1. Introduction to the Research Handbook on Mental Health Policy

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An ongoing challenge in the mental health field has been to assure that its guiding policies are grounded on the best possible research. The fragmentation of the field, including its diverse practices, agencies, and policies, is evidence that popular fads, political expediency, simplistic rules, and even guesswork too often guide policy decisions. Barriers to the use of research in decision making involve its availability, relevance, and quality; the values and expertise of policy makers and their advisors; and the urgency of emergent problems and opportunities. A critical barrier involves the lack of fit between, on one hand, current mental health policies and systems, and, on the other hand, available research, including its data, methods, and the skills of researchers.

This Handbook is designed to address this lack of fit between the needs for better information on existing mental health policies and systems and the opportunities and limitations inherent in the existing body of mental health research. In both the case of mental health policies and research, this Handbook seeks to bridge considerations of what actually exists, and the associated processes for developing enhanced policies and more useful research. In both cases, a critical bridge between these domains consists of our evolving understanding of decision-making processes. A related theme is the need for multiple methodologies for research and policy development, especially the use of diverse perspectives and voices on the part of current and recovered patients, families, practitioners, administrators and policy makers, and the larger public.

This Handbook also examines mental health policy in an international context, one that is reflected in an emerging body of research in the field of global mental health. This includes the completion of psychiatric epidemiology surveys in 28 of the nations participating in the World Mental Health Survey Initiative (see Kessler & Üstün, 2008). These studies have highlighted the high global burden of disease attributable to psychiatric, neurological, and substance abuse disorders, 14.7 percent by 2020 (Murray & Lopez, 1996). In total, neuropsychiatric conditions constitute the most important cause of disability across the world, accounting for 37 per cent of years lived with disability among those 15 and older (Mathers, Ezzqati, & Lopez, 2007). This research has also highlighted stark disparities between developed and developing nations, not only in terms of prevalence of major mental disorders (Kohn et al., 2004), but also in respect to access to services (see World Health Report 2001).

While much research on national mental health systems has been driven by calls for system development, there are some who are skeptical about the impact of well-coordinated and systematized services to enhance outcomes, believing that what is most important is instead the implementation of empirically based practice models at the local level, whatever the organizational context. One such research group is Rosenheck and his colleagues (2002) who examined 18 communities in the US, comparing the nine with integrated mental health authorities with those without. They found no evidence that efforts to better coordinate mental health services...
enhanced service outcomes. There were, however, limited statistical controls used in this research, and thus, the results should be regarded as, at best, suggestive.

Research on national mental health systems has been the exception and the results have unfortunately not been cumulative. A plethora of editorials on this research have been supplemented by case studies of single nation mental health systems and qualitative comparisons of two to five nations, with only an occasional descriptive study or quasi-experimental analysis. Editorials in psychiatric journals have often highlighted the dramatic disparities between the mental health systems of developed and developing nations. Discussions of the sparsity of resources in the developing nations repeatedly urge the need for better integration of mental health into the work of primary care medical practitioners, given the sparsity of mental health professionals in many such developing nations. Along these same lines is the recommendation for improved public education, more creative use of non-professional staff, and improved access to psychotropic drugs, all viewed as cost-effective measures. Comparative studies on a more favorable course of schizophrenia in developing countries (Hopper & Wanderling, 2000) have been interpreted as support for a more effective engagement of natural and family supports in these nations (Law, 1985). Finally, such editorials regularly urge more consistent and rigorous collection of data on epidemiology, services, and outcomes. Such commentators increasingly recommend more research on mental health systems, for instance, Minas and Cohen (2007) argue that “While mental health research attention and funds are devoted predominantly to neuroscience and clinical research, we believe that the highest global mental health research priority is mental health systems research.”

