

A Theoretical, Historical, and Socio-Economic Case for Saving Lives through Strategic Improvement of Mental Health Systems around the World

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Abstract

Introduction: Comparing mental health systems between different countries illuminates the potential for change by showing us different approaches exist in the global here and now. Globally, people are suffering and dying daily from untreated mental health conditions and those working in these systems have to live in this reality.

Purpose: The purpose of this paper is to examine how stigma, underfunding, deficits in best practices, confusing systems, and failed strategic planning are all variables causing systems' deficits that have people unnecessarily suffering and dying around the world.

Methodology: To make the case for change, we use critical analysis to examine mental health systems through an analytic framework that includes history, systems investment, and general treatment approaches. We review mental health care systems through theories of structural functionalism, conflict, social dynamics, and socio-economic asset development.

Results: The historical examination provides vital systems-development insight while the systems investment examination delves into the overall funding structures and strategies of each country. Theoretical analysis reveals how problems seem intractable, but also how progress is always possible.

Conclusion: This examination informs critically thinking advocates, through historical and theoretical lenses, to generate precise calls for win-win strategies that can be individualized per World Health Organization and other advancing treatment recommendations.

Keywords

mental health, mental health treatment, national mental health evaluation, mental health problems, mental health administration, mental health system history, mental health practice approaches, and international mental health recommendations

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Introduction

The World Health Organization's (WHO, 2020) best practice approach, adopted by most European countries, includes robust inpatient, intensive outpatient, and outpatient services that address all levels of need. Though it may seem obvious, it must be stated that these recommendations necessitate adequate resourcing that create a sustainable relationship with quality communications between patients (clients) and mental health practitioners. How societies and governments view this resourcing, as investment or as poorly utilized limited funding, largely dictates mental health outcomes. This paper argues for a substantiated positive investments attitude that leads to a win-win for those suffering from mental problems and the broader societies in which they live.

Mental illnesses, including psychological and emotional struggles, occur across a wide and complex spectrum, and for a treatment system to be effective it has to precisely reflect that complexity. Especially with advances in neuroscience (Shapiro, 2012; van der Kolk, 2014) we have increasingly effective treatments for every area of defined mental health condition. In the Mental Health Action Plan 2013-2020 (which has been extended to 2030), the World Health Organization (WHO, 2013) states,

"Health systems have not yet adequately responded to the burden of mental disorders; as a consequence, the gap between the need for treatment and its provision is large all over the world. Between 76% and 85% of people with severe mental disorders receive no treatment for their disorder in low-income and middle-income countries; the corresponding range for high-income countries is also high: between 35% and 50%. A further compounding problem is the poor quality of care for those receiving treatment."

An optimized mental health system requires particular characteristics for both practitioners and clients. First, in terms of capacity, practitioners need access to affordable and high-quality education and training followed by clear career options with user-friendly and adequately remunerating pay. The World Health Organization (2020) emphasizes prioritizing mental well-being, eradicating stigma, discrimination, and social exclusion, providing effective and comprehensive care with choice for those in need. The obvious impediment is funding, which includes both societal and governmental willingness and financial capacity. In any case, nothing changes until such funding is committed.

Purpose

This paper examines mental health systems in three countries, which vary across a spectrum of mental health systems and outcomes, in order to

provide historical, theoretical, and socio-economic analyses for problems and the critical need for change. Important contrasts can be drawn between the largely private and profit-oriented United States, more robust and universal systems of Western Europe (e.g., Germany), and countries with limited resources and still in early developmental phases, such as in Eastern Europe (e.g., Lithuania). Population and GDP per capita estimates provide context for the size and relative prosperity of people in each country (The Organization for Economic Cooperation and Development [2022]). The World Health Organization's (WHO, 2020) Mental Health Action Plan 2013-2020 (extended to 2030) recommends a guiding framework for best practices. The systems, historical and theoretical analyses work together to make a case for vital, complete, and sustainable change, especially emphasizing theories of functionalism, social-dynamics, and the socio-economic asset development perspective (Dolgoff & Feldstein, 2007).

