MENTAL HEALTH

A Call for Action by World Health Ministers
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Preface

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

Coordinators of the round tables:

**Meena Cabral de Mello**
Scientist
Department of Mental Health and Substance Dependence
World Health Organization
Geneva

**Thomas Bornemann**
Senior Adviser
Department of Mental Health and Substance Dependence
World Health Organization
Geneva

**Itzhak Levav**
Senior Adviser
Ministry of Health
Jerusalem, Israel
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 sub-themes 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 sub-theme 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 to 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 socio-economic 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 socio-economic 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 discussed. 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.
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 (DALY’s) shows that mental and neurological conditions are among the most important contributors; for instance, in 1999 they accounted for 11% of the DALY’s 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 DALY’s 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 aggraved 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?

**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?
The state of the evidence

Mental health services and barriers to implementation

Julian Leff
Professor of Social and Cultural Psychiatry
Head of the Section of Social Psychiatry
Institute of Psychiatry
London, U.K.
Executive summary

The move to community-based mental health care

Psychiatric services in developed countries were highly centralized as a result of the massive programme of building psychiatric hospitals. The process of running down and closing these hospitals has resulted in decentralization, with the establishment of community-based services. In many developing countries, the great majority of people with psychiatric conditions are managed in the community, but with very few specialized professionals. In many of these countries, the development of psychiatric services continues to have a low priority despite the high level of chronic disability caused by psychiatric illnesses.

Individuals and their families must have access to affordable psychiatric services and to sufficiently trained health workers to correctly diagnose and treat the problems. An optimal balance between specialist and primary health care services is needed. Mental health legislation also requires a balance between the right to individual liberty, the right to treatment, and protection of the public. In those countries which lack a mental health law, it is of high priority that one be enacted.

New interventions

In the last two decades there have been major advances in both drug and social treatments for a wide range of psychiatric conditions. New types of antipsychotic drugs and antidepressants have been introduced which have fewer side effects than the older drugs, but are more expensive. Cognitive-behavioural therapies, which aim to alter faulty thinking patterns and equip patients with helpful strategies to combat symptoms, have been introduced both for neuroses and for schizophrenia and manic-depression. Involving families in treatment has been shown to improve the outcome for alcoholism, eating disorders, depression, schizophrenia, and childhood neuroses and behavioural problems. These innovative developments greatly extend the range of effective psychiatric interventions, but are available to very few patients, even in developed countries.

Making drug and psychosocial treatments available to all who could benefit

Disseminating effective psychosocial treatments is a major challenge in all countries. In developing countries in which psychiatric services need to be established in primary care facilities, the costs of providing appropriate psychiatric training to the staff and of ensuring an uninterrupted supply of essential drugs must be budgeted for nationally. Some drugs may be purchased under generic names from non-profit organizations. There are good examples of training paramedical staff to prescribe a limited range of psychotropic medication. In addition, with minimal training, they can use flow-charts for diagnosis, assessment, management and referral.

In the absence of specialized professionals, paramedical staff and family members can be trained to help other families cope better with a mentally ill member. Although the responsibility for the care of people with psychiatric illness falls almost entirely on the family in developing countries, a genuine collaboration between professionals and family members is rare.

The therapeutic value of work

Work is a crucial factor in the social reintegration of psychiatric patients. However, in developed countries it is very difficult to find a job if you have a history of mental illness. The recent development of social firms or co-operatives has provided an answer to this problem. In order to improve the quality of life of people with mental illness living in the community, it is essential to forge strong links between mental health services and departments of employment, welfare and housing.

The growth of users and relatives organizations

Non-governmental organizations for users and relatives have grown to become national advocacy groups, as well as providers of services, in many developed countries. They are still embryonic in most developing countries. The recognition that users have a legitimate voice is empowering and also has the effect of reducing the stigma of mental illness.
Special groups and their needs

Children and Adolescents: In most countries in the world, the development of psychiatric services for children has lagged behind those for adults. Children and adolescents are more exposed to the psychiatric consequences of poverty, famine and loss of parents in developing countries, precisely where child psychiatric services are least in evidence. With the spread of universal education, schools are becoming the most appropriate venue for health related interventions for children. Primary care workers need to be based in schools and to be equipped with skills to identify emotional and behavioural problems in children, and to treat and manage them. The possibility also exists of training mothers in the better care of infants to prevent later problems in psychological development.

Substance Misuse: The scale of misuse of psychoactive substances, including multiple substance use, has grown dramatically worldwide in the past three decades. A wide range of effective treatments is available for alcohol and drug problems, including psychosocial, medical and educational interventions. These are best located in primary care services, which should collaborate with available community agencies, including self-help groups. Equal attention should be given to measures to reduce the demand for psychoactive substances and to reduce the supply.

The Elderly: Older people are at high risk for suicide (particularly men), depression and dementia. The psychiatric problems of the elderly are increasing yearly as the proportion of older people rises steadily worldwide. At the same time, the dissolution of the extended family under the pressures of urbanization and industrialization is slowly removing the natural support networks that sustain the elderly. Therefore there is a pressing need to support and improve the care already provided to the elderly by their families, including the provision of respite care, and the incorporation of mental health assessment and management into general health services for the elderly.
Mental health care in developed and developing countries

Introduction

The development of psychiatric services has diverged markedly in developed and developing countries. In the former, services became strongly centralized through a massive programme of building psychiatric hospitals in the nineteenth and early twentieth centuries. These were usually sited outside towns and cities. These hospitals were enclosed worlds, isolated from the rest of society, and patients, once admitted, were likely to remain for the rest of their life.

In developing countries a few psychiatric hospitals were built by the colonial powers, but these were often designated for their own personnel to the exclusion of the local population. With the ending of colonial rule, the psychiatric hospitals were taken over by the new governments, but they have never catered to more than a tiny proportion of the population. In India, for example, there are only about 25,000 psychiatric beds for a population exceeding one billion (Wig, 1997).

Consequently, in developing countries families continue to be the main source of care and support for people with psychiatric disorders, including those of the greatest severity.

Following the end of the Second World War, the focus of care in developed countries began to shift from the psychiatric hospitals to community based services. This was in response to changes in the attitudes of staff, increasing public awareness of abusive practices in the hospitals, and the introduction in 1955 of chlorpromazine, a drug with specific antipsychotic action. In North America, Europe and Australia the process of deinstitutionalization (transferring services from psychiatric hospitals to community facilities) has proceeded steadily, resulting in the closure of many psychiatric hospitals. In Italy, Law 180 was enacted in 1978 preventing the admission of patients to psychiatric hospitals, though psychiatric beds in general hospitals remain available. In England and Wales, by 2000 only 14 of the 130 psychiatric hospitals were still open. In Valencia, Spain, the last of the 8 psychiatric hospitals was closed in 2001. The neglect of mental hospitals continues to date in both developed and developing countries.

The old psychiatric hospitals represent a large investment of capital in both the buildings and the grounds, and of revenue in the staff. The land on which they stand has become quite valuable as cities have expanded to incorporate the once-distant asylums. In many countries the sites of the psychiatric hospitals have been sold to developers and the funds raised have been invested in community services. Staff in the psychiatric hospitals have been redeployed to work in the community. The dominant model in the organization of comprehensive psychiatric care in many European countries has been the creation of geographically defined areas, known as sectors; this concept was developed in France in the mid-20th century. From the 1960s on, the organizing principle of sectorization has been widely applied to many areas in almost all countries in Western Europe, with sector size ranging from 25,000 to 30,000 population.

Deinstitutionalization has not however been an unqualified success and community care still faces many operational problems. Among the reasons for the lack of better results are that some governments have not allocated resources saved by closing hospitals to community care, and that professionals have not been adequately prepared to fully understand and accept the changing place of care and roles. Critics of the community based approach claim that it has led to many more mentally ill people becoming homeless or being imprisoned (Lamb, 1976). However, follow-up studies of cohorts of long-stay patients discharged from psychiatric hospitals have shown that if community services are well organized and adequately funded, these negative outcomes can be avoided, with improvement in the patients’ quality of life (Trieman et al, 1999; Leff et al, 2000; Rothbard et al, 1999).

In many developing countries on the other hand, care programmes for the individuals with mental and behavioural problems continue to have a low priority. There is no psychiatric care for the majority of the population: care is still mostly limited to a small number of institutions – usually overcrowded, understaffed and inefficient – and services do not reflect the needs of the ill individuals or the range of approaches available for treatment and
The public seeks help in these centres as a last resort. Many hospitals continue to operate under legislation that is more penal than therapeutic. For example, in 15% of countries around the world, (WHO Project ATLAS. Preliminary analysis of information collected during an initial study, from October 2000 to March 2001, from 181 countries) the laws governing admission and discharge are more than 60 years old; these laws place barriers to admission and discharge. Also, since there are few specialized professionals, the community resorts to the available traditional healers. Most of these countries do not have adequate national level training programmes for psychiatrists, psychiatric nurses, clinical psychologists, psychiatric social workers and occupational therapists.

A result of all these factors is a negative institutional image of the mentally ill which is added to the stigma of being mentally ill. Even now, these institutions continue to be out of step with the developments and human rights of persons with mental illness as seen from reports on mental hospitals in several countries. However, stimulated by the accumulating evidence of the inadequacies and failures of the psychiatric hospital coupled with the appearance of “institutionalism”, (the development of disabilities as a consequence of social isolation and institutional care in remote asylums) many developing countries have initiated the process of de-institutionalization.

**Community-based mental health care**

De-institutionalization can be defined as a basic precondition of any serious mental health care reform. De-institutionalization is not synonymous with de-hospitalization. This has to be seen as a complex process leading to the implementation of a solid network of community alternatives. Closing mental hospitals, without community alternatives is as dangerous as creating community alternatives without closing the mental hospitals. Both have to occur at the same time.

To prevent and treat mental disorders a spectrum of services is needed, including mental health promotion, illness prevention, early intervention, treatment and rehabilitation (Jenkins and Üstün, 1998; Rahman et al, 1998). The complexity of delivering these services to meet community needs is a challenge. For example, community education, school and workplace mental health promotion require collaboration between different government departments and other stakeholders. Chronic mental disorders require integrated treatment and support services to reduce disability, increase social functioning and improve quality of life (Katschnig et al, 1997).

For other more prevalent conditions, cost effective treatments are now available to remove active symptoms and disability (Nathan and Gorman, 1998) and can often be applied by primary health care providers (Saraceno et al, 1995; Abas et al, 1995; Üstün and Sartorius, 1995). For this, individuals and/ or their families or other members of the community must recognize the problem, have accessible and affordable professional services and sufficiently trained health workers to correctly diagnose and treat the problems. An optimal balance and collaboration between specialist and primary health care services and between hospital and community care is needed. Mental health legislation also requires a balance, between the right to individual liberty, the right to treatment and the legitimate expectation of community safety.

In most countries where deinstitutionalization has occurred, the process began with local initiatives and was only officially endorsed as government policy at a later stage. The exceptions are some countries in Europe and Latin America where the law was altered to start the process of change. For the transition to community care to be successfully achieved, it is essential to have the full backing of the government so that there is equity of services nationally, and so that mental health legislation is amended to meet new standards of caring for patients. The process of formulating new laws must be carried out in collaboration with representatives of the criminal justice system. In those countries where there is no existing mental health law, it is of high priority that one should be enacted.

In some countries, even when decisions have been made to deliver a balanced spectrum of services nationally, the outcome has often fallen short of its full potential because insufficient attention was given to structural, functional and financial issues that are principal barriers to successful policy
implementation. Examples that demonstrate the importance of those issues include:

- The deinstitutionalization of patients with severe mental illness needs to be linked to an upgrading of the health care system within the community that will have to receive the patients (Lamb, 1992).
- The utilization of primary health and social services to deliver care to people with mental illness requires that these services have sufficient training and structural linkages to specialist mental health service providers (Strathdee and Jenkins, 1996).
- Training mental health professionals as a means of expanding access to care requires that sufficient attention is given to issues of distribution and specific role based skills through certification and other means (Jenkins, 1999).
- The dependence on families and community support systems, including self-help groups, public housing etc, requires that sufficient structural and financial linkages be established to the mental health services (Whiteford, 1994).

Good quality care in the community is no cheaper than psychiatric hospital care (Hallam et al, 1994), and there are transitional costs which need to be met before the new service is fully established. Hence mental health budgets need to reflect this. Furthermore, in developing countries in which psychiatric services need to be established in primary care facilities, the costs of providing primary care workers with appropriate psychiatric training, and of ensuring an uninterrupted supply of essential drugs, must be budgeted for nationally. Health budgets are under constant pressure to expand from all medical and surgical specialties. In view of the heavy burden of disability produced by psychiatric disorders budgets for mental health need to be protected. (WHO, 1997)

In conclusion, community based mental health care is about empowerment of people with mental and behavioural disorders and refers to the stage in which the main goal is to develop a wide range of services within local settings. In this process, which has not yet begun in many regions and countries, it is aimed to ensure that some of the protective functions of the asylum are fully provided, and the negative aspects of the institutions are not perpetuated. The care in the community approach aims to provide services which offer treatment and care with the following characteristics:
- services which are close to home through primary health care, including general hospital-care for acute admissions, and long-term residential facilities in the community;
- interventions related to disabilities as well as symptoms;
- treatment and care specific to the diagnosis and needs of each individual;
- wide range of services which address the needs of service users themselves and of other ill persons;
- services which are co-ordinated between mental health professionals and community agencies;
- mobile rather than static services, including those which can offer home treatment;
- partnership with carers and meeting their needs;
- legislation to support the above aspects of care.

The advent of new treatments for psychiatric conditions

In the last two decades there have been major advances in both drug and social interventions for a wide range of psychiatric conditions:

Drug therapies

New types of drugs have been introduced for treating the symptoms of psychosis. Following the introduction of chlorpromazine in 1955, a number of related antipsychotic drugs came on the market. These all had the disadvantage of causing severe neuromuscular side effects at therapeutic doses, which deterred many patients from taking them regularly. Clozapine, a drug which was free of these side effects, became available, but had the dangerous propensity of suppressing white cells in 1-2 percent of patients. Since 1973 four or five novel antipsychotic drugs have been introduced which lack the neuromuscular side effects of the older drugs and do not affect the white cells. Hence they are more acceptable to patients. However they are much more costly: for example, in the United Kingdom, the monthly cost of haloperidol is £5, while clozapine costs £241.
New types of antidepressant drugs have been developed which are considerably safer than the older types when taken as an overdose, but are also more expensive.

**Psychosocial therapies**

Cognitive-behavioural therapies, which aim to alter faulty thinking patterns and equip patients with helpful strategies to combat symptoms, have been introduced for depression (Beck et al, 1979), anxiety states, phobias (Marks, 1987), and obsessive-compulsive disorders (Marks et al, 1975). For each of these conditions the psychological treatment is as effective as drug treatments or better. Patients are generally reluctant to take drugs for long periods and greatly prefer non-drug treatments. Recently a cognitive-behavioural approach to psychotic symptoms (delusions and hallucinations) has been shown to be of benefit, particularly for patients who have responded poorly to antipsychotic drugs (Kuipers et al, 1998; Tarrier et al, 1999).

Family therapy improves the outcome for adults with alcoholism, eating disorders, and depression, and for children with neuroses and behavioural problems. Working with families of people with schizophrenia adds a significant advantage to maintenance drug treatment in reducing the relapse rate (Leff, 2001) and has been endorsed by a Cochrane Review as evidence based (Pharoah et al, 1999).