Single and comparative national case studies date back many years, most notably to Donna Kemp’s compendium, *International Handbook of Mental Health Policy* (1991). More recent studies such as Lurie’s (2005) comparison of the systems in the UK, US, Canada, and New Zealand have highlighted themes of recovery, stigma reduction, developing services for particular client populations, for example, children and older adults, use of new technologies, workforce training, improved performance measurement and research. Increasingly, governments are no longer being expected to provide services, but rather to just fund and regulate them. A comparison (Liu et al., 2008) of the systems in Australia and China has highlighted the need for developing nations not to rely exclusively on institutional services, and to emulate those nations, such as Australia, which have moved more aggressively toward the creation of community mental health service systems. Particular barriers, relevant to China and many developing nations, include the lack of professionals and services in rural areas, in part, due to problems inherent in the poor economies of scale in service development in such environments. Just as is the case with the editorial literature, national case studies have not lent themselves to the development of a cumulative knowledge base, given the diversity of systems, issues, and data sources that they have examined.

**PROBLEMS ADDRESSED BY MENTAL HEALTH POLICY**

The policies reviewed in this Handbook represent a diverse array of responses to substantial levels of mental illness and disability in most countries, including substance abuse, and developmental disabilities. Mental illnesses occur around the world with substantial frequency. The World Health Organization (WHO) estimates that in 2019 approximately 970 million people world-wide have mental health conditions. Such conditions range from depression (more than
280 million people at any time) to schizophrenia (approximately 24 million people) (WHO, 2022). In the US, the National Comorbidity Study found that 46.5 percent of the adult population has had a diagnosable mental disorder at some point in their life, with 23.5 percent having such a disorder in the prior year. In addition, 5.3 percent has a serious mental disorder involving a significant level of disability. Given such levels of need, there has been, at best, an uneven level of availability of services, both inpatient hospital as well as community mental health services. Gaps in community services involving emergency care, day programs, supported housing, and forensic services for mentally ill individuals involved with the criminal justice system are particularly acute.

Inadequate service coverage either leads to or exacerbates a range of problems involving unjust service disparities and inaccessibility, ineffectiveness, and lack of confidence both on the part of patients and the general public in the mental health system. Limited budgets undermine the implementation of evidence-based services, through low salaries, inadequate training, large caseloads, and scant staff supports. The presence of numerous service gaps, along with limited service effectiveness, generates a range of dysfunctional service patterns, with discontinuities between the various types of service modalities involving, on one hand, service gaps for those with the most severe needs, and on the other hand, duplication of services for patients who have greater resources. Some of the most important discontinuities involve traditional counseling services and physical health, substance abuse, and especially services involving concrete supports such as income, housing, employment, and training. In recent years, an increasing awareness of gaps in these areas has stimulated sporadic attempts to develop integrated services.

All of the above problems have eroded public confidence and, thus, political support for mental health services, undermining the ability of many jurisdictions to adequately budget for the required services. This problem has, in turn, been severely aggravated by that of ignorance and stigma associated with severe mental illness. Too often the attitude “Out of sight, out of mind” has led either to isolation in institutional services or to difficulties in developing community services located close to recipients’ homes.

An important conflict affecting mentally ill persons is that between, on one hand, the pervasive individual focus of many mental health professionals who attribute mental illness exclusively to either psychological or biological breakdowns, and on the other hand, the results of hundreds of sociocultural studies which have documented the impact of low socioeconomic status, economic inequality, geographic isolation, and related conditions in generating and perpetuating disproportionate levels of mental illness (see Silva, Loureiro, & Cardoso, 2016). While it is still not fully understood what the respective roles are of social stress and social selection in explaining these effects, a growing consensus is that social stress and lack of social supports contribute substantially, although some individuals with the most severe conditions such as schizophrenia may be “socially selected” into impoverished conditions due to downward geographic and socioeconomic drift. For this reason, most mental health services are not designed to assist with concrete needs, whether they involve income, employment, housing, or education, that are central challenges for a substantial proportion of the mentally ill.