Methodology

This critical analysis includes historical research, systems examination, and theory-based analysis. Critical analysis was selected because of how it guides a logical deconstruction that makes way for criticisms and recommendations for progress in mental health care (Browne & Keeley, 2012). For this study, 86 scholarly sources were examined and 54 were included in the article. There were 19 for Germany, 21 for Lithuania, and 27 for the United States. The remaining sources for this article provided comparisons and important context, such as World Health Organization (2020) accounts of best practice recommendations. Key search terms include each country's name with mental health, mental health treatment, national mental health evaluation, mental health problems, mental health administration, mental health system history, mental health practice approaches, and international mental health recommendations.

The authors also scanned the literature for comparisons of any of these countries' mental health systems to others. The order of examination for each country was current mental health conditions (e.g., suicide rates), type of system and administration (health care and mental health care), investment in context of overall economy, specifics of types and depth of mental health treatment, and outcomes evaluation. This critical analysis deconstructs systems, especially focusing on historical context and specific systems evolutions. Theory is used to evaluate the relevance of these historical and systems development findings and provides frameworks through which to guide important questions for continued advocacy and research.

Results

Multinational Comparison

Table 1: Comparison of Countries' Mental Health Systems (History, Systems Investment, General Treatment Approaches)

Country	Population (GDP per Capita)	Historical Development	Systems Investment	General Treatment Approaches
Germany	83.1 million (58,386 USD)	Public funded through the two major churches; cost-regulated private insurance market	4% GDP (cost saving measures)	<ul style="list-style-type: none"> Medication Inpatient psychiatric Comprehensive psychotherapy
Lithuania	2.8 million (42,551 USD))	Public funded, government administered	.125% GDP	<ul style="list-style-type: none"> Emphasize medication Limited Psychotherapy
United States	331.9 million (69,558 USD)	Private for-profit with selective government non-profit (disabled, elderly, veterans)	3.5% GDP (no cost saving measures in private market)	<ul style="list-style-type: none"> Emphasize medication Inpatient psychiatric Comprehensive psychotherapy

Note.

- Population and GDP per Capita (The Organization for Economic Cooperation and Development [OECD] [2022])
- Citations for all other information are in the text of the article.
- Systems Investment Column
 - Estimates do not reflect indirect costs of untreated mental health problems.
 - Estimates do not reflect cost saving measures which, for example, do exist for Germany but do not for the United States (i.e., Germany getting more for their investment).

Germany

WHO (2011b) reports that Germany (population 83.1 million; GDP per Capita 58,386 USD [OECD, 2022]) has a quite robust mental health care delivery system, considering it a top public health priority, including authorizations at the level of primary care. Perhaps their largest impediment to mental health care is stigma, which reduces mental health help-seeking (Kessler, Agines, & Bowen, 2014).

History of Mental Health System- Germany

The timing of medical advancement and post-World War II reconstruction led to many western European countries reforming their health care systems. It took a couple of decades post-World War II for this change to occur; during the 1950s and 1960s there was widespread shame and neglect and thus care was "restricted to large, old-fashioned institutions in remote areas" (Salize, Rossler, & Becker, 2007). Germany experienced a deinstitutionalization of chronic and severely mentally ill people in the 1970s, leading to an increased need for community mental health. Later, the reorganization of East and West Germany "required dramatic changes in the structure and quality of the mental health system

of the former German Democratic Republic (GDR)" (Salize, Rossler, & Becker, 2007). A big and expensive effort, but federal law from the 1970s set very high standards for access to high quality and affordable services. Also, in the 1970s Germany's system of subsidiarity was born (Göçmen, 2013). Subsidiarity stipulates decisions about services should be made as close to those in need as possible, so the German government sends funding through the two major churches (Diakonisches Werk der Evangelischen Kirche in Deutschland [Diakonie] and Deutscher Caritas Verband [Caritas]) in Germany to provide all health and human services.

