



## **HUMAN RESOURCES AND TRAINING FOR MENTAL HEALTH**

### **Rationale: Present Challenges for Mental Health**

#### **The burden of disease and the lack of human resources and services**

While Human Resources (HR) are the most valuable asset of a mental health service, major difficulties are frequently encountered in the planning and training of personnel for mental health treatment and care. Many countries having few trained and available human resources, and often face distribution difficulties within the country or region (e.g. too few staff in rural settings or too many staff in large institutional settings). Moreover, staff competencies may be outdated or may not meet the population's needs. In addition, the available personnel may not be used appropriately and many of the staff may be unproductive or demoralized, and experience burnout. This situation clearly demands that mental health, and more specifically HR and training for mental health, be given significant importance on the public health agenda of countries.

### **The need for changing models of mental health care**

#### **Main Elements and Implications from a Human Resource Perspective: Towards a more Holistic and Accessible Care for All.**

During the past 50 years, mental health care has undergone major changes towards community-based care in some countries. Institutionalised mental health care systems limited to a few large mental asylums in the main urban areas, disconnecting hospitalized people with mental disorders from their family and community, and run by a small number of overburdened health workers are no longer acceptable.

Worldwide, a **widespread need remains in many countries for a radical in depth shift in models of mental health care**, not only in the organization of services but in the mental health care paradigm itself and in the fundamental function and training of human resources for mental health.

#### **2.1. Main elements of changing models of mental health care**

■ **Community focus and deinstitutionalization** is being made possible largely by innovations in treatment interventions, and is being encouraged by the growth of the human rights movement concerned with gross violations of basic human rights in mental asylums (WHO, 2003b; WHO, 2005c). This has substantial implications for the Human Resources planning, training and management perspective (WHO, 2005a) in Mental Health, including:

- \* A reallocation of health staff from institutions to community-based service settings and from urban to remote, rural areas.
- \* Among health staff, the development of a new set of competencies for work in community-based settings, and a new emphasis on recovery and rehabilitation in hospital settings;





- \* The recruitment and training of a wider range of workers (for informal community care and primary care) in mental health; and
- \* The reform of associated models of training, in keeping with new, evidence-based care and new policies directions for changing paradigm in mental health care.

■ **Integration of mental health with general health care** is an important strategy for increasing access of underserved populations to mental health care, particularly in countries with acute shortages of mental health professionals. Furthermore, mental disorders and physical health problems are closely associated and often influence each other, therefore by integrating mental health into general health care, overall health outcomes will be improved (WHO, 2003c).

This too has multiple implications for human resources (WHO, 2005a), mainly the following:

- \* The need for training general health care staff in basic mental health competencies, to enable them to detect mental disorders, provide basic care and refer complex cases to specialist services;
- \* The need to train mental health specialists to work collaboratively with general health workers, and to provide them with supervision and support.

■ **Addressing stigma and discrimination** in HR development and training. People with mental disorders face stigma and discrimination in all sectors of society, including by the health-care workforce (WHO, 2003b; WHO, 2005c). Stigmatizing attitudes can be an important barrier preventing people with mental disorders from accessing or receiving the care they need. Although the recent move towards deinstitutionalization, the integration of mental health services into general health care and the development of community services, are expected to have a positive impact on stigma and discrimination towards people with mental disorders (in health care settings), training and management of health workers on these specific issues are essential. It is also important to address stigma among non health personnel (e.g. police, school teachers, social workers) who are often the first point of contact for people with mental disorders.

■ **Multidisciplinary approaches within the health sector.** In order to take into account of the many facets of mental health, care should no longer be delivered by any one mental health professional alone but by a multidisciplinary team including psychiatrists, psychologists, nurses, general practitioners, occupational therapists and community/social workers sharing their expertise and working in collaboration, each with their own roles and responsibilities (The Sainsbury Centre for Mental Health, 1997).

This multidisciplinary approach must also actively involve (when possible) **traditional healers** in collaboration for prevention, early detection and appropriate referral but also for care, treatment and follow-up.





