MINISTERIAL ROUND TABLES 2001

54TH WORLD HEALTH ASSEMBLY

MENTAL HEALTH

A Call for Action by World Health Ministers

World Health Organization
Geneva

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Table of contents

5 **Preface** *by Gro Harlem Brundtland, Director General*
WHO and ministers of health forge an alliance on mental health

9 **Introduction** *by the coordinators of the round tables*
Mental health: World health ministers call for action

15 **Background document**

23 **The state of the evidence: review papers**
23 Mental health services and barriers to implementation
39 Socioeconomic factors and mental health
57 Stigmatization and human rights violations
73 Gender disparities in mental health

93 **The discussions: summary records of statements by ministers**

135 **Report by the secretariat**

141 **Speech to the plenary**
A new beginning

145 **Regional statements: renewing commitment to mental health**
Regional office for Africa
Regional office for the Americas
Regional office for the Eastern Mediterranean
Regional office for Europe
Regional office for South-East Asia
Regional office for the Western Pacific

155 **Epilogue** *by Benedetto Saraceno, Director, Department of mental health and substance dependance*
WHO's response to the ministers call for action

159 **Annex**
List of participants of the round tables

Preface

WHO and ministers of health forge an alliance on mental health

Gro Harlem Brundtland
Director General
World Health Organization
Geneva

I have great pleasure in presenting this publication which reflects our determined efforts to put mental health right at the core of the global health and development agendas. We are in the process of building a significant movement for mental health which will allow us to make a lasting difference for the millions of people who expect that societies and policy makers devote as much attention to mental problems as to physical illnesses. This has not been the case until now. In contrast to the dramatic improvements in physical health in most countries over the course of the past century – in particular, unprecedented improvements in mortality rates – the mental component of health has in many places not improved. As many as 450 million people worldwide are estimated to be suffering at any given time from some kind of mental or brain disorder, including behavioural and substance abuse disorders. This is an overwhelming figure considering that mental health is not only essential for individual well-being, but also essential for enhancing human development including economic growth and poverty reduction. Unsurprisingly, it is this statement that was echoed by many Ministers of Health during the Round Tables. "There is no development without health and no health without mental health."

We know that one out of every four persons who turn to the health services for help is troubled by mental or behavioural disorders, which are not often correctly diagnosed and/or treated. And mental health care has simply not received until now the level of visibility, commitment and resources that is warranted by the magnitude of the mental health burden. Only a very small percentage of national health budgets in most countries go to mental health. One consequence of this inadequate attention is the "treatment gap" – the gulf between the huge numbers who need treatment and the small minority who actually receive it. More than 40% of countries have no mental health policy and over 30% have no mental health programme. Even countries that do have mental health policies often disappointingly neglect some of the more vulnerable populations. For example, over 90% of countries have no mental health policy that includes children and adolescents. In most countries, stigma and human rights violations of persons with mental illness are rampant. Few efforts are in place to address discrimination and stigmatization both of which represent a substantial hidden burden of mental illness. WHO and Ministers of Health have concluded that this lack of investment in mental health is now unacceptable.

Over the years, we have followed the evolution of new knowledge and evidence. We now have a clear picture of the burden of disease arising from mental disorders. In the World Health Report 2001 that we devote to mental health, we bring updated figures which show that four of the ten leading causes of disability worldwide are neuropsychiatric disorders, accounting for 30.8% of total disability and 12.3% of the total burden of disease. This latter figure is expected to rise to 15% by the year 2020. The rise will be particularly sharp in developing countries primarily due to the projected increase in the number of individuals entering the age of risk for these disorders and as a result of social problems and unrest, including the rising number of persons affected by violent conflicts, civil wars, displacements and disasters. If we take the example of depression which is currently ranked fourth among the 10 leading causes of the global burden of disease, it is predicted that by the year 2020, it will have jumped to second place. Major depression is linked to suicide. Most people who commit suicide are also clinically depressed. If we take suicide into account, then the already huge burden associated with depression increases much more.

But there is good news also. Today we are in a better position to make use of the accumulated wealth of knowledge and the technologies that allow us more effectively to manage, treat and prevent a wide range of mental and neurological problems. We have made huge strides in developing effective treatments for most of the mental disorders and further improvements in treatments are likely thanks to advances in the understanding of brain functioning and psychosocial factors. With the current treatments, most persons with mental, brain or behavioural disorders can become functioning and productive members of the community and live normal lives. We also have some effective preventive approaches based on a better understanding of the interrelation between the complex biological, psychological and social determinants of mental disorders. A number of demonstration programmes in countries have provided evidence based interventions for improved access and quali-

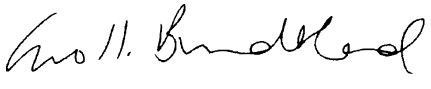
ty of mental health care. This means ensuring that mental health services are incorporated in all levels of health services, ranging from primary health care to support for families and other social services.