Development of policy responses to the foregoing problems are complicated by the fact that such problems are embedded in the perennial conundrums of social policy, those involving conflicts between competing social and philosophical positions for which there are no solutions that are optimal. A sampling of these is discussed below and illustrated in Figure 1.1,
with the interconnecting lines indicating implications of how the solutions to each complicate the solutions to the others listed.

Figure 1.1  Examples of the perennial conundrums of social and mental health policy

**Targeting vs. Universalization**

Strong arguments can be made for targeting or restricting eligibility criteria for various mental health services to only those in greatest need, such as the seriously and persistently mentally ill (SPMI) who often cannot care for themselves, experience considerable levels of personal distress, and for whom family ties often fall by the wayside. Limited resources are often cited as a key argument for such targeting. Yet, compelling arguments are also made for making access to such services as non-restrictive as possible, available to all in need, so as not to discourage the provision of support at early stages in the development of such conditions when there is
a more favorable prognosis. It should not be necessary for clients to have total breakdowns before receiving services.

**Specialist vs. Generalist Services**

On one hand, the complexity of mental health problems calls for high levels of training on the part of mental health professionals requiring substantial specialization. Yet, it is well known that so many mental health clients are confronted by multiple, interlocking problems involving legal issues, housing, employment, social relations, and profound intrapsychic, biological, and neurological dysfunctions, all calling for the ability to skillfully orchestrate multiple interventions without overwhelming the client, based on a generalist or biopsychosocial perspective. There have been various efforts to reconcile these demands, for example, in social work’s advanced generalist model of practice (Roy & Vecchiolla, 2004).

**Rational Planning vs. Organic Bottom-up Administration**

Mental health professionals are under considerable pressure to base not only their practice interventions but their agency service designs on the best available scientific results and to do this in a planful and systematic manner. Yet, the many limitations in both the availability and relevance of such results create pressures to involve many stakeholders in mental health decision making. Many decisions are often deferred or periodically updated, and often the strategy is one of an iterative or successive approximation to goal achievement. Such practices capitalize on a bottom-up emergent approach to decision making. The primary challenge in many contexts involves deciding on the best possible way of balancing and integrating rational planning methods with organic, bottom-up approaches, for example, through advocacy planning models.

**Transparency and Accountability vs. Privatization and Competitive Incentives**

Some service systems, especially those publicly operated, often optimize the transparent provision of information and public accountability through such means as freedom-of-information laws and advisory boards. In contrast, when services are contracted out or otherwise privately provided, the privatization of service delivery often minimizes such accountability, but maximizes professional autonomy. When financial or other incentives for productivity and outcomes are enhanced, transparency and public accountability may be further diminished. What the optimal balance is for public accountability and private autonomy and competition is by no means clear, and undoubtedly will vary between cultures and service systems.

**Independent Oversight vs. Integrated Service Delivery**

Whether one is concerned with a direct practice such as case management, or the design of service systems, an important decision involves the degree of independence of those who regulate or provide oversight to the services. For example, in certain models of case management, the case managers abstain from directly providing services, but instead focus on brokering and monitoring them, so as to oversee them as objectively as possible. In contrast, other models of case management encourage the case managers to provide counseling and various other
services themselves so as to most effectively coordinate them and engage with clients who often have difficulty with split roles, referrals, and multiple providers. Again, the challenge is designing the system and professional roles in a way that optimally balances objective oversight with the need for client engagements and service integration.

How any of these conundra are resolved in a particular service system design both influence and are influenced by the resolutions of various related dilemmas. For example, strengthening integrated service delivery will create a pressure for generalist practitioners and more universal, less targeted eligibility criteria. Universalizing services in turn can lead to some fragmentation as diverse providers have the flexibility to skew their services – often unintentionally – to those problems and diagnoses that are well reimbursed, and avoiding those that are not. Such developments would then create pressure to identify parties and lead agencies that can provide systematic planning and independent oversight. In every case involving the conundra depicted in Figure 1.1, one can identify not only intended but unintended effects of any given solution. It is for this reason that the development of research-based solutions to such mental health policy problems requires a broad lens for their discovery.