Systems Investment- Germany

Germany is among the nations with highest GDP dedicated to health care (11.43%) (WHO, 2021) and mental health (~4%) and has been growing consistently in recent years (Schwarz, et al., 2020). The German system has Statutory Health Insurance (SHI) known in German as Krankenkasse. The government requires that all German citizens (and actually many non-German citizens) have market access to any insurance provider they choose at what the government sets as a reasonable rate. More recently, Germany shifted to a Global Treatment Budget approach.

Schwarz, et al. (2020) state that this change, popular among practitioners and patients, shifts from a daily performance-based approach to a “lump-sum GTB”, shifting from in- to outpatient settings. Savings can then be reinvested along the full spectrum of care. While there are strong federal policies there still is a struggle to systematize mental health services across 16 German states. In particular, differences can be found between actual number of psychiatric beds (Salize, Rössler, & Becker, 2007).

General Treatment Approaches- Germany

Germany’s treatment approaches span a wide spectrum of services deeply steeped in expert tradition and backed by a robust economy and heavy regulations that ensure there is accessibility and outreach. Germany designates three theory-based psychotherapeutic approaches: Behavioral, Depth, and (Psycho) Analytic (PubMed Health, 2016). Concepts frequently enunciated within the German mental health care system are social education, mental health consulting, assessment, and case management, in addition to those providing deep, intensive psychoanalytic approaches. Germany produced and hosted some of the world’s most influential psychoanalysts, including Karen Horney, Erich Fromm, Erik Erikson, and Gustav Kafka. German was also the language of Sigmund Freud and thus the early field of psychoanalysis (Ermann, 2010). They also track utilization through what they call a Point of Contact system (National Library of Medicine, 2016). This requires health care professionals throughout the system to intentionally perform exploratory examination along with psychoeducation to ensure people understand the availability of mental health services.

Lithuania

Lithuania (population 2.8 million; GDP per Capita 42,551 USD [OECD, 2022]) has a triad of problems related to mental health care, including troubling behavioral trends (i.e., addiction, suicide), under-resourced mental health care delivery system (WHO, 2011c), and profound culture-based avoidance to mental health care. Perceptions of soviet era institutionalization magnifies stigma toward mental illness (Pūras, 2019). In spite of these challenges, there remains a growing push for increased funding and investment in WHO oriented best practices (Skvernelis & Veryga, 2017).

History of Mental Health System- Lithuania

Lithuania struggles with some of the highest rates of suicide and alcoholism, all while attempting to revise their health care systems, since 1991, after 100+ years of occupation (Puras et al., 2004). Mental health clinics started in 1996 and grew to ~115 clinics by 2016 (Skvernelis & Veryga, 2017). In 2007 the Lithuanian parliament

voted to adopt the European mental health principles recommended by the World Health Organization (WHO) (Muntianas, 2007). They hoped to ensure human rights of patients and to integrate modern services to address mental health needs through a biopsychosocial method.

Systems Investment- Lithuania

Records on financing of the Lithuanian mental health system can be hard to find, but financing for the overall health care system increased from 45.7 to 57.5 million Euros (~\$56 to \$70 million USD) between 2012-2016 (Skvernelis & Veryga, 2017). The amount of mental health clinics and professionals have increased, but there are still deficits, particularly in child and adolescent psychiatry). There is a lack of diversified and prioritized financing in Lithuanian mental health care, which obscures and limits innovative services that could benefit the system in the long run (Šumskienė, 2017; Šumskienė & Petružytė, 2017). Ironically, the current financing approach most resembles the soviet model, denying innovation and advancement. Becoming a European Union (EU) member in 2004 did not bring essential systemic changes (Pūras et al., 2013). Certain institutions have stable financing and no competition. Experts further argue that inadequate financing hurts non-governmental organizations, which seek alternative approaches, a wider range of specialized interventions, innovative service models, and current mental health care system reform (Pūras et al., 2013).