WHO has a critical role to play in turning this knowledge into reality. Accordingly, I have made mental health a priority programme of WHO. This programme has set the stage for global mental health action through a combination of special events taking place throughout 2001. These events aim to raise awareness of the nature and scope of mental problems and the life circumstances of people suffering from them (World Health Day), generate political will for national action (World Health Assembly Ministerial Round Tables), and disseminate the evidence and science related to prevention and care. (World Health Report 2001 on Mental Health). These activities have been instrumental in mobilizing interest and commitment for global and national action to redress the mental health status of populations around the world.

The publication of this document is particularly important because it brings together the background, the proceedings as well as the outcomes of the World Health Assembly's Ministerial Round Tables on Mental Health. The Round Tables were a historic occasion for Health Ministers from countries around the world to come together and review with their peers the major challenges they face in the prevention, treatment and care of mental problems. They engaged in open discussions on the progress that had been made in dealing with the priority mental health problems in their countries and acknowledged that this was not sufficiently consistent or widespread. A high level of political will was apparent along with growing awareness of the need for change in policies and health systems. In some countries impressive efforts have been made to expand mental health services through intersectoral partnerships. Some innovative approaches to reach vulnerable and underserved populations and to strengthen community-based care were noted. A number of factors however restrain the implementation of national strategies. Rapid economic reforms and social change including economic transitions are bringing about alarming rates of unemployment, family breakdown, personal insecurity and income inequality. Political instability, violence especially against women, natural disasters, armed conflicts, and the HIV/AIDS crisis are seriously challenging the coping capacity of the affected populations. Managerial weakness in health systems persist. Most importantly, the serious shortage of mental health resources, especially service providers, was noted in many countries. There were large technical gaps in countries regarding prevalence, diagnosis and treatment issues compounded by lack of knowledge about financing schemes, anti-stigma and legislation issues as well as intersectoral collaboration in mental health. Ministers explored and clarified the critical issues in these areas and outlined the strategic steps required in resolving them. They also identified what needs to be done by the international community.

All the messages and statements of Ministers are contained in various sections of this publication. They are reflections of a promise for a brighter future for all the millions of people suffering from mental disorders and the attendant discrimination. We look forward to working more intensely with countries, forging wholesome and sustainable partnerships that will do justice to the Ministers call for action. We will continue our efforts to become more effective in providing technical support to countries at a time when they seek to restructure and reform their mental health systems, generate policies and improve the provision of services and treatment for all those who need them. That I believe is not only our responsibility but also an opportunity for reducing suffering, disability, poverty, and premature death.

The time for action is now. I therefore invite politicians, scientists, technicians, humanitarians, social activists and programme managers in health to read this publication and build upon its messages for the improvement of mental health and well-being of all peoples.



Gro Harlem Brundtland
Director General
World Health Organization

Introduction

Mental health: World health ministers call for action

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Background

The sheer magnitude of the mental disorders and the huge social and economic burden they place on families and communities warrant an urgent call for global and national mental health initiatives. This is doubly so since cost effective interventions for the treatment and care of almost all people with mental disorders exist and can be implemented by all countries. A major challenge facing policy makers, however, is how to increase access to quality mental health care that is anchored in the communities where people with mental illness live.

Many countries have initiated and/or are undergoing reforms of their mental health care systems, moving from traditional institutional care or simply frank neglect, to care which is local, humane, and unrestricted. Through an analysis of such country processes, precious lessons can be drawn to better inform policy and programme development. It is timely therefore that countries have the opportunity to examine together the evidence for prevention, treatment and care so that they are in better position to develop effective action plans for addressing the mental health problems in their countries.

The cumulative experience of developing mental health care across countries at various resource levels coupled with the new evidence emerging from scientific research, shows that actions to address the mental health of populations have multiple benefits. These include direct benefits of services in decreasing the symptoms associated with mental disorders, reducing the overall burden of these diseases by lowering mortality and disability, and, improving the functioning, productivity and quality of life of affected people.

At the global level, the benefits of mental health interventions for decreasing the burden are substantial. Mental disorders account for about 160 million lost years of healthy life. Of this at least 30% can be easily averted with existing interventions. For example, the disability associated with depressive disorders in a community could be reduced to half with adequate care.