As difficult as such conundra may be to resolve, there are both practical steps that are known for designing workable mental health policies for particular national or local environments, as well as recognized criteria for evaluating such solutions. One critical reminder is that such conundra can be understood as representing continua in which solutions can be integrated, and are regarded as matters of degree. Rarely do they represent either/or issues, but often may amount to both/and integrated strategies when creative and practical solutions are found.

Discovering these solutions requires moving beyond ideologically framed positions and grounding such plans on the results of actual research whenever possible. For example, in allocating resources between institutional and community services, what data can be marshalled to decide on the number of patients and service units, along with their particular needs, that will be needed for the types of inpatient and community services proven to be most efficacious? Guiding both the search for data, and its use in planning, are conceptual models of professional interventions and service system design. But most important is the need for engaging visions, derived from practitioners, consumers, and others as to what such services and systems would actually look like when fully implemented. With luck, exemplars may be discovered in other communities or nations, but when not available, the imagination of stakeholders will be particularly needed and should be unduly tethered to research and a variety of practical decisions.

Two other elements are also needed in such planning and development initiatives. One is confidence building, sometimes through incremental steps, so as to assure the continued involvement of such stakeholders in the process. Also, it is often important to plan ahead for periods of service innovation, and is particularly needed in the period between such planning initiatives when fiscal austerity prevails. One of many ways of doing this may be through a kind of preliminary identification or “stockpiling” of ideas, ready to go when new imperatives and resources emerge.

Both system design and the evaluation of particular services that have been implemented need to be guided by relevant and clear criteria. The literature on program and policy evaluation, both in mental health and beyond, has typically emphasized the importance of the various generic criteria listed in Table 1.1. Those selected for a particular initiative need to be defined and tailored to the relevant goals, values, and other features of the initiative, as well as being conceptually meaningful and measurable. For example, effectiveness for a day hospital program might be defined to include development of social and vocational skills, minimiza-
tion of psychiatric symptoms, stabilization of functioning, finalization of housing arrange-
ments, improved quality of life, or improved self-monitoring, or some combination. Selection
of criteria is typically based on the most important legal mandates and official purposes of the
services, as well an effort to address the interests of consumers, staff, and other stakeholders
in the community. For this reason, it is important not to unduly restrict the range of criteria
to only one or two, but conversely, not to be overly ambitious in attempting to satisfy a wide
variety of criteria.

Clarity regarding criteria for the evaluation of policies and programs is of crucial impor-
tance in the development of solutions for the various conundra and problems reviewed above. Also, of central importance are the strategies that developers of mental systems can employ in
this regard. Thus, we will now turn to discussing both generic strategies which have been used
around the world, as well as ideas that should be considered in the mental health field.

### POLICY DEVELOPMENT STRATEGIES

Efforts to improve public health programs have historically involved a number of strategies,
one that have been extensively reviewed elsewhere. Most notable is the review of Pallasa et
al. (2012) of 181 studies that identified seven broad strategic domains of change: standards
and guidelines; organizational structure and governance; human resource knowledge and skill;
process re-engineering and technology development; use of incentives; organizational culture;

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**Table 1.1 Common criteria for evaluation of policies and programs**