General Treatment Approaches- Lithuania

Lithuania has both inpatient and outpatient psychiatric services that utilize a blend of counseling, psychopharmacology, and social supports (often referred to as case management or psychosocial support) (Dembinskas, 2003). Lithuanians may more commonly be able to access mental health care that reflects a psychosocial paradigm (Šumskienė & Petružytė, 2017). These services focus on sustaining independent living for those struggling with mental health issues (Šukys, 2012). While this is likely done with sensitivity and compassion for the mental health struggle the person is experiencing, the level of funding indicates that this psychosocial approach does not necessarily include deep and effective psychotherapeutic treatment (Šumskienė & Petružytė, 2017). There are discussions in the ministry of health to make psychotherapy a part of the system, but for now psychotherapy is primarily attainable only through private practices (LPS, 2021). There is a government supported emotional mental hotline and a complex services packet.

Addiction and suicide continue to plague Lithuania as rates are among the highest in the world. Funding and prevention programs have been inadequate thus far (Skruibis & Žemaitienė,

2015; Šumskienė & Petružytė, 2017). There have been proactive efforts on both of these issues. Strategic planning includes capacity building in areas of recruitment, education, training, professional development, and prevention programs, all of which would increase the quality and availability of mental health services.

United States of America

The mental health care system in the United States (population 83.1 million; GDP per Capita 58,386 USD [OECD, 2022]) is in a state of emergency, especially considering both mental health and addiction problems. The National Alliance on Mental Illness (NAMI) is “the nation’s [United States] largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness... started as a small group of families... blossomed into the nation’s leading voice on mental health. (NAMI, 2022)” NAMI gives the United States a grade of D, stating “Mental health care in America is in crisis. Even states that have worked hard to build life-saving, recovery-oriented systems of care stand to see their progress wiped out. (2009)” Advances in health care along with the AMA’s lock on a private entrepreneurial model for medicine making the U.S. health care system exorbitantly expensive, far beyond most American’s ability to sustain. As a strength in the United States, medical training and expertise are world class (Garson & Engelhard, 2008), but millions are shunned (50 million prior to the Patient Protection and Affordable Care Act of 2010 [PPACA] and 31.6 million now [National Center for Health Statistics, 2022]). The United States is also the only industrialized country that bankrupts citizens for catastrophic medical debt; two-thirds of people who file for bankruptcy in the United States cite medical issues as the primary cause (Konish, 2019).

History of Mental Health System- United States

The United States mental health system is a study in contradiction and ambivalence, mostly an extension of the profit-driven medical system with also an underfunded and inconsistent government-based system (i.e., Medicaid, Medicare, and Veterans Administration) primarily for the poor, disabled, elderly, and veterans. The profit driven private health care system, created by the American Medical Association (AMA) and amplified through an evolution of private health insurance and pharmaceutical industries, necessarily creates scarcity while passing along high and ever-escalating costs to clients and patients.

The AMA began in 1845 with a stated purpose, “Scientific advancement, standards for medical education, launching a program of medical ethics, improved public health” (AMA, 2021). But the

AMA evolved as a wealthy and powerful lobbying group and its most prominent impact is that it ensured the field of medicine would remain a private, entrepreneurial, and for-profit system (Rosenthal, 2018). Hospitals, clinics, and health insurance companies followed the for-profit model.

Health insurance companies started as nonprofits in the 1890s to stabilize doctor and hospital revenue over the course of a year to avoid sharp financial peaks and valleys. Rosenthal (2018) states,

“They intended it to help the sick. And in the beginning, it did. A hundred years ago medical treatments were basic, cheap, and not terribly effective. Often run by religious charities, hospitals were places where people mostly went to die. ‘Care,’ such as it was, was delivered at dispensaries by doctors or quacks for minimal fees.”

Eventually insurance companies followed the AMA’s for-profit approach and between the 1920s and the 1960s, progressively engaged in discriminatory practices, in particular denying coverage to those with pre-existing conditions. There is evidence that the early health insurance companies (e.g., Blue Cross) held out as exclusively nonprofits but could not compete with newer for-profit insurance companies (e.g., Aetna and Cigna), and caved to economic pressures to gain access to the stock market (Rosenthal, 2018).