The discussions

The Executive Board of WHO in January 2001 approved the theme of mental health for the Round Table Discussions at the 54th World Health Assembly. Thus, four Ministerial Round Tables took place concurrently on May 15, 2001 to discuss the broad perspectives on mental health with special attention to four sub-themes namely: Mental health services and barriers to implementation; Mental health and socioeconomic factors; Stigmatization and human rights violations; and Gender disparities in mental health.

The purpose and objectives

The Round Tables provided a forum for health ministers to review jointly the major challenges they face in addressing mental health problems in their countries and to engage in a dialogue through which they shared information, approaches, and opportunities for redressing the situation. The objectives were to raise awareness of the urgent need to address the mental health burden; to place mental health firmly on the national and international health and development agendas; and to generate political commitment for increasing support to mental health policies, legislation, programmes and services in all countries.

The participants

Over 30 Ministers of Health participated in each Round Table. (In a few cases senior members of delegations were specifically designated to represent the Ministers.) A balanced mix of low, middle and high income countries with different political and health systems, priorities and level of resources for mental health was achieved in each group. Four Ministers elected by the World Health Assembly served as Chairpersons. They were: Mr Phillip Goddard of Barbados; Mr Lyonpo Sangay Ngedup of Bhutan; Mrs Annette King of New Zealand; and Prof. M. Eyad Chatty of the Syrian Arab Republic (see annex for a complete list of participants by round table).

The facilitators

Eight external experts with extensive international and national experience in mental health assisted the Chairpersons in facilitating discussion and triggering debate. They brought a broad range of scientific, clinical, policy and programme expertise to the round tables from different regions of the world. They also contributed state-of-the-art review papers on the four subthemes of the discussions. These facilitators were:

Dr Jill Astbury

Associate Professor and Director of the Postgraduate Teaching Programs of the Key Centre for Women's Health in Society, World Health Organization Collaborating Centre in Women's Health at the University of Melbourne.

Dr Lourdes L. Ignacio

Chair of the Department of Psychiatry and Professor of Psychiatry in charge of the Social and Community Psychiatry Program of the University of Philippines, Manila.

Dr Sylvia Kaaya

Head of the Department of Psychiatry at Muhimbili University College of Health Sciences in Dar-es-Salaam, Tanzania.

Dr Arthur Kleinman

Professor of Social Anthropology at the Department of Anthropology of Harvard University; and Maude and Lillian Presley Professor of Medical Anthropology and Professor of Psychiatry at Harvard Medical School in Cambridge, USA.

Dr Julian Paul Leff

Professor of Social and Cultural Psychiatry and Head of the Section of Social Psychiatry at the Institute of Psychiatry, University of London, London, UK.

Dr Juan José Lopez-Ibor

President of the World Psychiatric Association and Director of the WHO Research and Training Centre for Spain in Madrid, Spain.

Ms Ana Paula de Almeida G.C. Ferrao Mogne

Co-ordinator of the National Mental Health Program of Mozambique.

Dr Vikram Patel

Senior Lecturer at the Department of Infectious and Tropical Diseases and the Department of Epidemiology and Population Health of the London School of Hygiene and Tropical Medicine in London, UK. Dr Patel is also Director of Sangath Society in Goa, India.

Documentation

Two sets of background documents were prepared for the Round Tables. The first was the official *Background Document* reproduced in *Section 3* of this publication. It contains a general discussion on the status of mental health around the world and brief discussions of the four subtheme topics. The document highlights the lack of community-based mental health services, the widespread stigmatization of people with mental disorders, and the roles of poverty and gender inequality on mental health. All these factors are known to be linked o poor mental health outcomes but the role of the health sector in dealing with them is not always sufficiently defined. Each section of the document is followed by a set of discussion points aimed at stimulating reflection, awareness and dialogue around the issues and what needs to be done to address them.

A second set of documents, distributed *in site*, was prepared in the form of review papers. These papers present in considerable detail the latest scientific and research evidence related to each of the sub-theme topics, model policies, programmes and service examples from different countries, as well as illustrations and consumers/carers testimonies. The reviews reflect not only the current status of knowledge on the issues but they also provide guidance on policy and programmatic implications, as well as future research. The four documents are contained in *Section 4 entitled The State of the Evidence.*

The process

To catalyse attention on Mental Health in 2001, the invited speakers of the Director General at the opening Plenary of the World Health Assembly were two family members namely: Ms Noreine Kaleeba, (widowed by AIDS) Community mobilization adviser of UNAIDS and founder of The AIDS Support Organization of Uganda, and Ms. Diane Froggart, mother of a son affected by schizophrenia and Executive Director of the World Fellowship for Schizophrenia and Allied Disorders. Both speakers highlighted key mental health concerns such as the need to overcome fear, silence and stigma; raise community awareness and stimulate involvement; decrease the burden of care on families and encourage partnerships between families and professionals. Their testimonies were powerful reminders of the human dimension of mental illness and its huge socioeconomic impact on families and communities.