These innovative developments greatly extend the range of effective psychiatric treatments, but are available to very few patients, even in developed countries with well-resourced national health services. The difficulty in disseminating these treatments is partly due to the lack of training in the necessary skills, and partly to the fact that there is no commercial organization with an interest in promoting the product.

**Integrating psychiatric care within primary health care**

Despite the major differences between mental health care in developing and developed countries, they share a common problem: the poor utilization of available psychiatric services. Even in countries with well established services, fewer than half of those individuals needing them make use of them. This is related to the stigma attached to the individuals with mental and behavioural disorders and the inadequacy of services provided.

This stigma issue was also highlighted in the US Surgeon General’s Report of December 1999. The report noted: “Despite the efficacy of treatment options and the many possible ways of obtaining a treatment of choice, nearly half of all Americans who have a severe mental illness do not seek treatment. Most often, reluctance to seek care is an unfortunate outcome of very real barriers. Foremost among these is the stigma that many in our society attach to mental illness and to people who have a mental illness.”

Integrating psychiatric care within general health care – which includes the opening of psychiatric admission wards in general hospitals – has the added advantage of reducing the stigma of admission for psychiatric illness. In developed countries it is rare nowadays for patients with non-psychotic disorders to be admitted, and admission wards are almost exclusively occupied by patients with psychoses. The great majority of patients with non-psychotic disorders are treated by primary care physicians, only 5% of them being referred to secondary care (Goldberg & Huxley, 1980).

However, up to one half of patients consulting primary care physicians with psychological disorders are incorrectly perceived as suffering from physical illnesses (Docherty, 1997; Goldberg & Huxley, 1992) leading to a waste of money on physical tests and delay in their receiving appropriate treatment, or its absence. This is partly because many patients present to their doctors with bodily rather than psychiatric complaints (Üstün & Sartorius, 1995). The problem is very serious because depression accounted for more than 10 per cent of years of life lived with a disability worldwide in 1990. Many episodes of depression become chronic, par-
particularly if untreated: persistent symptoms were found in 32 per cent of 60 patients 12 to 15 months after remission (Paykel et al, 1995). Improvements in training of primary health care providers for assessment and management of mental disorders is a priority for both developing and developed countries.

The organization of mental services as part of primary health care is a general approach in developing countries. At one level it can be seen as necessity in the face of lack of trained professionals and resources to provide specialized services. At another level it is a reflection of the opportunity to organize mental health services in a manner that is devoid of isolation, stigma and discrimination. The approach of utilizing all the available community resources has an attraction of empowering individuals, families and communities to make mental health an agenda of people rather than professionals. However, currently mental health care is not receiving the attention that is needed. Even in countries where pilot programmes have shown the value of integrating mental health care within primary health care (e.g. Brazil, Colombia, India, Sudan) the expansion to cover the whole country has not occurred.

**Treatment interventions through primary health care**

**Drug treatments**

Psychiatric drug treatments can be delivered by primary care physicians in developed countries, although they are not always as skilled in their use as psychiatrists. This is particularly the case with antidepressant drugs which tend to be prescribed in too low a dosage. In developing countries even the cheapest, most basic drugs may be available only sporadically, or not at all. This problem stems from a combination of insufficient central funds and an inadequate infrastructure for distribution. It has been tackled successfully in Sichuan Province, China, by training village medical auxiliaries in the use of three low cost psychiatric drugs: an antidepressant, an antipsychotic, and carbamazepine, which is effective both for stabilizing mood disorders and controlling epilepsy. In a similar initiative in Belize, Central America, well trained psychiatric nurse practitioners have been prescribing psychotropic medication for some years, a service which has been positively evaluated (Kohn et al, 2000). This exemplifies the approach recommended by the Expert Committee on the Use of Essential Drugs (WHO, 1988).

Continuous maintenance medication is often required for the psychoses (schizophrenia and manic-depressive illness) and sometimes for depressive disorders. An interruption in the supply of drugs can lead to relapse of these conditions. In certain circumstances, drugs may be purchased under generic names from non-profit organizations such as ECHO (Equipment for Charitable Hospitals Overseas) and UNIPAC (UNICEF Procurement and Assembly Centre), which supply drugs of good quality at economic prices (World Health Organization, 1990).

Even with a very limited range of psychotropic drugs to prescribe, the health worker will need to decide which are indicated for particular clients. Flow-charts have been developed for psychiatric conditions that incorporate decisions about diagnosis, assessment, management and referral. Their advantage is that they can be used with minimal training (World Health Organization, 1990).

**Psychosocial treatments**

In developed countries there is usually a cadre of psychiatric staff based in the community who could deliver these effective new treatments. However there is a logistic problem in training a sufficient number of them in the requisite skills. Training in psychosocial interventions that have been proven efficacious is time-consuming, and during training the staff member is absent from the work site and has to be replaced. Funds need to be made available both for the training and for replacement staff. Managers are often reluctant to commit funds to the short term investment, even though there are long term economic gains in terms of reduced hospitalization rates (Cardin et al, 1985; Zhang et al, 1994). Even when staff are trained, they are not always able to utilise their skills efficiently. This is partly due to the pressure of their case load, and partly to the lack of adequate supervision and support for work that is emotionally demanding. In order to integrate psychosocial interventions into a clinical service it is necessary to achieve a culture change in the whole service by educating all the staff, including man-
agers, in the value of the interventions, and training a core group of workers who can provide mutual support (Fadden, 1998).

A cascade model of training in family work, cognitive-behavioural approaches for schizophrenia, and assertive community treatment has been established in Britain for psychiatric personnel (the Thorn Initiative) (Lancashire et al, 1997). Two national training centres accept trainees from anywhere in Britain, and provide training both in the necessary skills and, for selected individuals, to become trainers themselves. Six satellite training centres are now operating and a further six are being established. However, even after several years of operation of this programme only a small proportion of families who could benefit from this intervention are receiving it. This technological innovation is not available for most of the world, although training in family work is becoming established in certain centres in Europe and the US.

A model of this kind is inappropriate for a developing country due to lack of sufficient psychiatrically trained personnel available to work at the community level. Furthermore, even when providers exist, there is often maldistribution, due to their commitment to private patients and a reluctance to practice in rural communities. The strategy of training health workers in the use of a limited range of drugs cannot be applied to psychosocial treatments, since the effective components in these complex interventions have yet to be identified. A different approach has been attempted in Britain which may be applicable to developing countries. A voluntary organization for patients with schizophrenia and their families (the National Schizophrenia Fellowship) has introduced a novel programme which uses family members as trainers for other families (Carers Education and Support Project). The training programme for ten to twelve carers is delivered in ten three hour sessions. It aims to improve carers' understanding of severe mental illness, to reduce stress and ease the burden of caring, and to improve communication skills (Shore & Holmshaw, 1998). Although not yet fully evaluated, this strategy is promising. However, the approach to working with families will need to be modified to be sensitive to local cultures, as has been achieved successfully in Malaysia (Razali et al, 2000) and China (Xiong et al, 1994; Zhang et al, 1994). In all these endeavours it is crucial to recognize that the family is not the target of treatment but is a partner in the treatment process. Effective working relationships between families and mental health staff depend upon consultation, co-operation, mutual respect, equality, sharing of complementary resources and skills, and clarity of expectations (Community Liaison Committee of the Royal Australian and New Zealand College of Psychiatrists, 2000).

Although the responsibility for the care of people with psychiatric illness falls almost entirely on the family in developing countries, a genuine collaboration between professionals and families remains in its infancy. For example, in India there are a few places where family interventions have been delivered (Shankar & Menon, 1993; Verghese et al, 1991), but these are specialized facilities and such approaches are not available in routine service settings. The importance of the family's commitment to the caring role cannot be overemphasized, particularly since there is evidence that the manifestly better outcome for patients with schizophrenia in developing countries (Jablensky, 1992) is partly due to a greater tolerance by relatives for symptoms and disturbed behaviour (Wig et al, 1987; Whyte, 1991)

Combating social exclusion

Work as a therapeutic activity

Long-term care in a psychiatric hospital excluded patients from participation in society. Since these institutions provided a total environment (Goffman, 1961) including shelter, work and recreation, there was no reason for patients to step outside the gate, even if they were allowed to do so. Transferring patients to homes in the community does not automatically ensure reintegration into society. There are a number of barriers to social integration including stigmatizing attitudes of the public, patients' lack of social skills, and the difficulty in obtaining a job in open employment. Work is a crucial ingredient in the reintegration of psychiatric patients since it can provide them with social contact with ordinary citizens, it can give them a sense of worth through contributing to society, it can alleviate the poverty that many endure (see Socioeconomic Factors and Mental Health), and it can help to reduce delusions...
and hallucinations. Patients discharged from psychiatric hospital who have a job are much less likely to be rehospitalized than those who are unemployed, regardless of their level of symptoms (Jacobs et al, 1992). The provision of sheltered workshops in the community maintains the social isolation of patients from mainstream society, and usually requires them to undertake repetitive, unsatisfying packing or assembly tasks. A preferable alternative is the recent development of social firms or co-operatives (Saraceno, 1997), which are a particular feature of the community psychiatry movement in Italy. A comparison of patients with schizophrenia in Bologna, Italy, and Boulder, Colorado, USA, found that 30% of the Italian patients worked more than 30 hours per week compared with 8% of the American patients, and the Italian patients earned two and a half times as much and enjoyed a better quality of life (Warner et al, 1998). Social firms for people with psychiatric disabilities are now reasonably well established in Europe, with Germany having by far the largest number (Grove et al, 1997).

In developing countries, in which families provide virtually all the care for people with psychotic illnesses, they are often able to find tasks within a family enterprise which their relative is able to perform. In this event, mentally ill family members can feel they are contributing to the family’s welfare and are included in a social unit. However, the spread of urbanization and industrialization inevitably curtails these opportunities for employment. Therefore social firms represent a way forward in both developed and developing countries. Their development could be encouraged by tax incentives from the government and by the involvement of local businessmen as advisors.

In order to improve the quality of life of people with mental illness living in the community, it is essential to forge strong links between mental health services and departments of employment, welfare, and housing.

### The user movement

#### The growth of users and relatives organizations

The past two decades have seen the rise of the user movement. Non-governmental organizations for users and relatives have grown to become national advocacy groups in many developed countries, for example, the National Alliance for the Mentally Ill in the USA, ENOSH in Israel, MIND in Britain. Through providing information about mental illness and raising public consciousness about the issues, these organizations play a vital role in combating stigma (see Stigmatization and Human Rights Violations). They have also become active players in policy development.

In Great Britain, MIND, receives a substantial grant from the government. Through such mechanisms, users are able to express their views of the kinds of services they would like to receive, and act as a pressure group on providers of mental health services, including the government. In developed countries, users are increasingly being included on bodies that make decisions about the development of psychiatric services. This recognition that users have a legitimate voice is empowering and also has the effect of decreasing stigma.

In developing countries they are currently small in membership or non-existent, though they are becoming established in Latin America in countries such as Argentina and Brazil. However, they are often locally based without a national identity, which inhibits them from acting as a pressure group for the improvement of services, and from providing adequate support to all users and relatives who need it.

In some countries there is a growing self-help movement organized by and for users.
Services needs of some special groups

Psychiatric problems in children and adolescents

In most countries in the world, the development of psychiatric services for children has lagged behind those for adults, with the deficiencies being greatest in low income countries.

Between 10 and 20 per cent of children and adolescents are affected annually, their psychiatric morbidity accounting for five of the top ten leading causes of disability for those aged 5 and above (Murray & Lopez, 1996). In Latin America and the Caribbean alone, 17 million children suffer from moderate to severe psychiatric disorders in need of care (Presentation, PAHO/WHO Directive Council, 1997). In many developing countries there is a paucity of adequately trained child and adolescent mental health professionals. Adolescents, a group at high risk for psychiatric disturbances, often have to be treated in facilities for adults. Substance abuse in children and adolescents also is a worldwide problem (Belfer & Heggenhougen, 1995) and has severe consequences in terms of morbidity and mortality.

Children and adolescents are more exposed to the psychiatric consequences of poverty, famine and loss of parents in developing countries, where child psychiatric services are least in evidence. In the absence of a cadre of adequately trained child and adolescent mental health professionals, it is unrealistic to plan for the institution of these services in developing countries in the near future. Instead the focus should be on equipping mental health workers with basic skills in the detection and treatment of child psychiatric disorders, as in Alexandria, Egypt, where child counsellors have been trained to work in schools (El-Din, 1993). With the spread of universal education, schools are becoming the most appropriate primary venue for health related interventions for children. Since child mental health symptoms do not differ significantly across cultures, it is feasible to use expertise from child psychiatry services in developed countries to compile training packages for primary care workers in developing countries (Nikapota, 1993), (Thabet & Vostanis, 1998). These training materials should be adapted so that they are culturally appropriate. These workers need to be based in schools and to be equipped with skills to identify emotional and behavioural problems in children and to treat and manage them. They should also be able to identify vulnerable children and to employ preventive strategies. Other forms of outreach are needed to work with children and adolescents who resist coming to conventional settings for care. Multi-function health clinics, after-school programmes, and activities programmes can be venues for counselling activities.

The possibility exists of training mothers in better care of infants in an attempt to prevent later problems in psychological development. A pilot project in one of the deprived townships in Cape Town has demonstrated the feasibility of this approach (Cooper et al, in press). Mothers of older children have been successfully trained to befriend postnataally depressed mothers in Ireland, with the aim of improving mother-infant interaction.

Children and adolescents with diagnosable serious mental illness require treatments analogous to adult treatments. However, caution must be used in the consideration of the use of psychopharmacologic agents that are not approved for use with children and adolescents. Though most care can now be done on an outpatient basis, for children and adolescents with the most serious problems and marginal support from families, appropriate inpatient care is indicated. Inpatient care should always be considered for suicidality and psychotic conditions.

Children continue to be traumatized in great numbers by armed conflict, by epidemics such as HIV/AIDS, and by natural disasters. Wars directly affect children by violence inflicted on them and their families, and indirectly by the emotional trauma caused to their carers. Eighty percent of the victims of war are children and women (Lee, 1991). Displacement due to war resulted in approximately 21.5 million refugees in 1999. AIDS is now a pandemic in sub-Saharan Africa, Russia and parts of Asia. Over one quarter of the youth population in sub-Saharan Africa is infected. The mental health consequences are both direct, including dementia and depression, and indirect, through loss of parental figures and stigmatization. For children not raised in situations of armed con-
conflict or disaster, there is increasing awareness of the high prevalence of physical and sexual abuse, neglect and poor parenting, and the serious and enduring effects of these experiences on mental health.

**Substance misuse**

The scale of misuse of psychoactive substances has grown dramatically worldwide in the past three decades. In many countries there has also been a rising prevalence of multiple substance use. Those at high risk include indigenous peoples, prisoners, young people, and refugees. A particularly vulnerable group are people with severe psychiatric illness, whose treatment and management is seriously compromised by concomitant substance misuse. While these problems are most prevalent in Western countries, they exist everywhere.

A wide range of effective treatments is available for alcohol and drug problems, including psychosocial, medical and educational interventions. Such interventions are best located in primary care services, particularly in developing countries, where specialized services may be absent. All available community agencies, including self-help groups, should be enlisted to assist substance users in recovery and rehabilitation.