Finally, as the boundaries between the “**private**”, “**public**” and “**not for profit sectors**” are increasingly becoming blurred in many countries it is also essential that HR planners and policy-makers within the public sector develop a pragmatic and holistic approach, with the aim of building partnerships between these 3 sectors.

### ■ **Intersectoral collaboration with non-health sectors.**

➔ In addition to multidisciplinary approaches within the health sector, **collaboration with other, non-health, sectors** is necessary. People with mental disorders have multiple needs related to health, welfare, employment, criminal justice and education. Thus the promotion of mental health within a country should cover a broad range of sectors and stakeholders, and should not be limited to the activities of the ministry of health. Improving the skills and knowledge of informal community mental health providers (both non health professionals and non professionals workers) in mental health management would also have a very positive impact in terms of prevention, early detection and appropriate referral, community integration, reduction of stigma and discrimination attached to people with mental disorders and improvement of their rights (among others).

Partnerships should also be developed with **NGOs** which can provide useful resources in terms of competencies and expertise for training and supervision of public sector staff; consultation for service planning and liaison over specific aspects of service provision (e.g. trauma services). Human resources are often developed by NGOs, using low-cost methods and locally available resources.

An example is that of Ashagram, an NGO working in rural **India**, where uneducated youth are trained as mental health workers to provide rehabilitation services for people with severe mental disorders (Chatterjee et al., 2003; cited in WHO, 2005a).

➔ **Non-professional health workers** are increasingly relied upon to deliver mental health care in some countries (Ivey, Scheffler & Zazzali, 1998). They often have a more direct knowledge of the community, language and customs. Moreover, service users can often more readily identify with them and form therapeutic alliances. It is important to ensure that non-professional workers are appropriately competent, and that professional staff can be drawn, upon when necessary, to deal with complex cases, provide supervision and consultation-liaison.

In **Ghana**, the exodus of mental health professionals has outweighed the numbers that can be recruited. Access to mental health care had already been a problem. It therefore became necessary to train volunteers. To this end, a pilot project through the WHO Nations for Mental Health Project was started in 1999 for three years. Volunteers selected by their communities were trained to identify people in their villages who had mental disorders. They referred the identified cases to providers – mainly nurses, medical assistants and midwives – trained to treat uncomplicated cases. A community mental health nurse visited the facilities and offered support. The volunteers, who lived in the communities, visited the patients and reported relapsed cases.





The Government has now adopted the project and it is being extended to other districts (J.B. Asare, personal communication; cited in WHO, 2005a).

➔ **People with mental disorders/service users.**

There is evidence that people are more likely to adhere to treatment plans if they understand their illness and its treatment. Knowledge about the symptoms, the natural history of a disorder and effective treatments has been shown to improve outcome (Craighead et al., 1998).

The concept of individuals and families being an integral part of the care process when interacting with the service system, including primary care, hospital services and formal community services must be emphasized and encouraged.

## 2.2. Changing staff roles

The change from hospital- to community-based care and the new emphasis on multidisciplinary and intersectoral approaches inevitably mean changing roles for staff. This is a major issue in mental health reform. Professionals may be concerned about losing their professional identity, status, income, familiar work environments and familiar ways of working. Many professionals resist reform for these reasons.

These changing roles present challenges for both management and health workers. For management, the challenge is to engage actively with the health workers, listen to their needs and present the case for service reform and new evidence-based ways of working. For health workers, the challenge is to develop new competencies in community settings, to work in a flexible manner with other disciplines and across traditionally defined sectors (such as community and political leaders, social workers, police and prison officers, lawyers, school teachers, the media, etc) and to embrace change as an opportunity for further learning and personal and professional development.

## WHO Recommendations

Countries can take several courses of action to address these difficulties:

- **Develop an appropriate policy for human resources** in mental health in order to provide a coherent framework for workforce development and directly link the policy to HR planning, in consultation with health care programme managers and training institutions.

