allocate funds for treatment facilities, personnel, professional training and service structure. Policies generate accountability in that they offer a standard against which government performance can be assessed.

2. An essential step is thinking about the countries' financial abilities and budgetary constraints. When considering budgetary constraints, a country can set priorities, choose a model of care in relation to high-, middle- or low-income countries and establish which services will be provided.

3. It is crucial to the overall well-being of patients with mental disorders to establish intermediate community services which facilitate rehabilitation and integration back into the community and by doing so minimize stigma.

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