The Discussions were opened by the Chairpersons and followed by general presentations made by one of the two facilitators assigned to each round table. The presentations highlighted the following issues:

- the epidemiology, disease burden and socioeconomic impact of mental disorders including future trends;
- the interdependence of bio-psycho-social determinants of mental disorders;
- the effects of social factors such as poverty, stigmatization and human rights violations, and gender discrimination on the onset, course and outcome of mental disorders;
- the availability of cost effective treatments and the vast treatment gap; and
- the barriers to the development of mental health policies and programmes, intersectoral collaboration, and comprehensive community-based mental health services.

Ministers were invited to discuss the general issues in the light of the following questions:

- What can be done to increase awareness, commitment and resources for addressing the burden of mental disorders?
- What is the level of responsibility of the public sector in addressing mental health issues (prevention and care) and maintaining the highest possible standards of care in the face of other health priorities and limited resources?
- What are the key mental health concerns in countries and through which strategies and approaches are they being addressed? What are the main technical and policy obstacles that must be overcome to improve mental health programmes and service provision?

Midway through the sessions, presentations were made by the second facilitator in each of the round tables to trigger more focused discussion on the selected sub-theme topics. Discussion points highlighted in the background document *(see Section 3)* were used to guide the debate.

Through a process of sharing experiences and ideas openly and frankly, Ministers of each Round Table build a clearer picture of the global mental health status, the social context within which mental problems were occurring, the mental health priorities in each region, what could be done, and how best it could be achieved. Strategies and approaches that were being implemented with success in selected projects within countries were discussed. Similarly the shortfalls in extending these to cover entire countries were highlighted. Ministers spoke of the policy, technical and managerial difficulties in providing equitable and humane care to all those in need, especially the most vulnerable groups in their countries. They were spontaneous in requesting intensified support from the international community and WHO in regards to certain crucial areas.

Reporting

Summary records of each Minister's interventions during the discussions are contained in *Section 5* of this publication. A single report of the event prepared by the secretariat, compiling and collapsing the reports of the four round tables, is provided in *Section 6*.

On behalf of all the participants, the integrated conclusions of the four Round Tables were presented to the final plenary of the World Health Assembly on 18 May 2001 by Mr Phillip Goddard, Minister of Health of Barbados. The text of this speech, which was adopted by the Assembly, is reproduced in full in *Section 7: A New Beginning*

The outcomes

The Ministerial Round Tables were successful in creating greater global co-operation and dialogue on mental health issues. Three features are prominent for follow-up action. The first is the consensus on the primordial importance of Mental Health for the health and development of societies. This provides a useful policy basis for prioritizing mental health at international, regional and national levels. The second refers to the commitment expressed by governments to intensify action in pursuit of evidence-based solutions to mental health policy development, appropriate legislation, access to treatment and care, and promotion and prevention. The third involves the strategic areas identified by the Ministers for strengthening technical support between the international community and countries.

The World Health Organization, including its headquarters, regional and country offices, is building on these features to better support countries in their quest for equitable and humane care for people with mental problems. It is in consideration of the concerns raised by the Ministers that WHO's Regional Directors and Advisers in Mental Health have issued statements reaffirming their strong commitment to support countries in addressing their mental health priorities. These statements are provided in *Section 8*.

Finally, the Epilogue of this publication *(Section 9)* is a statement by Dr Benedetto Saraceno, Director of WHO's Department of Mental Health and Substance Dependence, which outlines the new strategic orientation of the Programme. This is intended to better respond to the requests by Ministers for intense technical support in achieving national mental health goals.

In the words of Dr Gro Harlem Brundtland, Director General of WHO, "The message we can bring to the world is one of optimism. Effective treatments are there. Prevention and early detection can drastically reduce the burden." And hence the social and human suffering.