The government-based programs of Medicare, Medicaid, and military-affiliated health care (e.g., Veterans Administration [VA]) developed between the 1940s and 1960s to protect vulnerable populations and to take care of veterans (Tikkanen, Osborn, Mossialos, Djordjevic, & Wharton, 2020). These resources, though often inadequate, are critical for those meeting eligibility requirements (e.g., poverty, disability, old age, and veteran status).

President Obama’s Patient Protection and Affordable Care Act of 2010 (PPACA) was the most significant health care legislation since the 1960s. It has its strengths, but it was actually implemented without a core component, the Public Option, which would have been a government-based nonprofit health insurance plan that any American could purchase. The Congressional Budget Office (CBO), the strictly nonpartisan budget analyst for the U.S. Congress, estimated 6 million Americans would have opted for the public option in the roll-out of PPACA (CBO, 2009). That number likely would have grown exponentially by now since it has been shown that overall satisfaction is significantly higher for Americans with government-based health insurance (e.g., Medicare) than in the private market (McCarthy, 2012). It also could have generated market pressures for the private

insurance system to lower prices while improving coverage.

Systems Investment- United States

The National Institute of Mental Health (NIMH, 2011) cites a cost of \$57.8 billion in 2006, 163 billion in 2011, and \$238 billion in 2020. US GDP leads the world in percentage of investment in health care and is ever-growing at 17.7% in 2019 (Centers for Medicaid and Medicare Services [CMMS], 2019). But estimates on mental health, which also include certain aspects of indirect costs, put mental health GDP at 3.5%. Estimates on cost rise dramatically when including indirect costs of untreated mental health problems, which include those who could work but will remain on disability, those turning to addictions as coping mechanisms and ending up with catastrophic treatment costs or in the criminal justice system (Insel, 2008). “It goes without saying that the excess costs of untreated or poorly treated mental illness in the disability system, in prison, and on the streets are part of the mental health care crisis. We are spending too much on mental illness in all the wrong places. And the consequences for consumers are worse than the costs for taxpayers” (Hogan, 2002).

General Treatment Approaches- United States

Most mental disorders are treated solely with medication, even though more than 50% call for psychotherapy (Arean, Renn, & Ratzliff, 2020). Most mental health practitioners in the U.S. espouse a general cognitive-behavioral therapy approach, but for many of them that mostly means they simply talk with their clients about general thought and emotional disturbances. There is a significant population of practitioners with deep and high-quality proficiencies in specialized areas, including Psychodynamic, Motivational Interviewing, Attachment Theory, and, more recently, the neurobiological approaches, such as Eye Movement Desensitization and Reprocessing (EMDR) (Shapiro, 2012). For the percentage able to gain access to psychotherapy, it is very difficult to discern which practitioners will provide the best and most specialized services.

Community Mental Health

The vision behind Kennedy’s Community Mental Health Act of 1963 was to deinstitutionalize chronic and severely mentally ill people into a wide-reaching network of community-based outpatient centers. The agenda was broad and administration across presidential terms (e.g., from Carter to Reagan) varied and ultimately weakened outcomes (Drake & Latimer, 2012). The two biggest problems with community mental health are the lower prevalence of experienced and competent practitioners (owing mostly to low pay) and hyper-focus on case

management (basic resources for independent living) and psychopharmacology, in lieu of psychotherapeutic treatment. In truth, there are most excellent services provided through community mental health; here and there pockets of particularly good treatment teams arise. But this is a widely varying and unpredictable phenomenon. For those with Medicaid, they can expect their care to be mostly in the areas of psychopharmacology (e.g., anti-depressants) and case management. They may also receive individual and/or group therapy, but availability and quality also vary widely.