Equal attention should be given to measures to reduce demand for psychoactive substances and to reduce supply. This obviously requires collaboration between health and other governmental departments. Given that elimination of substance misuse is unlikely in the foreseeable future, there is growing interest in harm reduction strategies. (World Health Organization, 1998). This includes providing oral opioids such as methadone as maintenance therapy for injecting opioid users, and setting up syringe exchange facilities or making syringes legally available for drug injectors who are unwilling to abstain from injecting drugs. These strategies not only reduce mortality and morbidity among injecting drug users, but reduce the spread of infectious diseases such as hepatitis and HIV infection.

The service needs of multiple substance users and people with psychoses who also misuse substances should be considered. The latter require care from psychiatric services and drug abuse services, so that inputs from both need to be co-ordinated.

**The Elderly**

At the other end of life, the elderly are at high risk for suicide (particularly men), for depression, and for dementia. Rates of suicide are proportionately higher in older people in virtually all countries in which they have been measured reliably. Men over the age of 75 are the group with the highest incidence of all (De Leo, 1997). Some 70 per cent of older suicide victims are considered to have been suffering from a mental illness, most frequently a major depressive disorder (Conwell, 1997). In the United Kingdom, depression severe enough to warrant treatment is found in between 11 and 16 per cent of elderly people living at home (Copeland et al, 1987). This high rate is attributable to the existence of physical health problems (Robert et al, 1997). Presence of depression further increases the disability among this population. Depressive disorders among the elderly go undetected even more often than among younger adults because it is often mistakenly considered a part of the ageing process.

The main causes of dementia are Alzheimer’s disease and cerebrovascular disease, their relative importance varying from country to country (Jorm, 1991). The incidence rises approximately exponentially with age, but is lower in Asian countries than in Europe or North America (Jorm & Jolley, 1998). The prevalence of dementia reaches nearly 40% in people aged 90 years.

The mental problems of the elderly are increasing yearly as the proportion of older people in the population rises steadily worldwide. At the same time, the dissolution of the extended family under the pressures of urbanization and industrialization is slowly removing the natural support networks that used to sustain the elderly.

Special policy and service issues regarding the elderly include therefore the need to support and improve the care already provided to the elderly by their families, incorporating mental health assessment and management into general health services for the elderly, and providing respite care to family members who are still often the carers.
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The state of the evidence

Socioeconomic factors and mental health

Vikram Patel,
Senior Lecturer
London School of Hygiene and Tropical Medicine and Sangath Society
Goa, India

Ricardo Araya,
Senior Lecturer in Psychiatry
University of Wales College of Medicine
Formerly Associate Professor of Epidemiological Psychiatry
Universidad de Chile, Chile

Glyn Lewis,
Professor of Epidemiological Psychiatry
University of Wales College of Medicine, UK

Leslie Swartz,
Professor of Psychology
University of Stellenbosch, South Africa
Executive summary

This paper presents some of the current evidence that shows the links between socioeconomic determinants and mental disorders. The authors have chosen to focus on depressive and anxiety disorders for several reasons. First, these are the commonest of all mental disorders. Second, these disorders account for the largest proportion of the aggregate burden attributed to mental disorders, mainly because of their high frequency. Third, these disorders are typically seen in the general health care settings and can be managed effectively by general health workers with basic skills and training. Finally, there is good evidence of an association with socioeconomic determinants and depressive and anxiety disorders.

However, it needs to be recognized that severe, but far less common, mental disorders such as schizophrenia also cause a significant burden to society, for instance consuming most of the resources devoted to specialist mental health services. It is also evident that socioeconomic determinants play an important influence on other mental disorders, notably alcohol and substance abuse. Thus, policies, which are geared to reducing the impact of socioeconomic determinants on depressive and anxiety disorders, are likely to have a beneficial effect on the risk and outcome of other mental disorders as well.

This working paper has used research and programme evidence from across the world to demonstrate the following issues:

The burden of depression and anxiety

The prevalence rates of depressive and anxiety disorders varies between settings. Clinically significant disorder occurs in up to 20% of adults living in the community. The prevalence rate is higher in health settings, between 15% and 40% of adults attending primary care and general medical clinics. Depression and anxiety typically occur together and the term depression is used in this document to refer to both types of emotional disorders.

Depressive and anxiety disorders are not transient disorders; about half of all sufferers have a chronic or recurrent course.

Women are significantly more vulnerable to suffer these disorders than men. Some of the factors responsible for this increased risk may lie in the unequal status of women in most societies across the world.

Socioeconomic factors and depression

Socioeconomic disadvantage is strongly associated with the presence of depressive and anxiety disorders. This disadvantage can take many forms from obvious material deprivation to more subtle ways reflecting lack of opportunities due to poorer education, greater risk of adverse life events or other forms of covert or overt social discrimination.

Irrespective of the average per capita income of a society, persons who are at the bottom end of the social hierarchy are at a greater risk to suffer these disorders than those who are at the upper end, an effect which seems to be more pronounced in more unequal as well as poorer societies. Thus overcoming poverty might contribute to improve mental health but it is unlikely to be enough; a more equitable distribution of resources remains important.

A variety of social phenomena associated with rapid urbanization by globalization may be detrimental to mental health through increasing stress or reducing natural protective factors. Examples of such phenomena include squalid living conditions in urban areas for migrants, and the breakdown of families as sources of social support.

Depressive and anxiety disorders are disabling and can prevent sufferers from carrying out their tasks at home and in employment. Depressive and anxiety disorders have adverse economic implications for the individual, their families and society.

Implications for interventions and policy

The vast majority of persons with depressive and anxiety disorders never receive treatment. Few consult mental health professionals. If they do seek health care at all, they do so from general health care professionals and traditional medical practitioners.

There is evidence, mostly from developed countries, that some forms of treatments are effica-
cious and cost-effective for common mental health conditions such as depression and anxiety. These interventions can be easily delivered by general health care workers. Improved treatment is a priority though that alone would not lead to a reduction of the prevalence in the community.

Social and economic policies may impose an unacknowledged burden on society by influencing the prevalence of depressive and anxiety disorders. Policies aimed at reducing poverty and improving economic equity are likely to have the unanticipated benefit of improving mental health and reducing the burden of depression.

Some intervention programmes may help to reduce the impact of poverty on mental health. Poverty reduction and full employment policies should have benefits in reducing prevalence. Provision of micro-credit as a means of reducing dependence on informal moneylenders may also reduce financial strain. Investing in mainstream education and school completion should improve the individual’s long-term opportunities and improve mental health, especially in the developing world.

General practitioners and community health workers must be involved in mental health policies and programmes. The emphasis in health policy must be to achieve adequate skills for the diagnosis and treatment of depressive and anxiety disorders in general health care settings. Treatment with antidepressant medication and inexpensive psychosocial interventions should be available everywhere. These programmes can be implemented at little additional cost, because they use existing human and infra-structural resources.

Research is badly needed, especially from the less developed world, to strengthen the evidence base. Longitudinal research into the causes of depressive and anxiety disorders, and identifying the links between socioeconomic inequalities and depressive and anxiety disorders is required. This research should be designed so as to inform and evaluate changes in social and economic policy.
Introduction

As the nations of the world come closer to each other in this era of globalization, it is important to consider what relationship exists between socioeconomic factors and mental health within and between countries. It would be fair to say that, till recently, the relationship between poverty and mental health was a topic which was rarely taken seriously by health, social, or economic policies. Amidst various health priorities and concerns about economic inequality and poverty, where does mental health fit in? Can we really be mentally well when our bodies are sick and our stomachs empty? Can cash-strapped health services divert resources to mental illness with its vague, fuzzy boundaries and connotations of asylums, shock therapy and madness? Isn't mental illness largely due to consumerism and materialism rather than lack of essential things? Is mental illness a consequence of the material deprivation that some of the poorest members of our global village have to endure? These are just some of the clichés and challenges one faces in a discourse on impoverishment and mental health.

This paper presents evidence to demonstrate that, far from being a luxury item or a matter of concern only for rich nations, mental illness is closely associated with poverty and inequality and may impede some aspects of economic development. The relationship between socioeconomic status and mental disorder has important implications for all the nations of the world.

In presenting the evidence and implications of socioeconomic determinants of mental health, this paper will focus on depressive and anxiety disorders. The reasons for this focus are that depression is the commonest of all mental disorders and, arguably, poses the greatest public health burden. However, other mental health problems such as schizophrenia, dementia and alcohol and drug dependence are major sources of disability in their own right. For speciality mental health services, the costs of health and social care for schizophrenia and other functional psychoses are the main burden. Dementia will become an ever increasing issue within the developed and developing world as the population ages. Alcohol problems are a common source of work absence in all areas of the world. Nevertheless, it has become apparent that depression leads to more disability in aggregate than these other mental health problems and poses a special burden on primary health care services. The paper tackles the issue in three parts. First, it presents the global evidence to justify that depression is a serious global public health issue. Second, it presents evidence to demonstrate that there is a relationship between poverty, socioeconomic inequality and depression. Third, it considers policies and programmes, which may reduce the public health and individual burden posed by depression.

Depressive & anxiety disorders

What is depression and anxiety?

The symptoms of depression and anxiety are common and reported in all populations of the world. There needs to be a distinction drawn between the ups and downs of emotional life that everyone experiences and the more severe depressions and anxiety disorders seen in a clinical setting. Clinically significant depressive and anxiety disorders are largely a matter of judgement on behalf of the clinician and patient and the precise case definition used in a study can therefore markedly influence the prevalence. Over the past 30 years there has been a considerable amount of progress in measuring the symptoms of depression and anxiety in a reliable way. Relatively brief, standardised interviews exist that can be used in all the countries of the world. Though some methodological issues remain, these are relatively minor.

Symptoms of depression and anxiety

There is now a professional consensus about the major symptoms of depression and anxiety. For example, depression is characterised by a number of symptoms, in addition to a lowering of mood. These are loss of interest, poor concentration and forgetfulness, lack of motivation, tiredness, irritability, poor sleep and changes in appetite. The hallmark “negative” attitudes of depressed individuals is perhaps the most disabling aspect of the illness. Anxiety is associated with a fearful feeling, worrying thoughts and physical symptoms such as palpitations, tingling sensations, headaches and chest pain. The symptoms of depression and anxiety are universal and occur in all societies that have...
been studied\(^2\). Furthermore, depression and anxiety in the primary or general health care setting typically occur together. In this document, the term “depression” is used to denote the clinical presentation of both depression and anxiety. The presentation of symptoms, however, does appear to vary between different countries. In many developing countries, subjects with depression complain to doctors mainly of their physical symptoms (such as tiredness). The psychological symptoms are present when they are directly asked\(^3, 4\). Similarly, there is also some variation in how these symptoms are labelled around the world. For example, in Zimbabwe, the idiom of kufungisisa or “thinking too much” is used to describe psychological symptoms\(^5\).

The burden of depression

The evidence of high prevalence of depression has been building up over the past 20 odd years from a range of settings in high-, middle- and low-income countries from all regions of the world\(^6-12\). These studies reveal community prevalence figures that vary between different countries but can be up to 20% in some studies. For example, the prevalence in the UK psychiatric morbidity survey was about 14%. The case definition used in this study reflected a severity appropriate for treatment in primary health care. Just over 2% of the UK population had the more severe depressions that are familiar to psychiatric specialists. Prevalence estimates in attendees at primary health care, the sector catering for the poorest members of some societies, show levels that can be as high as 40%\(^13-15\). Depression often runs a chronic or recurrent course with nearly half of patients in treatment settings remaining ill for 12 months or more\(^16, 17\).

There is now a large body of evidence demonstrating the considerable disabling effects of depression both in the community and primary health sector (see below)\(^13, 18, 19\). In addition to disability, there is evidence that depression can also lead to increased mortality. The risk of death by suicide in persons with depression or substance abuse is well-described\(^20\). There is growing concern of the rising rates of suicide in many developing countries, particularly amongst adolescents and young adults in whom suicide is one of the three leading causes of death. In India, for example, the suicide rate increased by 6.2% per annum between 1980 and 1990, during which period the population growth rate was 2.1%; the highest growth in suicide rates was for young adults\(^21\). Deliberate self-harm (i.e. self-harm which does not lead to death) is far commoner than completed suicide and is fast becoming the commonest reason for emergency medical treatment in some developing countries such as Sri Lanka\(^22\).

Depression is also associated with poor physical health. Even after excluding suicide, recent cohort studies from the UK and USA have demonstrated a higher mortality rate in patients with depression\(^20, 23\). There is also an increased risk of ischaemic heart disease in those with depression\(^23\). It has been suggested that the impact of socioeconomic inequalities on physical health may be mediated by an effect on psychological health\(^24\).

Primary care is regarded as the cornerstone of health care in both the developed and developing world. Most treatment of depression occurs in primary health care rather than in specialist settings. However, despite the considerable evidence of the effectiveness of drug and psychological treatments for depression, albeit largely from the developed world\(^25\), the vast majority of patients in developing countries do not receive these treatments. Instead, they are prescribed a cocktail of medicines aimed at various symptoms, such as painkillers, vitamins and sleeping medicines\(^13, 26\). Thus, policies which strengthen the treatment services in primary care and improve the availability of antidepressants and brief and effective psychological interventions are needed to help reduce the burden of illness for affected persons.

Depression & Disability

Depression and anxiety are exceptionally disabling conditions and the disability is often not widely acknowledged, in part because of the stigma associated with these illnesses. In the Medical Outcomes Study in the US the disability associated with a variety of chronic medical conditions such as diabetes, arthritis and depression were compared. Depression was the most disabling condition of all those investigated\(^27\). Depression is disabling for a variety of reasons. The symptoms of depression such as poor concentration and lack of motivation impair the ability to carry out everyday tasks. Irritability combined with these can affect
the relationships with other family members and fellow workers. The “negative” attitudes of depression can impair judgement and reduce problem-solving abilities. It is perhaps this latter aspect of depression that is especially worrying in relation to socioeconomic inequalities. It is likely that depression impairs the ability of poor people to deal with the difficult circumstances they experience. Arguably, for the poorest people in the world, problem-solving abilities are essential in order to deal with their circumstances. One particular area with adverse consequences is the impact of depression in women on their children. Postnatal depression is common and it can have adverse effects on the intellectual and emotional development of children leading to cycles of disadvantage.

The relationship between the severity of disorder and disability is an important concern from a public health perspective. Depression can be thought of along a single continuum of severity. Disability increases in line with the increase in severity. In aggregate, mild depressive conditions may lead to more disability in the population than that attributable to the less common, more severe disorders. This paradoxical situation, in which less severe cases of a disorder are more important, is common in public health. It has important implications, nevertheless, for public policy and research as indicated below.

Public health and depression

The Global Burden of Disease (GBD) estimates developed by WHO, the World Bank and the Harvard School of Public Health, revealed that mental and neurological disorders accounted for 11% of the total Disability Adjusted LifeYears (DALYs) lost due to all diseases and injuries in 1999. Based on the analysis of trends, projections indicate that the burden due to mental and neurological disorders will increase to 15% by the year 2020.