Background Document

Mental health

The historical marginalization of mental health from mainstream health and welfare services in many countries has contributed to endemic stigmatization and discrimination of mentally ill people. It has also meant that mental health has received low priority in most public health agendas with consequences on budget, policy planning and service development. Estimation of the global burden of disease with disability adjusted life years (DALYs) shows that mental and neurological conditions are among the most important contributors; for instance, in 1999 they accounted for 11% of the DALYs lost due to all diseases and injuries. Among all the mental and neurological disorders, depression accounts for the largest proportion of the burden. Almost everywhere, the prevalence of depression is twice as high among women as among men. Four other mental disorders figure in the top 10 causes of disability in the world, namely alcohol abuse, bipolar disorder, schizophrenia and obsessive compulsive disorder.

The number of people with mental and neurological disorders will grow – with the burden rising to 15% of DALYs lost by the year 2020. The rise will be particularly sharp in developing countries primarily owing to the projected increase in the number of individuals entering the age of risk for the onset of these disorders. Groups at higher risk of developing mental disorders include people with serious or chronic physical illnesses, children and adolescents, whose upbringing has been disrupted, people living in poverty or in difficult conditions, the unemployed, female victims of violence and abuse, and neglected elderly persons.

The economic impact of mental disorders is wide-ranging, long-lasting and large. Measurable causes of economic burden include health and social service needs, impact on families and care givers (indirect costs) lost employment and lost productivity, crime and public safety, and premature death. Studies from countries with established economies have shown that mental disorders consume more than 20% of all health service costs. The aggregate yearly cost of mental disorders in 1990 for the United States of America was estimated at US$ 148 000 million. Estimates for other regions of the world are not yet available, but even in countries where the direct treatment costs are low it is likely that the indirect costs due to “productivity loss” account for a large proportion of the overall costs.

Future increases in the prevalence of mental problems will pose serious social and economic handicaps to global development unless substantive action is taken now.

At present, the mental health budget in most countries constitutes less than 1% of total (public sector) health expenditure. Moreover, mental health problems are frequently not covered by health plans at the same level as other illnesses, creating a significant, often overwhelming, economic burden for patients and their families, ranging from loss of income to disruptions in household routine, restriction of social activities and lost opportunities. Recently collected data show that more than 40% of Member States have no clear mental health policy and more than 30% have no national mental health programme. Although almost 140 of the 191 Member States have an updated list of essential drugs, including psychotropic drugs, one third of the global population has no access to the latter. In rural areas of developing countries psychotropic drugs are rarely available in adequate or regular supplies.

Research has shown that general health care providers can manage many mental and neurological problems both in terms of prevention as well as diagnosis and treatment. Yet, less than half of those patients whose condition meets diagnostic criteria for mental and neurological disorders are identified by doctors. Patients, too, are reluctant to seek professional help. Globally, less than 40% of people experiencing a mood, anxiety or substance use disorder seek assistance in the first year of its onset. Stigmatization complicates access to those who need help, treatment and care; it is responsible for a huge hidden burden of mental problems.

In most cases, a complex interaction between biological, psychological and social factors contributes to the emergence of mental health and neurological problems. Strong links have been made between mental health problems with a biological base, such as depression, and adverse social conditions such as unemployment, limited education, discrimination on the basis of sex, human rights violations and poverty.

Recent advances in neurosciences, genetics, psychosocial therapy, pharmacotherapy, and sociocultural disciplines have led to the elaboration of effective interventions for a wide range of mental

health problems, offering an opportunity for people with mental and behavioural disorders and their families to lead full and productive lives. Clinical trials have demonstrated the effectiveness of pharmacological treatments for the major mental, neurological and substance use disorders: neuroleptics for schizophrenia, mood stabilizers for bipolar disorder, antidepressants for depressive illness, anxiolytics for anxiety disorders, opioid substitutions for substance dependence, and anticonvulsants for epilepsy. Specific psychological and social interventions, including family intervention, cognitive-behavioural therapy, social skills training and vocational training, have been shown to be efficacious for severe mental illness. Rehabilitation is possible for most people with mental illness. There is evidence for the effectiveness of primary prevention strategies, especially for mental retardation, epilepsy, vascular dementia and some behavioural problems. Models of service delivery in primary care settings have been implemented around the world, and are being evaluated. Training of family members, community agents and consumers/users offer great scope to extend the capacity for services. Special mention needs to be made of the potential of staffing schools with mental health workers who have basic skills in detecting and treating developmental and emotional disorders in children. Training mothers to provide infants with psychosocial care, has demonstrated in many programmes around the world the feasibility and success of such an approach. Meeting the needs of children and adolescents who are most exposed to the psychiatric consequences of poverty, famine and loss of parents is critical in developing countries.