Private Health Insurance (Uninsured/Private Fee)

Most Americans have private health insurance that covers a percentage of mental health care costs. A typical copay to cover a \$125 outpatient psychotherapy fee is between \$30 and \$60. Insurance plans are not required to cover mental health, and many do not. A person seeking weekly psychotherapy for a year could pay as much as \$3000 for copays on top of expensive health insurance premiums. Increasingly, psychiatrists and psychotherapists opt out of insurance altogether, citing issues with low reimbursement and a disorganized, unreliable, and cumbersome billing system. 34% of people with private insurance seeking mental health care had difficulty finding a practitioner accepting their insurance (NAMI, 2016). And with increasing demand, mental health providers can charge higher rates and find plenty of financially able people to pay out of pocket. Yalom (2009) states:

“So I worry about psychotherapy—about how it may be deformed by economic pressures and impoverished by radically abbreviated training programs. Nonetheless, I am confident that, in the future, a cohort of therapists coming from a variety of educational disciplines (psychology, counseling, social work, pastoral counseling, clinical philosophy) will continue to pursue rigorous postgraduate training and, even in the crush of HMO reality, will find patients desiring extensive growth and change willing to make an open-ended commitment to therapy.”

This epitomizes a mental health systems status quo in the United States that includes no plan for affordable access to quality services to all in need.

Discussion and Theoretical Examination

History and theory are powerful teachers for understanding the present and making plans for the future. Lives and human well-being are at stake, so for our purposes we assume that we need to go no further in making the case that mental health systems improvements are vital,

even if in varying degrees between nations. Social dynamics (or sociodynamic theory) proposes that all systems are in a state of dynamic change through positive and negative feedback (Durlauf & Young, 2001). From this, we could deduce that when an argument for change does not appear to be winning in the public domain, enough feedback (frequency and intensity) eventually causes change to occur. This can explain how dramatic change often does seem to suddenly occur after decades of debate that seemed to go nowhere. Although aspects of certain systems may appear quite fixed, policy history shows that change can happen dramatically when there are motivated electorates and government officials (e.g., Advance Child Tax Credit and Economic Impact Payments in the United States [USA.gov, 2022]).

The Past

The reality is that in various ways most nations have not adequately responded to mental health needs of their societies, whether by underfunding (and thus de-prioritizing), ill-informed strategies, inadequate expertise, or stigma causing reluctance to seek professional help. WHO (2020) states, “Mental health is one of the most neglected areas of public health.” They further estimate an inadequate average of 2% of health budgets going toward mental health globally. And then where services are available, there tend to remain major impediments to help-seeking for those most in need. The weight and consequences of untreated mental illness on the health care, mental health care, and criminal justice systems, and most importantly on families and communities, are incalculable. Dedicating appropriate resources and expertise would equally bring about inestimable societal benefits.

A central tenet of conflict theory states that money interests win out at the expense of vulnerable populations (Marx, 1848; Turner, 1975). But conflict theory is not necessarily about how the rich and powerful victimize the vulnerable, per se; it is an indication of what naturally happens as humans look out for themselves and close others, rather than ways to mitigate the negative outcomes that might occur when marginalized groups suffer. The Socio-Economic Asset Developmental perspective (Dolgoﬀ & Feldstein, 2008) illuminates just such a mitigating approach. Robust longitudinal economic data demonstrate the financial wisdom of resolving social and health problems as early and thoroughly as possible (Centers for Disease Control [2022]). This reinforces the age-old wisdom, “an ounce of prevention is worth a pound of cure”. There is a win-win phenomenon when we avoid the cost of crisis care and also have many more people productively functioning at all levels of society.

The Present

A fundamental principle of governmental policy is that sweeping legislation is difficult, expensive, and always yields unintended consequences (Dolgoﬀ & Feldstein, 2007). There is no way for a country with millions in population to adopt sweeping legislation that immediately and universally works effectively for all. Change along with changing needs assures that there will always be complications that include some people struggling and suffering in the interim. It should be an axiom of every nation that aspires to principles of freedom and liberty to stay ever vigilant and committed to addressing and resolving these struggles and suffering as fast as humanly possible. But how does change really happen? And why can it be so slow in coming?