The GBD study ranked depression as the 4th leading cause of burden among all disease, accounting for 4.1% of total burden. It will rise from 4th to 2nd leading cause of DALYS by 2020. It will then be second only to ischaemic heart disease for DALYS among both sexes. It is notable that for the developing regions it will be the highest ranking cause of burden. These estimates have demonstrated that depression causes an enormous burden on society.

Taking the example of ischaemic heart disease, risk factors such as smoking and high blood pressure have been identified, and public health interventions target those risk factors and try to reduce their frequency in the population. We need such public health oriented research into depression that will then lead on to primary preventive programmes and to improved access to efficacious treatment for people with depression.

Summary

- Depression and anxiety disorders are two of a range of mental health disorder problems but they are the most common and thus important from a public health perspective.
- In primary or general health care settings, depression and anxiety typically occur together and the term depression is used in this document to reflect both types of emotional states.
- Depression exists in all countries of the world, even if there is variation in how patients present their complaints to health workers.
- Depression is one of the most disabling conditions seen in medical practice. An important source of disability is the impairment in problem solving ability.
- Most treatment of depression occurs in primary health care, not in specialist care. Even though effective pharmacological and brief psychological treatments have been developed, most patients do not seek nor receive appropriate treatment.
- Depression leads to as much burden as ischaemic heart disease; a public health approach is required.

Socioeconomic inequalities and depression

The definitions and use of terms in the area of socioeconomic inequalities can be especially confusing. From an epidemiological perspective it is useful to think of a variety of measurable indicators of socioeconomic inequalities. Occupational status is used by many governments as an indicator, which reflects the status or skill
level within the employed population. Unemployment, those without work who are actively seeking employment, can also be included under this heading. There is relatively little that governments can do to change the distribution of occupational status in a country, but unemployment is potentially more amenable to government economic policies. Low income and poverty are other important indicators of socioeconomic status that are also possible to influence. There are broadly two approaches to defining poverty – one based on income and the other on resources available to a household (deprivation). Though these measures are associated with each other there is, surprisingly, a little overlap between occupational status, low income and deprivation. These can therefore be studied separately and their relative importance investigated. Finally, educational attainment is also a commonly used measure of socioeconomic status.

The evidence of an association between poverty and depression

**Poverty**

There is now a substantial body of evidence, which demonstrates the relationship between poverty and socioeconomic inequalities with depression. In the United Kingdom there is good evidence showing an association between low standard of living (not owning a car and/ or a house) and the prevalence of depression. British data also suggest that socioeconomic measures appear to delay recovery rather than increase the onset of new episodes. However it is also possible that those with poor mental health have a reduced capacity to earn, and this might account for some or all of the observed socioeconomic gradient. This explanation has been called social selection. There is some evidence for social selection but it does not appear to be able to explain the whole socioeconomic gradient. There is evidence from a longitudinal study in the USA that low income is associated with depression.

Evidence is beginning to accumulate demonstrating a similar association between economic disadvantage and the presence of depression in developing countries too. For instance, a community study from Indonesia found strong associations between depression and the presence of household amenities such as electricity, and ownership of a television. In this study, the rates of depression in the least developed villages were twice those in the most developed villages. A recent community survey of 3,870 persons in Chile found that depression was associated with several socioeconomic adversities. On multivariate analyses, acute financial strain, described as a recent drop in income, and lower educational level remained significantly associated with the prevalence of depression.

Similar results have been reported from Northern Brazil, Pakistan, Lesotho, and Zimbabwe. There is also evidence, from prospective longitudinal studies in less developed countries, that economic deprivation is associated with incidence and persistence of depression. A study from Zimbabwe showed that economic variables, such as being in debt and having cash savings, were associated with the incidence of depression. Impoverishment was also associated with the persistence of morbidity; thus, individuals with depression whose economic difficulty resolved over a period of a one-year study, had much higher recovery rates than those who developed fresh economic difficulties.

**Unemployment in men**

There is good evidence from the UK that unemployment in men increases the risk of depression. The association between unemployment in women and the disorder is more complex. Many women without work, especially with children, do not regard themselves as unemployed. There is also the possibility that loss of job to a woman is regarded as less of a threat to self-esteem, at least in women with a partner.

**Poor educational achievement**

Education, which is strongly correlated with poverty, emerges as a factor strongly associated with the prevalence of depression in many developing countries. The mechanism through which education might protect persons from depression is unclear. However, it is plausible that education is an important determinant of present and future life opportunities which promote mental health in later life. In any case, it is important to realize that the socioeconomic variables beloved by epidemiologists might have different meanings and significance in different societies.
Gender inequality and depression

Women have been shown to be 2 to 3 times at greater risk to suffer from depression in most societies. It is likely that the severe adversities faced by women, in part as a result of gender inequality increases their vulnerability\textsuperscript{44}. Gender inequality operates within households unlike other types of inequality, which operate between households. Thus, gender inequality is superimposed on income and other inequalities. Factors associated with gender inequality include domestic violence and restriction of opportunities for education, employment and adequate health care. Further, the unique reproductive roles played by women may also predispose them to depression in different stages of the reproductive cycle, for example depression after childbirth\textsuperscript{45}. [See paper on Gender Disparities and Mental Health for a fuller discussion on this subject]

Causal pathways between socioeconomic factors and depression

Do socioeconomic factors cause depression?

Poverty was defined many years ago as “the mother of all diseases”. However there may be more explicit links between poverty and depression than many other conditions. We also need to understand more about the links and mechanisms if we are to plan preventive policies in a sensible way. At present, there is little real understanding about the mechanisms or mediating factors between low socioeconomic status and depression. The following section gives some plausible ideas about the importance of various factors.

Social supports

There is evidence that lack of social supports may increase the risk of depression. Low socioeconomic status might decrease a person’s ability to engage in social activities.

Unplanned urbanisation has and is posing great strains on traditional social support systems across the developing world\textsuperscript{46}. The lack of social support and the breakdown of kinship structures is probably the key stressor for the millions of migrant labourers to the urban centres of Asia, Africa and South America, leaving behind millions of dependants in the rural areas whose only hope of survival are the remittances their relatives will send from distant cities.

In developed countries, increased mobility of labour has reduced family ties and also led to the decline of the extended family.

Brown and Harris, identified factors such as having no one to confide in as one of the vulnerability factors for depression\textsuperscript{47}. For young women who are married far from their parental homes and live for most of the year without their husbands, it is not hard to imagine why they may be more likely to be depressed.

Lack of control on resources

There are the obvious material stresses, which accompany poverty. The daily worries about paying essential bills and being able to afford food in the face of inflationary pressures and insecure employment could be expected to wear even the strongest mind down. It is not surprising then that those individuals who experienced an income drop, mostly poor people, have a higher prevalence of depression\textsuperscript{11}.

The ability to deal with new difficulties is harder for those with less money. A car that has broken down or a leaking roof requires money, and for the poor these will be much greater stresses.

One of the most consistent predictors of mental disorder in developing country studies is lack of education. Education might provide a means of escape from poverty or access to knowledge and other ways to resolve problems\textsuperscript{11, 38, 43}. The lack of opportunity in a society where there is huge income inequality, high unemployment, and underemployment, and no social welfare provision can be expected to lead to feelings of hopelessness, anger and despair.

There is the well-recognized association between poverty and a higher burden of physical ill health, particularly infectious diseases, and inadequate access to good, affordable health care. This may mean that many poor persons with mental health problems go untreated, or treated inappropriately and suffer for long periods as has been already described earlier.
Social comparison

The potential stresses imposed by absolute poverty may be considerably different from those of relative poverty. It is suggested that the psychological impact of “relative” poverty is the result of both the indirect (e.g. increased exposure to behavioural risk factors due to psychosocial stress) and direct (e.g. physiological effects of chronic mental and emotional stress) effects of psychosocial circumstances associated with social position. One proposed mechanism is that of “cognitive comparison”, whereby people are made aware of the vast differences in socioeconomic status that prevail. The knowledge of how the richer “other half live” affects psychosocial well being and thus, overall health status.

Does depression worsen poverty?

There is a reason to support this possibility with evidence for two major mechanisms. First, the evidence that mental disorders lead to disability which has been described earlier. A range of studies has conclusively demonstrated that depression is profoundly disabling leading to a range of social and occupational disabilities. For example, studies of primary care attendees in India and Zimbabwe showed that subjects with depression spent more than twice the number of days in the previous month in bed or being unable to do their daily activities as compared to others.

Second, there is evidence that persons with depression receive more health care especially in primary care. Most people with depression consult for physical symptoms and in many health systems, both in developing and developed countries, this can lead to numerous costly consultations, investigations and polypharmacy. Often governments are not capable or willing to finance treatment and the costs are then transferred to the sufferers who resort to the private sector. No matter who pays the bill, depression drains away precious resources. There are no reliable economic estimates from developing countries but there is substantial evidence of the enormous economic burden of depression in developed countries.
Cycle of impoverishment and mental disorder

Thus, the nature of the relationship between impoverishment and mental illness is complex, bi-directional and dynamic, leading to a vicious cycle of impoverishment and mental illness (Figure 1). An example of such a vicious cycle could be as follows: an episode of depression is triggered by material deprivation and domestic violence, depression in turn robs the woman of the necessary coping skills and energy to overcome her problems and leads her to spend money and time seeking relief from various health practitioners, often without any benefit.

Illustrative narratives demonstrating linkages

The following are some narratives from various countries, which demonstrate the research linkages between socioeconomic factors and depression.

Suicides of farmers in India

Since the mid-1990s, the seasonal monsoon has consistently failed in some central regions of India leading to low harvests and, subsequently, lower incomes for farmers. Those who have suffered the most have been the poorest subsistence farmers, those who were not credit-worthy enough to get bank loans and had to borrow money from loan-sharks at exorbitant rates of interest to tide over the financial crisis. With their crops failing, the farmers were faced with the stark choice of selling whatever few assets they still had or become bonded labor to the moneylender until the debt was repaid. It is not surprising, then, that these circumstances led to suicide. There have been more than 200 reported suicides by farmers in recent years, and these figures only reflect the government statistics. Although these figures may appear small, they must be seen in the context of representing an occupational group of subsistence farmers in a geographically defined region of India. There is evidence that farmers from the backward castes were disproportionately more affected.

Poverty and maternal depression in South Africa

In an informal settlement in Khayelitsha, South Africa, the prevalence of depression amongst women who have recently given birth has been found to be 35% — roughly three times the expected rate based on studies in other countries. The women in this community are largely migrants from rural areas who come to an impoverished peri-urban settlement in search of employment and access to resources such as health care, especially at key times such as during pregnancy. Circular migration patterns between the countryside and the city may have an effect on social support and networks. Most of these women enjoy very little support from male partners, and many relationships do not last through the pregnancy. The women’s own mothers, a traditional source of support and assistance through pregnancy and early parenthood, are often far away in rural areas. Both maternal depression and economic hardship have been found to impact on children’s development. There is an association between maternal depression and impaired mother-infant interaction. This impairment has in other contexts been found to be a key predictor of poor social, emotional, and cognitive development in children. This could potentially lead a cycle of deprivation and demoralisation.

Poverty, income inequalities and depression in Chile

Chile shows the lowest proportion of people living below US$1/day among the ten most income unequal countries in the world. General morbidity and mortality indicators are in line with those encountered in most developed countries. However, the prevalence of depressive disorders is higher than in other countries with more poverty. Depression tends to concentrate on the most socially disadvantaged sectors of society. The poorest, especially under financial strain, the less educated, the unemployed, and the socially isolated show the highest prevalence of depression. These findings support the hypothesis that marked inequalities can act as risk factors for depression.
Depression and ageing in developing countries

The mental health of elders is even less well understood or acknowledged either by the community or the medical profession in developing countries. A major reason for this is that the elderly comprise less than 10% of the population in most developing countries. This is bound to change in the future with the falling birth rates and rising longevity leading to predictions that over the next 20 years this oldest sector of the population will exceed 100 million in India alone. The implications of this demographic ageing are grave, for few developing countries have systematic social welfare, pension or health care systems sensitive to the needs of the elderly. Further, all developing countries are facing dramatic socioeconomic changes which are accompanied by the gradual breakdown of traditional extended family systems which have formed the bulwark for the care of the disabled and chronically ill.

Summary

- There are strong cross-sectional associations between low income, low education and other indicators of poverty and depression
- There is evidence that depression impairs economic performance
- The evidence available cannot definitively point to whether depression is caused by deprived socioeconomic conditions or if these disorders lead to deprivation. It is likely that a combination of both is the best answer to this etiological puzzle.

Implications for health policies and programmes

The implication of the evidence we have reviewed is that policies and programmes aimed to reduce poverty, provide education and reduce socioeconomic inequalities are highly likely to help reduce the prevalence of depression. Reducing the prevalence should also have some economic benefits, in addition to health benefits for individuals and a reduction of the burden on health services. However, the present economic development policies adopted by many countries, particularly in the developing world, are fuelling socioeconomic inequalities. From a public health perspective, the evidence on socioeconomic determinants and depression can be used to consider a number of primary and secondary preventive strategies.

Primary prevention

Primary prevention is used to describe policies that aim to reduce the prevalence of incidence. The evidence to support the efficacy of interventions in this field is weak, mainly because few if any interventions have been tried and/or evaluated in terms of their impact on depression. It is difficult to persuade governments or international agencies to invest in these programmes compared to primary prevention programmes for malnutrition or infectious diseases. Based on the earlier discussions, we now consider examples of primary preventive strategies:

- Investing in education

The key factor may not be whether 100% of children are in primary school, but rather the proportion of children who fail to complete the minimum years needed to obtain a secondary school certificate [10-12 years in most countries]. This is a far more significant landmark in society for without it, the number of years of schooling is irrelevant to prospective higher educational institutions or employers. Thus, even though there are impressive gains in increasing school enrolment, there may need to be further emphasis on reducing school dropout rates; in many developing countries, less than half the children who are in primary school go on to complete their 10 years of secondary education. Several reasons may account for high dropout rates, such as the need to earn money very early in life and childhood mental health problems. Because education permits greater choices in life decisions and influences aspirations, self-image and opportunities, it is likely that investment in education will lead to improved mental health of the population. In many developing countries, this investment will need to focus on women who may be less likely to access adequate education.
Micro-credit: safe loans to the poorest

In many developing countries, indebtedness to loan-sharks is a consistent source of stress and worry. This was best demonstrated by the narrative on farmers and suicide from India. Indeed, it is not uncommon for the children of a family to spend their lives toiling to repay the interest of relatively small loans taken out by their parents. It is clear that here lies another potential preventive strategy in that local banks could step in and review their process of assessing credit-worthiness for persons who belong to the poorest sectors of society. Radical community banks and loan facilities such as those run by SEWA in India and the Grameen Bank in Bangladesh could be involved in setting up such loan facilities in areas where they do not exist. Provision of such loans may reduce mental illness by removing the key cause of stress: the threat posed by the informal moneylender.

Working towards healthier families

In Khayelitsha, South Africa, a community-based intervention to improve mother-infant interaction is currently underway. Women from the community, all mothers themselves, were recruited and given training based partly on the World Health Organization’s PEIMAC programme. Most women have not completed high school. Treatment focuses on emotional support for the mother as well as an educational component, which teaches mothers about infants’ interactivity and the importance and value of child-focused interaction from birth onwards. The intervention is being run as a controlled trial, and impacts on both mother and infant are being assessed by a team blind to whether the intervention has been delivered to a particular mother. An important feature of the intervention is that it is low cost and is of such a nature that if it proves successful it should be possible to integrate the programme into the existing primary health care system. This programme may lead to evidence for the effectiveness of prevention of maternal depression, and possibly, the adverse effects of maternal depression on infant development.