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<tr>
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<th>Description</th>
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<tr>
<td>1. Accessible</td>
<td>Are the services provided in a manner that is maximally accessible, geographically, economically, linguistically, and socially to the target population?</td>
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<td>2. Balanced</td>
<td>Does the mix of services correspond with the mix of needs in the population covered?</td>
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<td>3. Client-centered</td>
<td>Are the client assessments and the services themselves oriented to client needs?</td>
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<td>4. Comprehensive</td>
<td>To what extent does the policy address a range of needs?</td>
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<td>5. Continuity of care</td>
<td>Are the provided services carefully linked together so that they assure seamless transitions for clients, as needed, between the most restrictive to the least restrictive?</td>
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<td>6. Culturally sensitive</td>
<td>Is the design of the policies and program, and their management and delivery, done in a way that is sensitive to the various cultural groups involved?</td>
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<td>7. Efficient and cost-effective</td>
<td>Is the system and its services managed in a way that makes the best possible use of available resources?</td>
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<td>8. Effective</td>
<td>Do the services mostly succeed in achieving the goals sought, in resolving the problems addressed?</td>
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<td>9. Engaged</td>
<td>Is the system and the component services delivered in a manner that attract and interest clients?</td>
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<td>10. Equitable</td>
<td>Are the services provided in a fair and just manner, without favoritism, or consideration of irrelevant client characteristics such as race, age, gender, political or religious affiliations?</td>
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<td>11. Individualized</td>
<td>Are the service plans tailored to the specific needs of individual clients?</td>
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<td>12. Integrated</td>
<td>Are there effective provisions for coordinating services on the client, agency, and policy levels, both within the system, and with other service systems?</td>
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<td>13. Responsive</td>
<td>Is the design of the system and its services flexible and adaptable to changing client and community needs and characteristics?</td>
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<td>14. Science-based</td>
<td>Are the services provided based on the best available research data?</td>
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<td>15. Transparent</td>
<td>Are policies, procedures, and relevant information concerning the system and its outcomes, both positive and negative, easily available to all interested?</td>
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*Note:* The above are a sampling (in alphabetical order) of the most important and commonly used criteria for the evaluation of mental health policies and programs.
and leadership and management. Their identification of the pros and cons of such approaches forms the basis of their arguing for a prescriptive model for the selection of optimal strategies that is contingent on the answers to questions involving an analysis of the causes of performance deficits, feasibility and environmental fit, use of best practices, and organizational capability. Several of these involve the decentralization of decision making, which is a strategy that is increasingly used in contexts involving professional services. Decentralization often accompanies psychiatric deinstitutionalization and typically involves an expansion in the range of stakeholders such as community agencies, professionals, consumers, and families of the mentally ill who seek to influence the service delivery system.

In contrast, Bossert (1998) specifically reviewed research on decentralization in health care in developing nations. He draws on the traditional typology of types of decentralization used in public administration, which include deconcentration, delegation, devolution, and privatization, and focuses on the use of principle agent theory from econometrics, most commonly involving the application of financial incentives as a means for central public health administrations to retain some control over peripheral units or organizations within a newly decentralized service system.

Much of the existing theory and research suggests that the success of mental health reform initiatives hinges on the ability of a nation’s mental health authority, such as a ministry of health, to navigate the complexities and tradeoffs involved in shared decision making under an increasingly decentralized structure. Within the mental health field, increasing attention has been paid to incorporating various models of shared decision making as a means of assuring maximal responsiveness to the needs of diverse constituencies (see Chapter 17 and Ramon, Zisman-Ilani, & Kaminsky, 2017). Strategies to improve decision making may focus on any of several system levels. A common focus has been one involving the relationship of mental health professionals and their clients revolving around intervention planning. But also, in many systems concerted efforts have been made to improve both administrative and policy decision making through enhanced involvement of clients and a range of constituencies, often through such mechanisms as advisory boards and the like.

Another strategy for the improvement of decision making has involved the long history of efforts to integrate research into both practice and policy (Brown, 2019). These have included requirements for needs assessments, program evaluations, and other forms of research. Such efforts have had a minimal level of success, too often resulting in merely including research into the rhetoric surrounding mental health programs. Research is expensive, and most mental health professionals are ill prepared to undertake it, and otherwise prioritize other activities as either more lucrative or ones that provide greater visibility. When quality research is produced, the challenge has been disseminating it, and finding the means to translate its results into practice. One means by which system-wide research has been promoted has been through the establishment of system-wide registries of mental patients and the services they receive. Such data depositories permit highly generalizable studies of a wide variety of patients and services, often over extended periods of time. Several European nations, such as Israel, have implemented such systems. In the US, the Commonwealth of Massachusetts utilizes an inpatient registry that is referred to as a casemix system. Such systems enhance the possibilities for public monitoring and integration of the mental health system, but even when they exist, they are often underutilized. Data from these systems are optimally suited to enable the development of easily used “report card” systems in which either mental health authorities or advocacy groups can benchmark and regularly rate various facets of the service system, such
as its coverage, quality, effectiveness, and other indicators in a manner that is easily accessible and understood by administrators and advocates, thus enhancing its transparency.