An HR policy should define the values and goals for developing a mental health workforce, and provide a coherent framework within which countries can plan, train and develop human resources for mental health. It should also provide a means of accountability and encourage continuous improvement in the quality of care. With such a policy framework in place, countries can plan HR in a systematic manner (WHO, 2005b).





- **Establish a coordinating body:** It is important that countries establish a clearly designated body, representing the range of stakeholders concerned with HR development and training, to coordinate the many sectors involved in the development of a mental health workforce. This body can be led by an educational institution or simply by a mental health training group set up within the ministry of health to undertake this role.

For example, in **Grenada**, such a training group has been established within the Ministry, under the overall direction of the Minister of Health and the Permanent Secretary (Stan Kutcher, Associate Dean, Clinical Research Centre, Dalhousie University, Halifax, Nova Scotia, Canada, personal communication; cited in WHO, 2005a).

- **Use a systematic methodology,** based on population needs and service and provider functions, to determine how many health professionals and what mix of competencies is required at different levels of treatment and care (refer to Information sheet on the WHO pyramid on the optimal mix of services) as per figure 1. This is also useful for defining the training needs at the different levels of care. This model can also be applied to other professionals e.g. traditional healers, social and community workers, police and prison officers, lawyers, school teachers, etc (WHO, 2005a).

- **Adopt appropriate management strategies** to promote leadership, motivation, recruitment, deployment and retention of often scarce personnel:

- ↳ **Leadership** is as important in mental health as in any other aspect of the health service. The promotion of high quality leadership and management is more likely to contribute to the recruitment and retention of a motivated workforce.

- ↳ **Motivating staff** is central to the (clinical and humanitarian) quality and cost efficiency of services provided. A motivated workforce is more efficient (getting more work done for the same cost) and effective (with better outcomes for service users). Motivated workers are also more likely to remain satisfied with their work, continue in their existing posts and create greater stability for the service over time. Finally, motivation influences the capacity to adapt to or initiate appropriate change in an organization: highly motivated staff have been shown to need less direction and supervision, welcome more responsibility, and seek more feedback on their performance (WHO, 1993).

**Ghana** provides an example of how staff motivation can be improved in spite of limited resources. Although it has been difficult to increase the salaries of mental health staff compared to general health staff, in some instances it has been possible to provide free accommodation and faster promotions in the mental health sector. This has not only improved motivation but also attracted staff (J.B. Asare, Chief Psychiatrist, personal communication; cited in WHO, 2005a).





↳ **Staff morale and burnout** are important areas to consider in planning for mental health services. Staff often experience burnout because of factors specifically associated with mental health care, particularly when they are “low” in the clinical hierarchy, have the most face-to-face contact with service users, and little say in the nature and organization of their work. Nevertheless, for many people the stress of mental health work can be challenging and provides an opportunity for rewards, as clinicians see improvements in their clients and in the effectiveness of their services.

Successful strategies undertaken in **New Zealand** have included marketing mental health as a challenging and rewarding area of the health sector, and offering a special bridging programme for new graduate nurses to attract them into mental health (Todd Kriebler, Ministry of Health, Wellington, New Zealand, personal communication; cited in 2005a).

↳ Ensuring the consistency of the HR strategy with the wider organizational strategy helps secure the political and financial support necessary for **appropriate recruitment**. Effective recruitment strategies may also include combating stigma about working in a mental health setting.

↳ Strategies to **improve retention** of staff are essential. Staff who leave the service are often experienced and fulfill a particular function in a team, which makes them difficult to replace by a newly trained individual. In addition to financial incentives, retention can be improved by providing **active support**, such as the development and implementation of a mental health promotion strategy for staff and improved motivation, through the provision of training, support, supervision and various other incentives (legal, professional, financial, educational or management).

e.g. one-year mandatory community service immediately after qualification, as applied in **South Africa** to medical doctors and clinical psychologists (WHO, 2005a).

▪ **Review the curriculum and training of (mental and general) health staff**, and improve it in keeping with evidence-based practices and the mental health needs of the population.