A large gap separates the availability of effective mental health interventions from their widespread implementation. Even in established market economies with well developed health systems, less than half those suffering from depression receive treatment. In other countries, treatment rates for depression are as low as 5%. In areas stricken by disaster or war, the situation is even worse. In low-income countries, most patients suffering from severe mental and neurological problems such as schizophrenia and epilepsy do not get treatment even when it is available at low cost (anticonvulsant therapy for epilepsy can cost US$ 5 per patient per year).

In order to deal with the burden of mental and neurological disorders in countries and reduce the psychosocial vulnerabilities of individuals, attention needs urgently to be paid to the determinants that can be modified of the development, onset, progression and outcome of mental problems. Critical areas include: the organization of mental health services, which influences access, effectiveness and quality of prevention, treatment and care; stigmatization and discrimination, which detrimentally affect access to care, quality of care, recovery from illness, and equal participation in society; socioeconomic factors, which show a clear association with frequency and outcome of mental problems; and gender roles, which determine the differential power and control that men and women have over the determinants of their mental health, and their susceptibility and exposure to specific mental health risks.

Mental health services and barriers to implementation

"I was a resident or rather an inmate of the psychiatric hospital. My husband and children receded. I saw no one. The mental health workers were the only ones who could open the locked door. I left my hope on the other side of the locked door. It was a frightening experience. There was an air of unreality there." Female patient, United States of America

Some countries have reduced the burden of mental problems through national reform strategies that have shifted the emphasis of the mental health budget from out-dated mental asylums to community-based services and the integration of mental health care into primary health care. Cost-effective, community-based services can now be delivered in numerous ways that meet many individual and community needs, and principles for successful implementation of such services have been identified. Similarly, on the basis of country experiences, the requirements for successful integration of mental health into primary health care have been defined; they include strategies for ensuring sufficient numbers of adequately trained specialist and primary health care staff, regular supplies of essential psychotropic drugs, established linkages with specialist care services, referral criteria, information and communications systems, and appropriate links with other community

and social services. Several models of nongovernmental activity in a wide range of areas, from service delivery and training to political advocacy, have proven to be successful. The participation of the nongovernmental sector, an irreplaceable source of support for mental health programmes, remains to be expanded in much of the world.

Establishing effective mental health systems faces many challenges. A common issue is ensuring the transfer of care from mental hospitals to the community; the many obstacles include political considerations, stigmatization and the absence of community services. How to organize and finance mental health services is also an issue for most countries. Because of the significant disruption to social functioning caused by mental illnesses, cooperation is essential between private and public sectors such as education, housing, employment, criminal justice, media, social welfare and women's affairs.

Securing an adequate and affordable supply of psychotropic drugs is a major concern for many mental health systems. Similarly, most parts of the world are experiencing a critical shortage of trained professionals. Services are lacking for people with specialized needs, such as children, refugees and older persons, as well as those who have substance use disorders, particularly in rural areas. Services for linguistic and cultural minorities and indigenous people in many societies are often inadequate or inappropriate.

Most people who need and could potentially benefit greatly from services are not getting them. Even in developed countries with well resourced health services, less than half those people who need treatment and care receive it. Although we know a great deal about how to solve the many and varied problems, the challenge is to remove the barriers. The potential return to society is substantial.

Discussion points

- What are some of the critical barriers to the provision of community-based mental health services in your country and what efforts are being made to overcome them?
- What are the obstacles to providing services and psychotropic drugs in rural areas and how are they being tackled?
- What mechanisms can governments put in place to ensure an adequate supply of psychotropic drugs?
- How can nongovernmental and other community-based organizations, including traditional healers and religious agencies, be engaged in a national mental health programme?

Stigmatization and human rights violations

"Given the number of families in every society who are affected by mental illness, it is amazing that there has not been an outcry to do more. Shame and fear have built walls of silence." Caregiver, Belize

Stigmatization and violations of human rights represent a sizeable, albeit hidden, burden of mental illness. Around the world, many mental health patients still receive outmoded and inhumane care in large psychiatric hospitals or asylums, which are often in poor condition. Besides contributing to endemic stigmatization and discrimination of the mentally ill, these failings have led to a wide range of human rights violations. Mental illness has often been seen as untreatable, and mentally ill individuals are labelled as violent and dangerous. People with alcohol and substance dependence are considered morally and psychologically weak. The media perpetuate these negative characterizations. Stigmatization often leaves persons suffering from mental illness rejected by friends, relatives, neighbours and employers, leading to aggravated feelings of rejection, loneliness and demoralization.