The human capacity to adapt to dysfunction is immensely influential. In short, people adopt an “it is what it is” attitude, believing there would be no way to change large, problematic systems. Regardless of how we find ourselves in failing systems, we understand through a theory such as structural functionalism (Durkheim & Halls, 1894) that we can expect that there will always be resistance to change from the status quo, even when that change is clearly superior. Structural functionalism reveals how complex mental health systems have shifted, adapted, and evolved to become a sustainable general strategy aimed at alleviating mental health problems. Since the environment in which this system exists is a human construction, it does not necessarily follow laws of nature (Durkheim & Halls, 1894). Thus, if there was anything faulty about the overall system, for example an unbalanced ratio that prefers profit to human health, then subsystems seeking to adapt within this system, might necessarily only function as an extension of these imbalances. In that case you will have sometimes quite altruistic and developed resources (e.g., grant funded faith-based clinics in inner-cities) that would cease to exist if the system, as a whole, was rectified. This can lead to those with a heart for the vulnerable unwittingly arguing for strategies that prevent the greater-good for those they serve.

The Future

Since the global mental health community has ever-increasing clarity about maximally beneficial mental health systems (WHO, 2020), and it has been shown that investment in mental health systems is beneficial to both those in need and the broader society, there is no reasonable excuse for delay. According to Dolgoﬀ and Feldstein (2007), “The socio-economic asset development perspective evolved through attempts to harmonize social welfare with efforts directed at economic development that focuses on ways in which social welfare can contribute efficiently and effectively to economic

development through social investment.” Getting away from a liberal vs conservative struggle, there is political-theoretical middle ground. The socio-economic asset development perspective asserts a win-win scenario that it benefits society, both in social and economic terms, to ensure people have mental health needs affordably and effectively met. It is less expensive to prevent or catch problems early, and it is better to have people socially and occupationally functioning, as this is an economic and tax-base generator. Thus, it is a fiscally wise thing to aggressively treat all health conditions, mental and physical, that prevent people from thriving

Limitations and Strengths of the Study

Limitations of the Study

Limitations of this study include a small sample size of countries analyzed, a strong preference by the authors to see mental health systems improved (i.e., potential bias), and assumptions that such analysis and comparisons generate substantive guiding insights. There are no globally enforceable guiding regulations for mental health systems and numerous societal, economic, and cultural factors, beyond the scope of this article, also go into if and how a mental health system is developed and utilized. In an effort to promote progress, the authors also acknowledge that these theoretical interpretations could be affected by bias. The authors also acknowledge that many of the important socio-economic variables involved in mental health care systems are beyond the scope of this study.

Strengths of the Study

The strengths of this study include an elaborate analytic approach (history, systems, and theory-based analysis), unifying information about the global struggle toward effective mental health services, and substantial contribution to salient advocacy declarations. This article is a concise blend of examination and analysis that efficiently enhances advocate messaging and future research foci. Additionally, this format of analysis provides a framework for examining and comparing additional countries’ mental health systems

Conclusions

This article compares and contrasts these countries’ systems while also making the case for the inevitability of change. Nations vary in terms of stress, levels of mental struggles, mental health infrastructure, prevalence of stigma, and funding willingness and capacity, but there is still an international standard to evaluate each system against. The authors hope this article serves to

educate and bring clarity to people so they can, in turn, do their part to advocate for change in their home countries. Change is inevitable, but it serves all when it comes with strategic and resourced planning. Most countries can estimate numbers and types of mental struggles and develop local quotas for practitioners and resources. And this yields a multifaceted return on investment (i.e., socio-economic asset development [Dolgoff & Feldstein, 2008]). To continue this work, the authors recommend qualitative studies focusing in varying countries on front-line mental health providers, health care administrators, and economists familiar with funding and strategies in areas of health and mental health care. It is equally important that recommendations keep pace with constantly evolving data on best practices across the mental health continuum.

Conflict of interest

The authors declare that they have no conflicts of interest.

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