There are a wide variety of strategies for using research in system development, and these range from improvements in training and workforce development, agency-level requirements, and funding and stimulating of independent research. An emerging area involves integrating research generation into computerized management and clinical information systems so as to partially automate its management, analysis, and report generation in real-time. One lesson that is often forgotten is the frequent admonition to involve mental health practitioners and all users in the design of such systems, as they are the ones who experience the greatest burden of data entry, accountability, and scrutiny. Academics have for many years now complained about the minimal efforts in these areas, but too often do not consider the social and cultural dimensions of research generation and use and the training and acculturation of many practitioners that mitigate against the conduct and use of research.

There are a variety of other strategies for system development that go beyond decision making, consumer involvement, and integration of research. There is an extended history of experiments with approaches to improved service coordination, too extensive to fully review here. One idea that was developed as part of the Community Support Program (CSP) in the US is that there should be three levels of interlinked service coordination. Client-level service coordination, involving coordination on behalf of a particular client, has often involved the work of case managers, but a variety of other professional practices have also been used for this purpose, such as regular staff meetings, team work, or clinical information systems for data sharing. Agency-level coordination includes efforts to coordinate both with an agency, between its staff and programs, and with other providers in the local community. Approaches used include interagency agreements, appointment of staff representatives to other agencies, and monthly meetings of representative staff and clients. Finally, policy-level coordination involves such efforts at the regional, district, state, or national level. Much of such efforts have been undertaken by funding and regulatory organizations, such as state or national mental health authorities or ministries of health.

Many of the policy-level coordinative efforts have been implemented via development and monitoring of regulations, and, especially, through funding. When such units provide funding, they have the option to capitalize on the incentives that such funding creates for providers, whether these involve the proverbial “carrot” or “stick.” Economists have become increasingly interested in understanding such incentives, using what is known as agency theory (see Eisenhardt, 1989), in understanding how different types of funding mechanisms affect service provision. One insight that has come out of this field is that whereas funding that involves capitation, typically advanced fixed payments per person, often encourages service minimization, payment systems that involve set fees for particular service units, such as a hospital night, a course of ECT, or a psychotherapy appointment, paid after the service is delivered, have the effect of maximizing services, of encouraging providers to generate as many such payments as possible, whether or not needed. In reality, many systems employ complex hybrid funding models, sometimes with payment mechanisms with incentives that work at cross purposes with one another. Perhaps some of the most important lessons emerging from this experience is that funding and its resulting incentives need to be used judiciously, in a planned manner, in a way that minimizes extreme unintended consequences, preserves a needed degree of professional autonomy, yet is able to incentivize interagency and professional collaboration. On the organizational level, the use of salaries, supplemented by modest incentives, and on the system
level, use of set grants and contracts, also supplemented by some incentives for quality, may be the most promising approaches to achieving such a balance.

Another finance strategy that has been periodically pursued is the establishment of funding systems that permit funds to flexibly “follow the client,” whether he or she is hospitalized or is a recipient of community services. This contrasts with systems in which such services receive fixed allocations, thus, generating a system in which clients “follow the funds,” in which they may typically be referred to the best funded services, whether needed or not. Client-level funding through various forms of insurance sometimes can achieve this, as long as the repertoire of insurance benefits is comprehensive and well designed.