Health promotion

Most public health campaigns such as the Defeat Depression Campaign in the UK have generally aimed to increase awareness of depression, and increase knowledge about the effectiveness of interventions available in health services. There is also the potential to use health promotion to publicise “stress reduction” techniques that could be used more widely. Similarly, changing the characteristics of the workplace and working practices could have benefit on mental health. At present, these ideas are necessarily speculative but deserve further development and evaluation.

Secondary prevention

The key to secondary prevention, is to strengthen the treatment of depression in primary health care. There needs to be much greater cooperation and collaboration between mental health and primary care health workers. There would need to be greater emphasis on training general health workers on common mental health problems. Individual clinicians need training to recognize and effectively treat depression. The message is clear: patients with depression and anxiety are already in your clinic. These disorders are amongst the commonest of all health problems; they are profoundly disabling and prone to chronicity and there are cheap and effective pharmacological and psychosocial remedies for them. Just as clinicians must treat tuberculosis even if they cannot get rid of the overcrowding, so must we challenge the mental despair of clinicians who argue that if their patients are poor they must be depressed and there is little they can do about it. The greatest evidence that this belief is untrue is evidenced by the fact that the majority of the poor do not get depressed, they are only at greater risk than the rich.

Integration of mental health in primary health care

The integration of primary mental health into primary health care has been the mantra of the WHO for over a decade. The models for such integration are likely to vary considerably between different health systems. In areas such as the KwaZulu/Natal province in South Africa which experiences severe adversities such as poverty, high levels of violence and high rates of HIV/AIDS, there is enormous pressure on primary health care services to deal with physical illness. In this context of scarce resources, a programme was able to train primary health care nurses in KwaZulu/Natal to provide a comprehensive care approach which
took account of psychosocial and emotional factors amongst their clients. However, structural factors in the Organization of health care may inhibit providers' capacity to deliver appropriate comprehensive care. Any focussed intervention to deal with depression and other morbidity at primary health care level must be supported by a commitment on the part of health system management at all levels to viewing these issues as important and worthy of professional attention. Research from more developed countries has suggested that some resource intensive models such as those which employ formal psychotherapy and care managers to ensure compliance could be more cost-effective for the treatment of depression. Thus simpler and affordable interventions need to be implemented possibly focusing on those at higher risk. Some interesting and innovative programmes were developed and used many years ago. For instance in the absence of health professionals, lay community leaders and other health workers were trained to deal with mental disorders in Cali, Colombia with good results. In Chile, work is underway to test the cost-effectiveness of a simple, stepped care treatment package for depressed women from impoverished backgrounds in Santiago, Chile. Early results are promising and suggest that effective interventions can be delivered by people with minimal training, at a low cost and, most importantly, are well accepted by the local population. A randomized controlled trial for the treatment of depression in general health care has also been recently completed in Goa, India; the trial will provide data on efficacy and cost-effectiveness of anti-depressant and psychological treatment.

Integration of mental health into existing health promotion programmes

Depression typically occurs in situations of extreme stress. There are several examples of existing public health priorities in which depression are of great relevance such as maternal and child health, reproductive and sexual health, adolescent health and violence prevention. Attaching mental health interventions onto these programs would imply using existing resources and manpower and providing more comprehensive care, which reflects the broad concerns of health. Such integration can be implemented with minimal additional cost and would have the advantage of greater access to sufferers as a result of the lesser stigma than would be attached to seeking help from mental health services.

Intersectoral cooperation

In Pakistan, the Gujarkhan demonstration project involves community leaders, schoolteachers, and primary health care workers. For instance mass educational campaigns were launched and mental health issues were introduced into the school curriculum as a form of reducing stigma as well as educating families on how best to protect their mental health. Similar projects have also been developed in Latin America and other parts of the world but the evaluation of these initiatives is less well known. These initiatives can help to increase the involvement of communities in deciding and implementing solutions for their own problems. Local participation is a fundamental requisite for the success of any of these programmes.
Summary

Policies aimed at reducing poverty and inequality will have an effect in reducing the burden of depression.

Primary prevention of depression could include poverty reduction programmes, full employment policies, investment in education, micro-credit arrangements and public health promotion campaigns.

Secondary prevention would require integration of mental health care in primary health care by providing training and support to health care providers and improving collaboration with private, traditional and non-governmental health sectors.

Conclusions

This working paper has presented evidence, which demonstrates the public health importance of depressive and anxiety disorders for all countries independent of their level of development. We have argued for a close association between socioeconomic adversity and depression, an association that is present in most societies, again irrespective of the stage of economic development. This association is in both directions. Though there is still some uncertainty, all the evidence suggests that poor socioeconomic conditions can cause depression and that depression can reduce socioeconomic functioning. In the long run we need further research and evaluation of the kind of primary prevention programmes we have proposed as these are probably among the most suitable ways of dealing with the burden of depression in the community. There is also a need to address the burden of depression by strengthening primary care assessment and treatment. The paper has highlighted policies and programmes, which could work towards primary and secondary prevention of depression.

Despite the compelling evidence of an association between depression and economic deprivation, it is important to recognize that the majority of people living even in squalid poverty remain well, cope with the daily grind of existence and do not succumb to the stressors they face in their lives. Indeed, this is the real challenge for public health researchers; to identify the protective qualities in those who do not become depressed when faced with awful economic circumstances for therein lies a potential to help and prevent mental health problems. Could informal local community social networks protect some from depression? Could religious or spiritual involvement limit alcohol abuse in some men and help prevent suicide in women and teenagers? Could micro-credit schemes which are challenging the existing notions on who knows how to handle money properly help prevent some from succumbing to despair? Could being close to one’s family provide the necessary confidante and support? Could a caring local councillor’s efforts to clean up a slum help reduce the suicide rate? These are the practical research questions arising from the relationship between poverty and mental illness.

In societies where mental health services are poorly developed, it may be argued that preventive strategies aimed at strengthening protective factors in local communities may be a more sensible investment of scarce resources than duplicating the extensive mental health care systems of the developed world (whose existence has not led to any significant reduction in the prevalence of mental disorders). Thus, funding research on depression with a local significance should be an important consideration in allocation of research funds in developing countries. Future longitudinal research is needed in order to establish causal directions, and the mechanisms linking depression with low socioeconomic status.

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B. Patel, V., Chisholm, D., Mann, A. A randomized controlled trial of pharmacological and psychological treatment for common mental disorders in general health care settings in Goa, India (Wellcome Trust Tropical Health Services Project Grant)
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The state of the evidence

Stigmatization and human rights violations

J. Arboleda-Flórez
Professor and Head
Department of Psychiatry
Queen’s University
Kingston, Ontario, Canada
Executive summary

General theoretical considerations

Stizein, to tattoo or to brand, was a distinguishing physical mark placed during Greek times on slaves who were thus branded so that others would know that they were inferior or less valued members of society. Through Latin, the word has moved to modern languages as Stigma, a form of social construction to indicate a distinguishing mark of social disgrace that, at the same time, conveys a social identity. Stigma consists of two fundamental components: (1) the recognition of the differentiating “mark” and (2) the subsequent devaluation of the person. Stigmatizing conditions could develop from bodily physical deformities, group identifications such as race, sex, or religion, or assumed blemishes of individual character underlying cultural beliefs about the nature of mental disorders or unemployment. Stigma develops in the context of social relationships and interactions, and its strength and resilience depend on three dimensions: visibility, controllability, and origin. The more visible the mark, the more the blemish is perceived as being under the “control” of the bearer, and the more feared the impact such as conveying a sense of danger, the more the stigma. Cultural beliefs have led to the fear of mental illness and mental patients, hence the stigma. Stigmatizing attitudes are held by many, including health professionals and mental health personnel.

Effects of stigma

Stigmatization is closely related to prejudice in that the stigmatized person or group becomes the target of negative or prejudicial attitudes, but unlike prejudice, stigma involves definitions of character and class identification, hence, it has larger implications than mere prejudice. Negative attitudes include painting all mental patients as deranged, violent, homicidal, incompetent and incurable, morally flawed, unmotivated or inadequate and depicting them in the media as unpredictable and violent. Stigma and prejudice about persons with mental illness lead to discrimination and the denial of lawful legal entitlements. Surveys have shown that negative social attitudes toward persons with mental illness constitute barriers to reintegration and acceptability. These attitudinal barriers impact negatively on social and family relationships, employment, housing, community inclusion, self-esteem, and prompt access to treatment opportunities.

Changing policies and deinstitutionalization

Mental illnesses and disabilities are highly prevalent worldwide. They have major economical impacts beyond merely those directly related to health budgets. The recognition of their negative impacts has led many countries to implement legislative revisions and to modify health plans and mental health systems such as community alternatives, deinstitutionalization, and proper budgetary allocations.

Research on stigma

Research findings have led to the identification of strategies and best models for combating stigmatizing attitudes in populations such as choosing the best content for public campaigns and the targeting of specific subpopulations.

Efforts to combat stigma

A number of national and international programmes, campaigns, and reform efforts have been described to reflect the variety of initiatives being undertaken to combat the stigma of mental illness. Strategies most frequently used by different groups around the world are listed based on a review of what worked in different settings.
Objectives and purpose

Despite their relatively high frequency, sadly, the most frequent contact the general public has with mental illness is through the media where, often, mental patients are depicted as unpredictable, violent and dangerous (Steadman and Cocozza, 1978). Such depictions stem from sensational reporting of crimes purportedly committed by a person with a mental illness, or from movies in which a popular plot, long exploited by the cinematographic industry, is that of the "psycho-killer" (Byrne, 1998). The association between mental illness and violence is only one of the many negative stereotypes and prejudicial attitudes held by the public about persons with a mental illness that help perpetuate stigmatizing and discriminatory practices against them.

The objectives of this document include a review of the theoretical elements that lie at the foundations of stigma as a social construct and its negative consequences on persons with mental illness and their families, and to describe programs and research initiatives geared at managing, or erasing, the stigma about mental illness. The purpose is to help mental health planners and governments to adopt more comprehensive mental health policies. Such policies should address not only the legislative and budgetary aspects of mental health programs, but also the education of the public on mental health issues, the promotion of good mental health practices, and the prevention of mental conditions in the population.

Historical elements

Stizein, to tattoo or to brand in Greek, was a distinguishing mark burned or cut into the flesh of slaves or criminals by the ancient Greek, so that others would know who they were and that they were less valued members of society. Although the Greek did not use the term stigma in relation to mental illness, stigmatizing attitudes about the illnesses were already apparent in the sense that mental illness was associated with concepts of shame, loss of face, and humiliation (Simon, 1992) as in Sophocles’ Ajax, or Euripides’ The Madness of Hecules.

Later, and throughout the Christian world, the word stigmata became associated with peculiar marks on individuals re-enacting the wounds of Christ on their bodies, mostly on their palms and soles (Paul, Gal 6: 17). This religious connotation is not the same as the other derivative of the Greek word, stigma, which is a form of social construction to indicate a distinguishing mark of social disgrace that, at the same time, conveys a social identity. The Inquisitorial attitude toward witches, as dictated in the Malleus Maleficarum (The Hammer of the Witches 1486/1971), apart from being highly misogynous, also represents a negative and condemning attitude toward mental illness. This attitude might have been the origin of the stigmatizing attitudes toward persons with mental illness from the rise of rationalism in the 17th century to our days in Christian cultures (Mora, 1992). "Madness" has long been held among Christians as being a form of punishment inflicted by God on sinners (Neaman, 1975).

Theoretical considerations

Goffman (1963) thought of stigma as an attribute that is “deeply discrediting” so that stigmatized persons are regarded as being of less value and “spoiled” by the stigmatizing condition. He classified these conditions in three groups: “abominations” of the body, such as physical deformities, “tribal identities” such as race, sex, or religion, and “blemishes of individual character” such as mental disorders, or unemployment. Stigma, however, is not a static concept, but a social construction that is linked to values placed on social identities. It is a process consisting of two fundamental components: the recognition of the differentiating “mark”, and the subsequent devaluation of the bearer (Dovidio, Major and Crocker, 2000). These authors conceive of stigma as a relational construct that is based on attributes, so that, stigmatizing conditions may change with time and from a culture to another. Stigma, then, would develop within a social matrix of relationships and interactions and will have to be understood within a three-dimensional axis involving perspective, identity, and reactions.

Perspectives pertain to the way the stigma is perceived. Stigma is different, whether it is perceived by the person who does the stigmatizing (perceiv-
er) or by the person who is being stigmatized (target). Identities relate to group belongingness, and they lie in a continuum from entirely personal to group-based identifications. Finally, Reactions are the ways the stigmatizer and the stigmatized react to the stigma and its consequences; reactions could be measured at the cognitive (knowledge), affective (feelings, tones and attitudes), and behavioural levels.

Along with these three dimensions it is also important to distinguish three major characteristics of the stigmatizing mark: “visibility”, or how obvious the mark is, “controllability” which relates to the origin or reason for the mark and whether it is under the control of the bearer, and “impact” or how much those who do the stigmatizing fear the stigmatized (Crocker, Major and Steele, 1998). The more visible the mark, the more it might be perceived to be under the control of the bearer, and the more feared the impact such as conveying an element of danger, the more pronounced the stigma.

Mental patients who show visible signs of their conditions because their symptoms or the side effects to medications make them appear abnormal, who are socially construed as being weak of character or lazy, and who display threatening behaviours, usually score high on any of these three dimensions. By a process of association and class identity, all mental patients are equally stigmatized; the individual patient, regardless of level of impairment or disability, is lumped together into a class; class belongingness reinforces the stigma against the individual.

The description of the characteristics of stigma, or what it is, and how it develops begets the question of why it develops. Unfortunately, there is little literature on the subject, but Stangor and Crandall (2000) while indicating that very little is known about the development of stigma, advance the theory that three major components will be required: function, perception, and social sharing. They theorize that an original “functional impetus” is accentuated through “perception”, and subsequently consolidated through social “sharing” of information. The sharing of stigma becomes part of a society that creates, condones, and maintains the stigmatizing attitudes and behaviours. These authors further indicate that the most likely candidate for the initial “functional impetus” is the goal of avoiding threat to the self.

Initial perception of tangible or symbolic threat
Perceptual distortions that amplify group differences
Consensual sharing of threats and perceptions

Tangible threats are “instrumental” in the sense that they threaten a material or concrete good, while those that are symbolic threaten beliefs, values, ideology, or the way in which the group ordains its social, political or spiritual domains.

In relation to mental illness, cultural perceptions seem to indicate that it poses a tangible threat to the health of society because it engenders two kinds of fear: the fear of potential immediate physical threat of attack and the fear that we may all share of losing our own sanity. In addition, to the extent that mental ill persons are stereotyped as lazy, unable to contribute, and hence, a burden to the system, then, mental illness may be also seen as posing a symbolic threat to the beliefs and value system shared by members of the group.