In many countries, achieving training goals will require a change in the way in which mental health education and training is conducted. There is often a phase lag in which clinical practice moves ahead of the content of training courses, as their curricula tend to change more slowly (Thorncroft & Tansella, 1999). Therefore, curricula that have become outdated or are not consistent with new models of community-based care need to be updated (WHO, 2005a).

Once the personnel are qualified, **continuing education, training and supervision need to be conducted** to ensure provision of the best quality care that meets users' needs: Continuing education and training (CET) is in the interests of both the mental health service and the staff. For the service, it ensures that care remains up-to-date with the evidence for the most effective interventions. For the staff, it ensures that their occupation remains stimulating, and that their working life can follow a trajectory of career-long professional development. Lifelong learning is a cornerstone of continued





fitness to practice, and is closely tied with the quality of care and patients' safety. Changing and growing knowledge in the field of mental health means that mental health workers are required to know more and more, compared to what they first knew when they completed their basic training (WHO, 2005a).

- **Include a mental health component in the curriculum of a range of non-health professionals** whenever relevant to their function, also keeping with best practices including in terms of human rights (see Resource Book). This education/skills will need to be **updated and refreshed by regular onsite training**.

- **Evaluation** is key to assessing the effectiveness of a human resource policy for mental health. The evaluation must consider whether the key objectives of workforce development were achieved using clearly defined indicators. Important evaluation questions relate to recruitment, retention, the competencies of staff at different service levels, and their distribution throughout the country, in line with mental health policy direction and changing models of care.

### **A Successful Mental Health Reform requires the adoption of a new paradigm for Mental Health and the restructuring of Human Resources Management and Training: the case of Brazil.**

In the past 10 years the government of Brazil has made enormous investments in reforming of the national mental health care system, including unprecedented efforts in training and management of Brazilian Human Resources for mental health.

The story of this reform started in the 80s with the growing criticism of the hospital-centred model of care predominant in Brazil, as it was still in most of the countries.

In 1989, an intervention of the municipal secretary of health in a psychiatric hospital, where cases of mistreatment and deaths of patients have been reported, had important national repercussions. Foremost it was thought important to build a network of health care to substitute of the current institutionalized network of psychiatric hospitals. This marked the beginning of the reform process.

From 1992 to 2001, community and primary health care services (CAPS) developed into a structured network of centers providing mental health care, from 23 CAPS in 1992 to 295 CAPS in 2001. However, the mental health reform was only realised with the introduction of the Paul Delgado Law in 2001. From that point on the network CAPS providing mental health care at primary and community levels witnessed a huge exponential expansion, reaching 689 CAPS nationwide in 2005. This was accompanied by a progressive and programmed reduction of the existing psychiatric beds (from 72514 beds in 1996 to 42076 in 2005 i.e. a reduction of 30,438 (42%), reducing the expenditure on psychiatric hospitals down to 64% of the total expenditure for mental health today.





One of the most challenging aspects of the mental health reform in Brazil was the reform related to the Training of Human Resources - changing the traditional paradigm/representation of mental health workers as guardians to a more care-oriented model. A specific human resource policy was elaborated in order to broaden and improve the recruitment, the training and the management of mental health workers.

Recruitment remains difficult in rural areas as most of the professionals have been trained in large cities and prefer to practice there.

The Brazilian government had to face the challenge of providing more technical and theoretical education to health workers who had often lost their professional motivation because of poor remuneration and precarious working conditions. For this reason, since 2002, the MOH set up a Permanent Programme of Formation for Human Resources, through the establishment of conventions with institutes of formation (especially federal universities) at different levels. Since 2003, the Ministry instituted a wider organizational structure, the National Secretary of Management of Health Work in order to meet the quantitative and qualitative needs for Human Resources.

Now, as a result, at least 8,000 health professionals working in CAPS are exposed to regular ongoing training - every year around 1,500 of them participate in long courses (over 360 hours) and at least 6,000 health workers of different levels follow a short course (over 40 hours).

(Brasil: Ministerio de Saúde. Reforma Psiquiátrica e Política de Saúde Mental no Brasil, 2005)

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