Stigmatization also leads to discrimination; thus it becomes socially acceptable to deprive stigmatized individuals of legally granted entitlements. Health insurance companies discriminate between mental and physical disorders and provide inadequate coverage for mental health care. Labour and housing policies are less open to people with a history of mental disorders than people with physical disabilities.

Surveys have shown that negative social attitudes toward the mentally ill constitute barriers to reintegration and acceptability, and adversely affect social and family relationships, employment, housing, community inclusion and self-esteem. Equally,

they create barriers to parity of treatment opportunities, restrict the quality of treatment options and limit accessibility to best treatment practices and alternatives. Unfortunately, negative attitudes towards the mentally ill and stigmatizing stereotypes may also be shared by medical and hospital personnel; patients frequently complain that they feel most stigmatized by doctors and nurses.

The myths and negative stereotypes about mental illness, although strongly held by the community, can be overcome – as communities recognize the importance of both good mental and physical health care; as advocacy renders people with mental disorders and their families more visible; as effective treatments are made available at the community level; and, as society acknowledges the prevalence and burden of mental disorders.

Introducing legislative reforms that protect the civil, political, social, economic, and cultural entitlements and rights of the mentally ill is also crucial. However, this step alone will not bear the fruits expected by legislators without a concerted effort to erase stigmatization as one of the major obstacles to successful treatment and social reintegration of the mentally ill in communities. The public needs to be engaged in a dialogue about the true nature of mental illnesses, their devastating individual, family and societal impacts, and the prospects of better treatment and rehabilitation alternatives. At the same time, stigmatizing attitudes need to be tackled frontally through campaigns and programmes aimed at professionals and the public at large. Public information campaigns using mass media in its various forms; involvement of the community in the design and monitoring of mental health services; provision of support to nongovernmental organizations and for self-help and mutual-aid ventures, families and consumer groups; and education of personnel in the health and judicial systems and employers – all are critical strategies to start dispelling the indelible mark, the stigma caused by mental illness.

Discussion points

- What measures has your country put (or does it plan to put) in place to fight discrimination and stigmatization of mentally ill people and their families?
- What is the level of responsibility and the role of the public health sector in tackling such stigmatization and discrimination?
- How can other sectors contribute to stopping the denial, through discrimination, to mentally ill people of equitable access to services and consideration?
- Given that mental health legislation requires a balance between the right to individual liberty, the right to treatment and the legitimate expectation of community safety, what are the critical issues in formulating, implementing and enforcing balanced legislation?

Socioeconomic factors

*"Poverty is pain; it feels like a disease. It attacks a person not only materially but also morally. It eats away at one's dignity and drives one into total despair "*A woman, Republic of Moldova

Socioeconomic factors, especially poverty, influence mental health in powerful and complex ways. They are highly correlated with an increase in the prevalence of serious disorders such as schizophrenia, major depression, antisocial personality disorders and substance use. Most of these disorders are about twice as common among the poorest sections of society as in the richer ones. In addition, malnutrition, infectious diseases and lack of access to education can be risk factors for mental disorders and can worsen existing mental problems. These findings are consistent in countries across income levels. They illustrate the broader concept of poverty, which includes not only economic deprivation but also the associated lack of opportunities for accessing information and services.

The relationship between poverty and high prevalence rates of psychiatric disorders can be explained in two ways, which are not mutually exclusive and which appear to be operative for different disorders. First, poor people in most societies, even among the wealthiest countries, are exposed to greater levels (quality and quantity) of environmental and psychological adversity, which produces high levels of stress and psychological distress. They have major difficulties accessing information and mental health services. In most developing countries these services are so limited

that they remain out of reach for the poor: information is often not available to illiterate populations; transport is difficult and costly; and responsiveness of the health services is low. Not only do these factors contribute to chronicity and more disability, but they may also trigger non-psychotic forms of mental illness, especially depression and anxiety disorders. Considerable evidence points to the social origins of psychological distress and depression in women, both of which conditions affect them disproportionately.

The second explanation for the relationship between poverty and high prevalence rates of psychiatric disorders refers to "downward drift" with people with a mental illness incurring much greater risks for homelessness, unemployment and social isolation. While families remain the key providers of care in most parts of the world, the strain of providing care over time can lead to people with severe mental illness being rejected by their families. This estrangement enhances the risk for poverty. In all events, socioeconomic factors and mental health are inextricably linked. The treatment gap for most mental disorders is large but for the poor segments of populations in all countries it is seemingly unbridgeable.