More specifically, the stigma associated with mental illness can also be attributed to the traditional division of venues for treatment and health care systems. The division between the two systems meant that persons with mental illness were sent away to mental institutions or asylums consequently segregating them from those who were physically ill and who were cared and treated for in general hospitals in their own communities. The decision to send persons with mental illness to far away mental hospitals, although well intentioned in its origins, contributed to their dislocation from their communities, and the loss of their community ties, friendships and families. At a more systemic and academic level, the segregation between the two systems of health also meant the banishment of mental illness and of psychiatry from the general stream of medicine. At a different level, the lack of effective therapies that influenced most of psychiatric work for centuries also contributed to the asylum mentality. The few therapeutic successes, such as the cure for pellagra or for syphilis, only helped to reinforce the idea that the patients that remained in the mental hospitals suffering from other mental illnesses were incurable.

1. Adapted from Stangor and Crandall, p. 73
Myths and stigma

Stigma, or the feeling of being negatively differentiated because of being affected by a particular condition or state, is related to negative stereotyping and prejudicial attitudes. These in turn, lead to discriminatory practices that deprive the stigmatized person from legally recognized entitlements. Stigma, prejudice, and discrimination are, therefore, inextricably related. Unlike prejudice, however, stigma involves definitions of character and class identification, so it has larger implications and impacts. Often, prejudice stems from ignorance, or unwillingness to find the truth. For example, a study conducted by the Canadian Mental Health Association, Ontario Division (Ontario, Canada), in 1993-1994, found that the most prevalent misconceptions about mental illness included that mental patients were dangerous and violent (88%), that they had a low IQ or were developmentally handicapped (40%), that they could not function, hold a job, or had anything to contribute (32%), that they lacked will power or were weak or lazy (24%), that they were unpredictable (20%), and, finally, that they were to be blamed for their own condition and should just shape up (20%).

In a survey among first year university students in the United States, it was found that almost two-thirds believed that “multiple personalities” were a common symptom of schizophrenia (Torrey, 1995). The same author reports on a different poll conducted among the general public in which 55% of respondents did not believe that mental illness existed and only 1% acknowledged that mental illness was a major health problem. Some of these myths also surfaced in a study conducted in Calgary, Alberta, Canada, during the pilot study for the World Psychiatric Association (WPA) Programme “Open the Doors” (Stuart and Arboleda-Florez, 2001). In this study, it was found that respondents believed that persons with schizophrenia could not work in regular jobs (72%), had a split personality (47%), or were dangerous to the public because of violent behaviour (14%). In Africa, people’s thoughts about mental illness are strongly influenced by traditional beliefs in supernatural causes and remedies. Even policy makers frequently hold the opinion that mental illness is often incurable and unresponsive to accepted medical practices (Gureje and Alem, 2000).

Unfortunately, high levels of knowledge could coexist with high levels of prejudice and negative stereotypes. For while most of the myths about mental illness could be traced down to prejudice and ignorance of these conditions, enlightened knowledge does not necessarily translate into less stigma unless the tangible and symbolic threats that it poses are also eradicated. This could only be done through better education of the public and consumers about the facts of mental illness and violence, and through the provision of consistent appropriate treatment to prevent violent reactions. Good medication management should also aim at decreasing the visibility of symptoms among patients (consumers), and at providing better public educational programs on mental health promotion and prevention.

Human Rights infringements

Outright discriminatory policies ending in abuses of human rights and denial of legal entitlements can often be traced to stigmatizing attitudes, plain ignorance about the facts of mental illness, or lack of appreciation of the needs of persons with mental illness. These policies and abuses are not the preserve of developing countries only.

In countries with established economies, health insurance companies openly discriminate against persons who acknowledge that they have had a mental problem. Life insurance companies, as well as income protection insurance policies make a veritable ordeal out of collecting payments due to temporary disability caused by mental conditions such as anxiety or depression. Many patients see their payments denied or their policies discontinued. Government policies sometime demand that mental patients be registered in special files before pharmacies could dispense needed psychiatric medications. At a larger level, many developed countries provide only a modicum of funds from their national research budgets for research in mental conditions. In Canada, for example, mental health research commands less than 5% of all the health research budgets, yet mental illness affects directly 20% of Canadians (CAMIMH, 2000).
In developing countries, beliefs about the nature of mental conditions, sometimes enmeshed with religious beliefs and cultural determinants, tend to delay needed treatment by penalizing and stigmatizing not only the patients, but also their families, even when they are entitled to access treatment opportunities (Gureje and Alem, 2000). Within the Chinese culture, mental illness is highly stigmatized for the whole family not just the individual afflicted. The emphasis on collective responsibility leads to the belief that mental illness is a family problem. Thus, Chinese caregivers may prefer to cope with mental illness within the context of the family as long as possible. The downside to this approach is the subsequent delay in treatment that may result (Ryder, Bean and Dion, 2000).

In general, illness and disability due to mental disorders have received little attention from governments in developing countries including African governments. Mental health services have been poorly funded and most countries lack formal mental health policies, programmes, and action plans. In 1988 and 1990 two resolutions designed to improve mental health were adopted among African countries. A survey conducted two years later to follow-up on what progress had resulted from these resolutions unfortunately showed disappointing findings (Gureje, Alem, 2000).

In Uganda, per capita yearly expenditures for mental illness is only US$ 4.00, well below the US$ 10.00 recommended by the World Bank (The Monitor, 1998). In Nigeria, excessive workloads, frequent transfers, responsibility without authority, and other inherently poor management practices are blamed for the poor mental health conditions of employees and the consequences if they happened to complain about their difficulties (Vanguard Daily, 2000).

**Consequences of stigma**

Sartorius (1999) sustains that the stigma of mental illness affects the requirements for care of good quality in mental health. In his view, stigma attitudes compromise access to care through perceptions among policy makers and the public that persons with mental illness are dangerous, lazy, unreliable and unemployable. Eventually, these attitudes impact on the willingness of authorities to provide proper financial resources for their care.

Some researchers argue that persons with mental illness are not stigmatized. They base their conclusions on measurements of social distance that show acceptance of mental patients, findings showing that what is stigmatizing is the behaviour and not the label, and the fact that mental patients themselves are rarely able to report concrete instances of rejection. These findings, however, are contrary to multiple other reports among patients and their families, and even among mental health personnel who feel that their work is less appreciated and remunerated than similar intense work with other patient populations. Link et al (1992) refute findings denying the pernicious effects of stigma on the basis that these studies have been flawed by the types of questions they have asked and, consequently, by the types of replies that they have obtained. Real life perceptions and patients’ testimonials tell a different story about how it feels to have a mental illness.

Michelle, a vivacious 25 year-old office worker, tells about her major disappointment with her family and family friends who simply expected her to have an abortion when she announced that she was pregnant. They assumed that her schizophrenia would incapacitate her to deliver and to care for her baby. They were also afraid that her medications could have teratogenic effects on the baby. She carried her baby to term and is taking care of it despite the opposition of family and friends.

Michelle’s experience is not uncommon. For many persons with mental illness, the stigma of their illness is worse than the disease and it spreads a cloud over every aspect of their lives and even the lives of other members of the family.

John, a 19-year-old university student, had to accept the termination of a relationship he had just started with a girl from his neighbourhood. Her parents objected to the relationship and decided to send her to another city for her education, in part in an attempt to break up the relationship, once they knew that John’s mother’s frequent hospitalizations for the past several years were not due to “diabetes”, but to a manic depressive illness. John described the experience with some resignation, “it seems as if I have to carry the sins of my parents”.

In the study by the Canadian Mental Health Association, Ontario Division, in 1993-1994 quot-
ed above, mental patients felt that social and family life (84%), along with employment (78%) and housing (48%), were the areas most commonly affected by stigma. In that survey respondents also felt excluded from the community (22%) and complained that stigma has a negative impact on their self-esteem (20%).

In a survey conducted among members of their own support organization by “survivors” of mental illness in Thunder Bay, Ontario, Canada (P.A.C.E. Report, 1996), they identified housing, employment, and transportation in public buses as degrading and outright discriminatory.

“I have to lie to my landlord to get a place to live, like tell him you are on disability, if it is not visible or physical, they don’t take you. Even slumlords won’t take you because they don’t want psychiatrically ill people living in their buildings”

In this Report, “survivors” found that “mental health barriers” among the public often lead to stigmatization, prejudice and stereotyping and that they were not listened to, or understood. They also felt ignored, avoided, or treated without respect and sensitivity. They reported that these attitudes could also be found during their interactions with social assistance personnel and with clinical staff.

“At the agency the staff talk about patients and how crazy they are. No wonder there is such stigma in the community.”

And another patient commented poignantly about health staff:

“At the hospital, they take your clothes away. They put you in pyjamas... it strips away your identity. You know, we are not all crazy. We don’t all see the boogieman around the corner. Some of us have legitimate complaints. But if you are always told ‘oh, you are overreacting’ you know, you don’t know what you are talking about or stuff like that, after a while you start to believe that yeah, maybe I am. There are some doctors who don’t know, you know, an oesophagus from an asshole.”

In The Last Taboo (Simmie and Nunes, 2001), one of the authors, Scott Simmie, describes his feelings after a bout of major depression:

“Stigma was, for me, the most agonizing aspect of my disorder. It cost friendships, career opportunities, and most importantly - my self-esteem. It wasn’t long before I began internalizing the attitudes of others, viewing myself as a lesser person. Many of those long days in bed during the depression were spent thinking, ‘I’m mentally ill. I’m a manic-depressive. I’m not the same anymore’. I wondered, desperately, if I would ever again work, ever again be ‘normal’. It was a godawful feeling that contributed immensely to the suicidal yearnings that invaded my thoughts”

Violence and mental illness

Few popular notions and misconceptions are so pervasive and stigmatizing as is the belief that persons with mental illness are dangerous and violent. This could be hardly surprising when practically no month goes by without the media reporting on the sad story of yet another horrendous crime committed by an alleged mental patient. At times, the story also mentions that the culprit is suspected to be “psycho”, “paranoid”, “depressed”, or “schizophrenic”. This type of news, even when reported conscientiously and accurately, arouses fear and apprehension and pushes the public to demand measures to prevent further crimes. Persons with mental illness in general bear the brunt of impact because of the actions of the few.

The grotesque and sensationalistic portrayal of persons with mental illness in the media (Rovner, 1993) pales in comparison to how they have been portrayed in movies right from the beginning of this industry in the early 1900s. Wahl and Harman (1989) found that 85.6% of relatives of persons with mental illness identified movies about “mentally ill killers” as the most important contributor to the stigma of the illness. Movies have not only stigmatized those with mental illness, their negative stereotypes have extended also to psychiatrists who are often portrayed as libidinous lechers, eccentric buffoons, vindictive, repressive agents of society, or evil minded, and in the case of female psychiatrists, as loveless and unfulfilled women (Gabbard and Gabbard, 1992).

Media accounts of crimes allegedly committed by mental patients reinforce the association between violence and schizophrenia in the public mind. Such association has been traced to be directly related to how mental illness and persons with mental illness are portrayed in the media (Philo, 1997). Unfortunately, the media do not inform the
public that only a very small minority of mental patients commits serious crimes, or that the percentage of violence that could be attributed to mental illness as a portion of the general violence in the community is also small (Monahan, 1997). The association between mental illness and violence, specifically schizophrenia, although confirmed epidemiologically (Arboleda-Florez, 1998), remains still unclear and seems to flow not so much through direct links of causality, but through a series of confounders and covariating potential causes. Studies that purport to demonstrate an association between mental illness and violence still need to concentrate on several aspects of the relationship:

- they need to demonstrate that the association is one of causality;
- they need to tease out the contextual elements in which the violence occurs;
- they need to measure the risk of violence from a public health perspective; and
- they need to identify measures that could help manage the risk among those patients who could become violent.

Fear, as already indicated above, is the primary impulse to the development of stigma. The fear of mental illness, and the subsequent stigmatization of those with mental illness, is largely based on fears that they are unpredictable and dangerous. Unfortunately, one single case of violence is usually sufficient to counteract whatever gains mental patients have made to be accepted back into the community.

**Changing policies and deinstitutionalization**

The recognition worldwide that the large prevalence of mental conditions and their associated disabilities have major impacts not only on health budgets, but on the total economy, has spurred national governments to face the challenges and develop strategies to cope with mental illness in their respective countries. In the United States, the 1999 Report of the Surgeon General urged the nation to rally the national will to find better ways to fight mental conditions including among others, a fight against stigma (Surgeon General Report, 1999).

Government initiatives worldwide include a whole revamping of mental health systems to integrate the care of persons with mental illness in the mainstream of the health system, reorganization of budgetary allocations to protect access to mental health treatment, restructuring of mental health facilities, and introduction of legislation to protect the rights of persons with mental illness and their legal entitlements that tend to get eroded by discrimination.

Many of these initiatives are known generically as “deinstitutionalization policies”, because they have in common characteristics such as the divestment of mental hospitals, the treatment of mental patients in general hospitals, and their reintegration in their communities of origin. Important and enlightened as these initiatives have been, many have not met with the success expected simply because it is not enough to just transfer the patients to the community, or to deny beds to newly diagnosed patients. An integrated and seamless mental health system should cover the whole spectrum of needs for early diagnosis, treatment, and psychosocial rehabilitation, as well as initiatives for public education on the recognition and prevention of mental conditions and the promotion of mental health in the population.

Specifically, deinstitutionalization initiatives have to be implemented together with the development of adequate community systems to house those with mental illness and to provide for their successful reintegration into the community. Often, the lack of these community systems worsens the stigma held against persons with mental illness when they are observed walking aimlessly in the downtown areas of large cities, loitering in town squares, shopping centres or markets, or being destitute and homeless. In addition, mental health legislation has to be made more flexible and responsive to contemporary mental health policies and the realities of the mental health system.
Recent research on stigma of mental illness

Although there does not seem to be a one-to-one relationship between exposure to environmental stressors such as stigma and discrimination, and adaptational outcomes, research on stigma has demonstrated that it has negative outcomes on physical health and on self-esteem (Miller and Major, 2000). Persons with mental illness often experience prejudice similar to those who suffer racial or ethnic discrimination, but the practical effects are complex and affected by a number of factors such as age, sex, the degree of stigma felt by the patient, and the degree of self-stigmatization (Hayward and Bright, 1997).

Stigmatization and prejudice have often been confirmed in research studies as one of the reasons why many persons do not seek, or postpone until too late, seeking assistance (Wills, 1983). Recent research has also demonstrated that the fear of mental illness is not just related to the behaviour sometimes demonstrated by persons with mental illness, but to the label itself and the consequences that flow from the illness. Thus, in the pilot site of the WPA Programme “Open the Doors”, Edmonton, Canada, respondents rated “loss of mind” as more disabling than any other handicapping condition (Thompson et al, under review). In the same study, the Calgary group found that greater knowledge was associated with less distancing attitudes, but that exposure to persons with mental illness was not correlated with knowledge or attitudes (Stuart and Arboleda-Florez, 2001). Link et al (1999) came to a similar conclusion regarding the split between knowledge and attitude among the general public. The Alberta, Canada, groups concluded that broad approaches to increase mental health literacy (Jorm, 2000) may not be as effective among already highly educated population groups as would specifically focused interventions among small groups such as high school students, or clinical workers. Corrigan and Penn (1999) have come to the same conclusion in regard to the specific group targeting approach, which they extend to the targeting of specific beliefs about mental illness among ethnic minorities.