An increasingly popular strategy in many western nations has involved the privatization of services, especially community mental health services. This approach has been attractive to many public administrators as the contracting out of services to the public sector often proves to be less expensive, and to circumvent many regulations, including union protections of staff, common in services directly provided by public authorities. Such administrators see such purchase of service systems as providing them considerably greater flexibility in adapting services to local needs. Debates on the pros and cons of such approaches have been contentious and often ideologically driven, with limited data to enlighten such decisions. For this reason, mental health authorities need to pay considerable attention to the design of such systems, and to instituting a variety of protections and oversight mechanisms. A key principle is that services should only be privatized when such protections have been developed and when there is a sufficient body of agencies available that are fully competent in the services privatized. Such development is best accomplished in stages over several years, with public support with modest grants or contracts.

An ongoing problem in the development of mental health service systems is that of enhancing access to services. Some systems may have multiple points of possible entry in which clients can select from a wide range of providers. Such systems risk a lack of coordination, especially when there is insufficient information for clients to make prudent decisions. In contrast, other systems rely on a restricted array of entry points, perhaps a panel of assigned doctors, a case management program, or an information and referral unit. While such systems are better positioned to assure the coordination of services, they potentially complicate the effort of clients to freely access services. Critical is finding a balance of client freedom of choice with professional discretion, a balance that may vary in various cultures.

An alternative set of strategies seeks to improve mental health systems indirectly, through the development of better accreditation of agencies and licensing or certification of professionals. This often represents a bottom-up strategy in which resulting improvements on the micro or mezzo levels are expected to improve the larger policy systems. These kinds of improvements typically involve more stringent standards, or even higher levels of licensing that call for greater levels of educational preparation. A related strategy consists of the redesign of jobs so as to attract more qualified staff and minimize their burnout, ineffectiveness, and turnover. Sometimes such changes involve adding the possibilities for new service provision for professional groups which have not seen them previously, such as highly qualified social workers being permitted to engage in the private mental health practice, or nurse practitioners and doctoral-level psychologists being allowed to prescribe psychotropic medications.
PREVIEW OF HANDBOOK

These strategies, beginning with the integration of research in mental health policy making, will be explored in greater detail throughout the various chapters of this Handbook. Part II involves an examination of the conduct or process of research. Research examined will include its methodologies and their implications for administrators and policy makers tasked with translating the results into optimal practices, programs, and policies. Chapters about the process and conduct of research in Part II cover research formulation and planning, based on both theory and the needs of practitioners; qualitative methodologies, such as focus groups and concept mapping; quantitative studies, including epidemiological designs, and both quasi-experimental and experimental evaluations; and include one that introduces several state-of-the-art emerging methodologies. This will include the problem of adapting research to the needs of diverse populations based on such considerations as gender, race, ethnicity, and age.

Part III of the Handbook presents overviews of key research results that will be of interest to many students and professionals. The two initial chapters involve problems of disseminating and implementing research results, an area that has come to be known as implementation science. These will be organized by system level, starting with research with children, the sociology of mental illness, and psychiatric commitment. An important focus of the chapter on children involves their inclusion in the formulation, design, and conduct of research and that of partnering with local communities in this regard. The chapter on psychiatric commitment cuts across large and small systems and involves mental health laws, for example, assisted outpatient treatment, the right to treatment and to refuse treatment, competency and guardianship, advanced directives, and privacy issues. The next chapter covers psychiatric deinstitutionalization, including both the driving forces behind such policies as well as their effects on service delivery. The remaining chapter in Part III covers some of the outgrowths of deinstitutionalization such as the recovery movement and psychiatric rehabilitation and several associated service models. Part IV then reviews some of the most important results of mental health research relevant to a sampling of nations and regions, specifically, Australia, Europe, Israel, the UK, and the US. It focuses on policy development in these areas and the research methods that are being employed to support these efforts.

Part V summarizes the Handbook and reviews the various cross-cutting themes and lessons from the preceding chapters. It concludes with several recommendations pertinent to both continued policy development and the research that is needed to support it.

NOTES

1. Parts of this section have been adapted from Hudson (2010).
REFERENCES