Mental disabilities result in substantial societal burdens of lost productivity and added costs for support, not to mention the high cost of the loss of potential contributions to society of people or families who care for the mentally ill. Hence, the cumulative costs significantly drain the economies of poor countries. National policies to reduce poverty focus on stabilizing and improving income, strengthening education, and meeting basic human needs such as housing and employment. With the health of a nation increasingly being seen as a critical component of development, mental health, as a key aspect of public health, needs to be acknowledged as a priority for overall social development.

Discussion points

- What information on the magnitude and burden of mental and neurological disorders among the poor is available in your country? Are there any plans to collect further information?
- Is health, in particular mental health, a part of poverty reduction strategies and programmes in your country?
- Do individuals and families with mental and neurological disorders get social support or benefits under poverty-alleviation schemes or social-welfare measures in your country?
- What are the barriers faced by the poor in accessing mental health information and care in your country? What are your country's plans to make mental health services more equitable?

Gender disparities

"It is not the physical abuse which is the worst but the terror which follows – the emotional abuse. I am still angry and terrified." Battered woman, Australia

Gender roles are critical determinants of mental health that need to be considered in policies and programmes. They govern the unequal power relationship between men and women and the consequences of that inequality. They affect the control men and women have over socioeconomic determinants of their mental health, their social position, status and treatment in society. They also determine the susceptibility and exposure of men and women to specific mental health risks.

Sex differences are seen most graphically in the prevalence of common mental disorders – depression, anxiety and somatic complaints. These disorders, most prevalent in women, represent the most common diagnoses within primary health care settings and constitute serious public health problems. In particular, depression, predicted to be the second leading cause of global disability burden by 2020, is twice as common in women as in men, across most societies and social contexts; it may also be more persistent in women than men. Reducing the disproportionate number of women who are depressed would significantly lessen the global burden of disability caused by mental and behavioural disorders.

The lifetime prevalence rate for alcohol dependence, another common disorder, is more than twice as high for men as for women. Men are also more than three times more likely to have antisocial personality disorder than women.

Although the prevalence rates of severe mental disorders such as schizophrenia and bipolar disorder (together affecting less than 2% of the population)

are much the same between the sexes, differences have been reported in age of onset of symptoms, frequency of psychotic symptoms, course of these disorders, social adjustment and long-term outcome for men and women. The disability associated with mental illness falls most heavily on those who experience three or more concomitant disorders – again, mainly women.

Gender-specific risk factors

Depression, anxiety, somatic symptoms and high rates of comorbidity are significantly related to risk factors that can be related to gender, such as violence, socioeconomic disadvantage, income inequality, low or subordinate social status and rank, and unremitting responsibility for the care of others. For instance, the frequency and severity of mental problems in women, are directly related to the frequency and severity of such factors.

Economic restructuring has had gender-specific consequences for mental health. Economic and social policies that cause sudden, disruptive and severe changes in income, employment and social capital that cannot be controlled or avoided can significantly increase inequality between men and women and the prevalence rate of common mental disorders.

Violence against women is a public health concern in all countries, an estimated 20% to 50% of women have suffered domestic violence. Surveys in many countries reveal that 10% to 15% of women report that they are forced to have sex with their intimate partner. The high prevalence of sexual violence to which women of all ages are exposed, with the consequent high rate of post-traumatic stress disorder explains why women are most affected by this disorder.

Gender bias

Gender bias is seen in the diagnosis and treatment of psychological disorders. Doctors are more likely to diagnose depression in women than in men, even when patients have similar scores on standardized measures of depression or present with identical symptoms. Women are significantly more likely than men to be prescribed mood-altering psychotropic drugs. Also, alcohol problems in women are rarely recognized by health providers. Such gender stereotypes as proneness to emotional problems in women and to alcohol problems in men seem to reinforce social stigmatization and to constrain help-seeking behaviour. They impede the accurate identification and treatment of psychological disorders.

Mental health problems related to violence are also poorly identified. Among victims, women are reluctant to disclose information unless asked about it directly. When undetected, violence-related health problems increase and result in high and costly use of the health and mental health care system.

Discussion points

- To what extent is your country's mental health policy gender-sensitive and does it identify and address the gender-specific risk factors necessary for prevention?
- What needs to be done to enable primary health care providers to gain and use the skills necessary to identify gender-related violence and for the management and care of the ensuing mental problems?
- How can the health sector improve intersectoral collaboration between government departments in order to remove gender bias and discrimination, and to modify social structural factors such as child care responsibilities, transport, cost, and lack of health insurance that constrain women's access to mental health care?