Efforts to combat the stigma of mental illness

National and international organizations and associations as well as national and local governments have come to appreciate the need to change attitudes toward persons with mental illness and to sensitize the public to the notion that mental conditions are no different than other conditions in their origin and that diagnosis and treatments are available and effective. Campaigns like “Changing Minds” organized by the Royal College of Psychiatrists in the UK (www.changingminds, 2001) are based on providing information to the public so as to dispel myths and stereotypes about those with mental illness. The campaign has used leaflets, pamphlets, films and other ways of mass communication. In one well-known film, “1 in 4”, the message is direct and pithy as it emphasizes that mental health problems can touch anyone:

1 in 4, the film proclaims, could be your Brother, your Sister. Could be your Wife, your Girlfriend...] in 4 could be your Daughter...] in 4 could be me...it could be you

Pamphlets produced for the campaign emphasize messages indicating that social despair and isolation have replaced old methods of physical isolation:

For centuries people with mental illness were kept away from the rest of society, sometimes locked up, often in poor conditions, with little or no say in running their lives.

Today, negative attitudes lock them out of society more subtly but just as effectively.

One of the major goals of the Australian National Mental Health Promotion and Prevention Action Plan (1999) has been improving mental health literacy in the population. With this in mind, a series of campaigns like the Australian National Community Awareness Program (CAP) and the Australasian “Psychiatric Stigma Group ” have been aimed at increasing mental health literacy among the general population. The former, CAP, was a four-year program liberally funded to increase community awareness of all mental conditions. Specifically, it had three goals: to position mental health on the public agenda, to promote a greater understanding and acceptance of those experiencing mental illness, and to dispel myths and misconceptions about mental illness. The program had a built-in evaluation based on benchmark survey and
pre-post tracking design. The most significant results include, that while tolerant attitudes were consolidated, they did not increase; that there was a slight increase in the awareness of services; and that there was no clear evidence of behaviour change (Rosen, 2000).

The Australasian Psychiatric Stigma Group has more modest goals mostly by linking consumers, providers, and many other interested groups in a public evaluation of the impact of stereotyping and stigma on the lives of psychiatric service-users, their carers, and the lives of providers (Rosen, 2000).

SANE Australia is a national charity that helps people affected by mental conditions. One major and famous feature of this group is the popular TV soap opera “Home and Away” in which a storyline is about a young character that develops schizophrenia (SANE, 1999). SANE has a function similar to NAMI (National Alliance for the Mentally Ill) in the United States and CAMIMH (Canadian Alliance on Mental Illness and Mental Health, 2000); they are all umbrella family groups that lobby for better education, more research funding, and more accessible treatment opportunities for persons with mental illness.

In New Zealand, a National Plan (1998) has been devised as part of the Blueprint for Mental Health Services to combat stigma and discrimination associated with mental illness. An important component of this plan is the involvement of aboriginal communities. A similar program has been envisioned in Canada with the aboriginal communities that seek to empower them to organize their own cultural resources to develop programs and services that meet their own physical, mental and spiritual needs (Nishnawbe Aski-Nation, 1990).

In the United States of America, the National Institute of Mental Health (NIMH) has an extensive educational campaign available in pamphlets, booklets and on the internet. The information provided covers a wide variety of topics ranging from specific mental conditions to issues such as suicide or youth and violence. The web site (www.nimh.nih.gov/practitioners/patinfo.cfm#top) provides updated information on research topics, treatment, new medications and programs, and legislative initiatives. The site also has a Spanish portal. The U.S. Center for Mental Health Services Knowledge Exchange Network (KEN) provides online information (www.mentalhealth.org) on stigma.

Although not written anywhere yet as publications, but only as internal government documents, the mental health programmes presently devised in El Salvador (2000) are worth mentioning as initiatives from developing countries. In El Salvador, an extremely active advocate for better mental health policies, the present First Lady of the Nation, in her capacity as Director of the Secretaría Nacional de la Familia (National Family Secretariat) had started to set up a National Mental Health Council (Consejo Nacional de Salud Mental) in October of the year 2000, that would encompass the gamut of citizens and organizations that might have a function on issues pertaining to mental health in the country. Organigrams, plans and sets of functions and activities for the Council were thrown in disarray, however, and the development work delayed, by the earthquakes that have devastated the country since the beginning of this year, 2001. Yet, the groundwork already done in the organization of the Council gave impetus for a massive mobilization of national forces to set up community grassroots activities bent on immunizing the population against the deleterious mental health effects and impacts of the catastrophe, the prevention of panic reactions especially among young children, and the immediate treatment of those already affected by post-traumatic stress reactions.

Mental health and professional organizations have joined forces with government bureaucracies and educational establishments all over the country to develop on-the-field training for nurses, teachers, and other local community human resources personnel through sessions on training-for-trainers mental health counsellors and for the delivery of group therapy initiatives and individual counselling. Many of these activities are being carried out from semi-destroyed schools and government buildings, in the fields below half – uprooted trees, or in the plazas or street corners of little towns, right in the middle of the debris and rubble that is still being shaken by ongoing milder tremors. The experience of El Salvador on emergency mental health action, and the impact that it has had on demystifying mental illness and emotional problems and, hence, decreasing stigma, is one of those untold stories of how humans can mobilize and rise to the circum...
stances as long as they are given a few tools and the empowerment to act.

In Tajikistan, where the population has a hostile and fearful attitude toward psychiatric illness, stigma is a problem. In 1998, the Union of Mental Health Support, a national NGO, was created to prevent stigma related to psychiatric disorders and to provide appropriate measures and assistance to psychiatric institutions. A draft law, approved by the Ministers of Health, Justice, Social Welfare, Economics, and Labour, will be submitted to Parliament. The new law is needed because the existing laws allow for the abuse of psychiatry for political purposes. If the new law passes, it will be one of the most modern psychiatric laws in the area. Also encouraging is that within the last year a survey was conducted to assess community attitudes toward mental illness and psychosocial distress. The survey results will be used in the design of a community education and awareness campaign (Baibabayev, Cunningham and de Jong, 2000).

The Republic of Slovakia is another country that, since 1991, is struggling to reform its mental health care system to address better issues such as stigma. While some progress has been made in the past 10 years, the speed of reform has been slow. Factors contributing to morbidity from mental illness in Slovakia include the fact that the high hopes that blossomed immediately following the change in political power have remained mostly unrealized. This has resulted in a sense of hopelessness in the population. How to destigmatize persons with mental illness remains one of the three major mental health concerns in Slovakia. Reform efforts however are currently being intensified and there is an increased interest in the field of psychiatry among young physicians (Breier, 2000).

At an international level, two programmes, one from the World Psychiatric Association (WPA) and the other from the World Health Organization (WHO), merit a more extensive review. The WPA initiated in 1998 its Global Programme Against Stigma and Discrimination Because of Schizophrenia. Although the “Open the Doors” (www.openthedoors.com) programme is circumscribed to schizophrenia, its results in the different countries where it has been implemented are equally applicable to any other mental condition. The Programme was first pilot-tested in Calgary and Alberta, Canada in 1998, and has now moved to Spain, Austria, Germany, Israel, Italy, Greece, Egypt, India, and China. The Programme has targeted different audiences according to locations, but depends heavily on local action groups that organize themselves to plan and initiate projects that mobilize local resources into action to combat the stigma associated with this disease.

The WHO Programme (2000) has produced four volumes containing how-to guidelines and information on schizophrenia. Volume One is a step-by-step how-to guide to develop local programmes; Volume Two is a compendium of the latest knowledge on the diagnosis and treatment of schizophrenia including psychosocial reintegration strategies; Volume Three includes reports from different countries; and Volume Four is a collection of reports from other countries where similar initiatives are on-going or being planned. A final volume is being planned with an annotated bibliography of practical materials. All these materials are downloadable from the WPA Programme web site.

The World Health Organization (2001) has launched its initiative, “Stop exclusion. Dare to care” aimed at combating stigma and at rallying support for more enlightened and equitable structures for the care of those with mental illness and the acceptance of mental health as a major topic of concern among member-states. This initiative brings timely information to correct the myths surrounding mental conditions such as the beliefs that they affect only adults in rich countries, that they are not real illnesses but incurable blemishes of character, or that the only alternative would be to lock mental patients in institutions.

“Stop exclusion. Dare to care” provides a sobering reminder of the extent of mental conditions throughout the world with about 45 million persons worldwide suffering from schizophrenia alone, not to mention the many million of persons who suffer from depression, dementia, alcoholism or other mental problems. Sadly, it also shows how the majority of these persons are deprived of even the most basic treatments, such as, for example, persons suffering from alcohol dependency of whom only 22% receive treatment, or persons affected by epilepsy of whom, in some countries, less than 10% have access to treatment. The WHO Mental Health Programme makes the point that
mental health should be made part of the general health care services in countries and that it is the ethical responsibility of nations to be inclusive of all citizens and respect their human rights.

This WHO Mental Health Programme invites individuals, families, communities, professionals, scientists, policy makers, the media, and NGOs to join forces and to share a vision where individuals recognize the importance of their own mental health; patients, families and communities feel sufficiently empowered to act on their own mental health needs; professionals will not only treat those with mental illness, but will also engage actively in mental health promotion and preventative activities; and policy makers will plan and devise policies that are more responsive to the needs of the entire population.

"Stop exclusion. Dare to care" has so far used as methodologies the distribution of pamphlets, posters, booklets, and stickers, and through the many collateral organizations and distribution channels open to WHO, it aims at providing incentives to national governments and health care organizations to change policies and to become actively involved in the reorganization of services and in the development of appropriate mental health policies.

The conceptual elements of all these programs follow cognitive methodologies for behavioural change. Their three major goals are similar:

- to increase awareness and knowledge of the nature of mental illness;
- to improve public attitudes toward those who suffer from mental illness and their families; and
- to generate action to prevent and to eliminate stigma and discrimination.

Strategies to combat stigma

Sartorius (1999) recommends that breaking the cycle of disadvantage resulting from stigma should be made a priority. He describes several steps leading to disadvantage such as disease, impairment, the stigma linked to these two, discrimination, reduction of opportunities for rehabilitation and role malfunctioning, and places the corresponding interventions at each one of these steps. Apart from recovery with proper treatment and therapeutic efforts to reduce disability, several strategies to combat stigma and discrimination because of mental illness have been found successful by different groups around the world. Usually, these include the participation of all those who care and who treat those with mental illness, as well as the patients, or consumers themselves. The following are the strategies most frequently used:

- Speakers’ bureaux that train and organize individual consumers, or patients, and their families to provide talks to specialized groups such as students, nurses, or business people, about their mental illness and how they are coping and managing their lives.

- Plays and other artistic expressions offered by consumers that highlight the importance of the illness and its debilitating effects as well as the impact of stigma and discrimination.

- Organization of special mental health curricula in public schools according to level of maturity, age, and grade of the students.

- Targeting particular groups that consumers consider tend to stigmatize them with some regularity such as emergency room personnel, the clergy, or bureaucrats, and offer them information, talks, or presentations about mental illness.

- Differentiate anti-stigma campaigns according to specific target groups rather than mounting massive generic public efforts.

- Work closely with the media and prepare "infokits" that provide timely information when issues pertaining to mental conditions break out in the news.

- Participate actively in organized activities such as World Mental Health Day sponsored by the World Federation for Mental Health (October 10 each year), or Mental Health Awareness Week.

- Become a “stigma-buster” by being aware and ready to denounce local or national news, advertisements, or movies that stigmatize, ridicule, or demonize people with mental illness as violent, unpredictable or dangerous.

- Advise decision-makers on the difficulties that persons with mental illness face in securing proper housing and employment, and in accessing treatment, or using public facilities.
Help consumers and families organize themselves locally and join nationally in “consumer movements”.

Organize local groups and help amalgamate them into single national conglomerates or Alliances for Mental Health. For example, help form a National Association for Mental Health that works in close association with professional groups such as the National Psychiatric, Psychological, Nurses, or Social Workers Associations, that could speak with authority to national governments on behalf of persons with mental illness.

Stimulate national groups or mental health conglomerates to lobby the government to introduce legislation that combats stigma and that outlaws discrimination whether based on group characteristics or individual physical or mental disabilities.

Stand up and be ready to clear out prejudice and misconceptions about the persons with mental illness.

Conclusion

Empowerment is intrinsic to the mental health of communities. The support and involvement of communities in the development, implementation, and organization of their own health structures and programs lead to the realization at the community level of the impact and the ramifications to health of social scourges such as drug and alcohol abuse, family and social violence, suicide and homicide, and mental illness themselves.

Centuries of prejudice, discrimination and stigma, however, cannot be changed solely through government pronouncements and legislative fiat, important as they are. The successful treatment and community management of mental illness relies heavily on the involvement of many levels of government, social institutions, clinicians, caregivers, the public at large, the patients or consumers themselves, and their families. Successful community reintegration of mental patients and the acceptance of mental illness as an inescapable fact of our social fabrics can only be achieved when communities take control and become masters of their own mental health structures, programmes, services and organizational arrangements.

There is a need, therefore, to engage the public in a dialogue about the true nature of mental illness, their devastating effects on individuals, their families, and society in general, and the promises of better treatment and rehabilitation alternatives. An enlightened public working in unison with professional associations and with lobby groups on behalf of persons with mental illness can leverage national governments and health care organizations to provide equitable access to treatment and to develop legislation against discrimination. With these tools, communities could then enter into a candid exchange of ideas about what causes stigma and what are the consequences of stigmatizing attitudes in their midst. Only these concerted efforts will, eventually, dispel the indelible mark. the stigma caused by mental illness.

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The state of the evidence

Gender disparities in mental health

Jill Astbury
Associate Professor and Director
WHO Collaborating Centre in Women's Health
Key Centre for Women's Health in Society
School of Population Health
University of Melbourne, Australia
Executive summary

This paper examines current evidence regarding rates, risk factors, correlates and consequences of gender disparities in mental health. Gender is conceptualized as a structural determinant of mental health and mental illness that runs like a fault line, interconnecting with and deepening the disparities associated with other important socioeconomic determinants such as income, employment and social position.

Gender differentially affects the power and control men and women have over these socioeconomic determinants, their access to resources, and their status, roles, options and treatment in society. Gender has significant explanatory power regarding differential susceptibility and exposure to mental health risks and differences in mental health outcomes. Gender differences in rates of overall mental disorder, including rare disorders such as schizophrenia and bipolar disorders, are negligible. However, highly significant gender differences exist for depression, anxiety and somatic complaints that affect more than 20% of the population in established economies. Depression accounts for the largest proportion of the burden associated with all the mental and neurological disorders and is a particular focus of this paper. It is predicted to be the second leading cause of global burden of disease by 2020.

To address this mounting problem, a much improved understanding of the gender dimensions of mental health is mandatory. Evidence is available on some aspects of the problem but serious gaps remain. It is known that:

- Rates of depression vary markedly between countries suggesting the importance of macrosocial factors. Nevertheless, depression is almost always reported to be twice as common in women compared with men across diverse societies and social contexts.

- Despite its high prevalence, less than half the patients with depression disorder are likely to be identified by their doctors in primary care settings. Gender differences in patterns of help seeking and gender stereotyping in diagnosis compound difficulties with identification and treatment. Female gender predicts being prescribed psychotropic drugs. Even when presenting with identical symptoms, women are more likely to be diagnosed as depressed than men and less likely to be diagnosed as having problems with alcohol.

- Men predominate in diagnoses of alcohol dependence with lifetime prevalence rates of 20% compared with 8% for women, reported in population based studies in established economies. However, depression and anxiety are also common comorbid diagnoses, highlighting the need for gender awareness training to overcome gender stereotypes and promote accurate diagnosis of both depression and alcohol dependence in men and women if they are present.

- Comorbidity is associated with mental illness of increased severity, higher levels of disability and higher utilization of services. Women have higher prevalence rates than men of both lifetime and 12 month comorbidity involving three or more disorders. Depression and anxiety are the most common comorbid disorders but concurrent disorders include many of those in which women predominate such as agoraphobia, panic disorder, somatoform disorders and post traumatic stress disorder.

- Reducing the overrepresentation of women who are depressed must be tackled as a matter of urgency in order to lessen the global burden caused by mental and behavioural disorders by 2020. This requires a multi-level, intersectoral approach, gendered mental health policy with a public health focus and gender-specific risk factor reduction strategies, as well as gender sensitive services and equitable access to them.

- Gender acquired risks are multiple and interconnected. Many arise from women’s greater exposure to poverty, discrimination and socioeconomic disadvantage. The social gradient in health is heavily gendered, as women constitute around 70% of the world’s poor and earn significantly less than men when in paid work.

- Low rank is a powerful predictor of depression. Women’s subordinate social status is reinforced in the workplace as they are more likely to occupy insecure, low status jobs with no decision making authority. Those in such jobs experience higher levels of negative life events, insecure housing tenure, more chronic stressors and reduced social support. Traditional gender roles
further increase susceptibility by stressing passivity, submission and dependence and impose a duty to take on the unremitting care of others and unpaid domestic and agricultural labour. Conversely, gains in gender development that improve women’s status are likely to bring with them improvements in women’s mental health.

Globalization has overseen a dramatic widening of inequality within and between countries including gender-based income disparities. For poor women in developing countries undergoing restructuring, rates of depression and anxiety have increased significantly. Increased sexual trafficking of girls and women is another mental, physical, sexual health and human rights issue. The mental health costs of economic reforms need to be carefully monitored.

Finally, the epidemic of gender based violence must be arrested. The severity and the duration of exposure to violence are highly predictive of the severity of mental health outcomes. Rates of depression in adult life are 3 to 4 fold higher in women exposed to childhood sexual abuse or physical partner violence in adult life. Following rape, nearly 1 in 3 women will develop PTSD compared with 1 in 20 non victims. Current levels of detection of violent victimization are poor and primary health care providers require better training to intervene successfully to arrest the compounding of mental health problems.

Rates of psychiatric comorbidity and multi somatization are high, but neither well identified nor treated. The gendered nature of comorbidity poses complex therapeutic challenges regarding detection and appropriate models of care.

Research needs to be conducted into the relationship of violence to comorbidity. Women are at significantly increased risk of violence from an intimate and are over represented amongst the population of highly comorbid people who carry the major burden of psychiatric disorder. Equally, research is needed to understand better the sources of resilience and capacity for good mental health that the majority of women maintain, despite the experience of violence in their lives.

Access to safe affordable housing is essential if women and children are to escape violent victimization and the cessation of violence is highly therapeutic in reducing depression. Improved balance in gender roles and obligations, pay equity, poverty reduction and renewed attention to the maintenance of social capital would further redress the gender disparities in mental health.
Background

Data on the size of the global burden of mental disorders reveal a significant and growing public health problem (Murray & Lopez, 1996). Mental illness is associated with a significant burden of morbidity and disability and lifetime prevalence rates for any kind of psychological disorder are higher than previously thought. Rates are increasing in recent cohorts and affect nearly half the population (Kessler, McGonagle, Zhao et al., 1994; WHO & ICPE, 2000).

Despite being common, mental illnesses are underdiagnosed by doctors. Less than half of those who meet diagnostic criteria for psychological disorders are identified by their primary care providers (Üstün & Sartorius, 1995). Patients, too, appear reluctant to seek professional help. Only 2 in every 5 people experiencing a mood, anxiety or substance use disorder report seeking assistance in the year of the onset of the disorder (WHO & ICPE, 2000).

Other factors besides patient reluctance determine mental health care service utilization. Of increasing importance is the way mental health care is financed and organized including the shift to “user pays” health policies. Income level and medical insurance status can significantly predict access, particularly to specialist care (McAlpine & Mechanic, 2000; Alegria, Bijl, Lin et al., 2000).

Overall rates of mental disorder are almost identical for men and women (Kessler, McGonagle, Zhao et al., 1994) but striking gender differences in the patterns of mental illness.

Gender, human rights and the global burden of disease

Gender is a critical determinant of health, including mental health. It influences the power and control men and women have over the determinants of their mental health, including their socioeconomic position, roles, rank and social status, access to resources and treatment in society. As such, gender is important in defining susceptibility and exposure to a number of mental health risks.

If it is accepted that both women and men have a fundamental right to mental health, it becomes impossible to examine the impact of gender on mental health without considering gender-based discrimination and gender-based violence. Consequently, a human rights framework is needed to interpret gender differences in mental health and to identify and redress the injustices that lead to poor mental health. Many of the negative experiences and exposures to mental health risk factors that lead to and maintain the psychological disorders in which women predominate involve serious violations of their rights as human beings including their sexual and reproductive rights. The 1999 Human Development Report, referring to the increase in organized crime related to globalization, noted an escalation in the trafficking of women and girls for sexual exploitation – some 500,000 girls and women trafficked to Western Europe alone – and described trafficking as one of the “most heinous violations of human rights”. The multiple, severe mental health consequences of sexual violence and abuse are discussed below.

Gender and patterns of mental disorder

In examining the role of gender in mental illness a distinction needs to be made between the low-prevalence and severe mental disorders such as schizophrenia and bipolar disorder, where no consistent gender differences in prevalence rates have been found, and the high-prevalence disorders of depression and anxiety where large gender differences in rates have been consistently reported. Depression and anxiety, often associated with somatic complaints, are known to affect around 1 in 5 people in the general community and more than 2 in 5 primary care attenders in a variety of countries (Üstün & Sartorius, 1995; Patel, 1999).

General population studies indicate that lifetime prevalence rates for schizophrenia and bipolar disorder range from 0.1% to 3% for schizophrenia and from 0.2% to 1.6% for bipolar disorders (Piccinelli & Homen 1997) and no significant gender differences have been reported.

Differences in rates of disorder are only one dimension of the role played by gender in mental health.
health and illness. Beyond rates, gender is related to differences in risk and susceptibility, the timing of onset and course of disorders, diagnosis, treatment and adjustment to mental disorder.

A comprehensive review of schizophrenia research found frequent reports of gender differences in age of onset of symptoms. Men typically had an earlier onset of symptoms than women and poorer pre-morbid psychosocial development and functioning (Piccinelli & Homen, 1997). Despite later onset, some studies report that women experience a higher frequency of hallucinations or more positive psychotic symptoms than men (Lindamer et al. 1999). Similarly, while the population prevalence rates of bipolar disorder appear not to differ, gender differences occur in the course of the illness. Women are more likely to develop the rapid cycling form of the illness, exhibit more comorbidity (Leibenluft, 1997) and have a greater likelihood of being hospitalized during the manic phase of the disorder (Hendrick, Altschuler, Gitlin et al. 2000).

A number of studies report that women with schizophrenia have higher quality social relationships than men. However, a cross national survey drawn from Canada, Cuba and the USA (Vandiver, 1998) found that this was only true for Canadian women; Cuban men reported higher quality of life than Cuban women. A Finnish study on gender differences in living skills, involving self care and shopping, cooking and cleaning for oneself, found that half the men but only one third of the women lacked these skills that are so important for independent living (Hintikka et al., 1999). Thus skills inculcated through gender socialization can affect long term adjustment to and outcome of a severe mental disorder.

Gender specific exposure to risk also complicates the type and range of adverse outcomes associated with severe mental disorder. When schizophrenia coexists with homelessness, women experience higher rates of sexual and physical victimization, and more comorbid anxiety, depression and medical illness than men (Brunette & Drake, 1998).

Gender and Depression

Depression contributes most significantly to the global burden of disease and it is the most frequently encountered women’s mental health problem (Piccinelli & Homen, 1997). Unipolar or major depression occurs approximately twice as often in women as in men and is predicted to be the second leading cause of global disease burden by 2020 (Murray & Lopez 1996). Any significant reduction in the overrepresentation of women who are depressed would make a significant contribution to reducing the global burden of disease and disability. Depression and anxiety are the most common comorbid disorders and a significant gender difference exists in the rate of comorbidity (Linzer et al., 1996). Comorbidity contributes significantly to the burden of disability caused by psychological disorders (Kessler et al., 1994; Üstün & Sartorius 1995, WHO & ICPE, 2000).

The gender difference in depression is one of the most robust findings in psychiatric epidemiology. A comprehensive review of almost all general population studies conducted to date in the United States of America, Puerto Rico, Canada, France, Iceland, Taiwan, Korea, Germany and Hong Kong, reported that women predominated over men in lifetime prevalence rates of major depression (Piccinelli & Homen, 1997). This difference is documented in clinical and community samples and

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**National Comorbidity Survey: Prevalence rates of selected disorders**

<table>
<thead>
<tr>
<th>Mental Disorders</th>
<th>Lifetime Prevalence Female</th>
<th>Lifetime Prevalence Male</th>
<th>12 Month Prevalence Female</th>
<th>12 Month Prevalence Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major depressive episode</td>
<td>21.3%</td>
<td>12.7%</td>
<td>12.9%</td>
<td>7.7%</td>
</tr>
<tr>
<td>Alcohol dependence</td>
<td>8.2%</td>
<td>20.1%</td>
<td>3.7%</td>
<td>10.7%</td>
</tr>
<tr>
<td>Antisocial personality disorder</td>
<td>1.2%</td>
<td>5.8%</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

Source: Kessler et al., 1994
across racial groups (Kessler et al., 1994; Gater et al., 1998, W H O & ICPE, 2000). Depression may also be more persistent in women (Bracke, 2000) and female gender is a significant predictor of relapse (Kuehner, 1999).

The US National Comorbidity Survey (Kessler et al., 1994), like many other studies before and since (Üstün & Sartorius 1995; Linzer et al., 1996; Brown, 1998), found women had a higher prevalence of most affective disorders and non affective psychosis and men had higher rates of substance use disorders and antisocial personality disorder.

The most common disorders were major depression and anxiety are common comorbid diagnoses and women have higher prevalence than men of both lifetime and 12 month comorbidity of three or more disorders (Kessler et al., 1994, W H O & ICPE, 2000). Almost half of patients with at least one psychiatric disorder have a disorder from at least one other cluster of psychiatric disorders (Üstün & Sartorius, 1995). These clusters included most disorders, apart from alcohol dependence, in which women have already been found to predominate (Russo, 1990), including depressive episode, agoraphobia, panic disorder and generalized anxiety; somatization, hypochondriasis and somatoform pain. Psychiatric comorbidity, with depression as a common factor, is a characteristic finding of many studies on women's mental health (Brown et al. 1996; Linzer, Spitzer, Kroenke et al, 1996) and a repeated finding from studies on the mental health effects of violence from an intimate (Resnick et al., 1997).

Recent research findings have pointed to the need for improved recognition of the presence and significance of comorbid conditions. Comorbidity is associated with increased severity, higher levels of disability and higher utilization of services and is concentrated in a small group of people. Highly comorbid people, who as a group represent about one sixth of the population between 15 and 54 years in the US, have been found to carry the major burden of psychiatric disorder (Kessler et al, 1994). When all lifetime disorders were examined in the National Comorbidity Survey only 21% occurred in people who over their lifetime had experienced only one disorder, while 79% of lifetime disorders, in this sample, were comorbid disorders. For 12 month disorders, the findings were even stronger. It is therefore of considerable importance that women had significantly higher lifetime and 12 month comorbidity of three or more disorders than men in this and other studies (Üstün & Sartorius 1995, W H O ICPE, 2000).

Subsequent analysis of data from the National Comorbidity Survey reported strong associations between panic attacks and panic disorder and major depression, with panic attacks being predictive of the first onset of major depression and primary depression predicting a first onset of subsequent panic attacks. Of gender significance was the finding that this relationship was weaker when the influence of prior traumatic experiences and histories of other mental disorders were statistically controlled in the analysis (Kessler, Stang, Wittchen et al, 1998).

The multi-country W H O study on Psychological Problems in General Health Care also found that current panic attacks and a diagnosis of panic disorder were frequently associated with the presence of a depressive disorder. Women predominate in all
three disorders - panic attacks, panic disorder and depressive disorder. The combination of these disorders resulted in a long lasting and severe disorder that was linked to a higher rate of suicidality. (Lecrubier & Üstün, 1998).

Comorbidity and compounding over time

It is not only the co presence of multiple disorders at one point in time that needs urgent attention. Clinicians, policy makers and researchers also require a better understanding of why psychological disorders compound and proliferate over the life course of a sub group of highly comorbid people, women in particular, in order to devise effective interventions.

For example, patients who are initially free from disability, but then experience a depressive illness, can experience a change in their disability status which may gather momentum over time. Ormel, Vonkorff, Oldehinkel et al. (1999) found that the risk of onset of physical disability, even after controlling for the severity of the physical disease, increased 1.5 fold three months after the onset of a depressive illness and 1.8 fold at 12 months. The risk of onset of social disability increased even more significantly from a 2.2 fold risk at 3 months to a 23 fold risk at 12 months.

Of particular importance is the need to identify women who have a history of and/or are currently experiencing violent victimization. Violence related health outcomes including higher rates of depression and post traumatic stress disorder increase and compound when victimization goes undetected. This results in increased and more costly utilization of the health and mental health care system (AMA, 1992; Koss, 1994; Acierno, Resnick and O’Brien, 1999).

Gender bias

Research

Gender bias has skewed the research agenda. The relationship of women’s reproductive functioning to their mental health has received protracted and intense scrutiny over many years while other areas of women’s health have been neglected. Recent research suggests that the impact of biological and reproductive factors on women’s mental health is strongly mediated and, in many cases disappears, when psychosocial factors are taken into account. For example, research on menopause has revealed that emotional well being in middle aged women is positively associated with their current general health status, psychosocial and lifestyle variables, but not with their menopausal status nor their hormone levels (Dennerstein, Dudley and Burger, 1997).

By contrast, the contribution of men’s reproductive functioning to their mental health has been virtually ignored. The few studies that have been conducted reveal that men are emotionally responsive to many of the same events as women. For example, men as well as women experience depression following the birth of a child and there is a high level of correlation between parents regarding depressive symptoms (Sollday, McCluskey-Fawcett and O’Brien, 1999).

Health programmes directed towards women have typically had a narrow focus on reproductive health and fertility control, especially in developing countries. The preoccupations of health planners, aid agencies and researchers are not necessarily shared by the women towards whom these programmes are directed. In a study conducted in the Volta region of Ghana, nearly three quarters of the women, when asked to identify their most important health concerns, nominated psychosocial health problems such as “thinking too much” and “worrying too much”, not reproductive health concerns (Avotri & Walters, 1999). The explanations women gave of their health problems stressed heavy workloads, the gendered division of labour, financial insecurity and unremitting responsibility for the care of children.

Treatment

Gender bias and stereotyping in the treatment of female patients and the diagnosis of psychological disorders has been reported since the 1970’s (Broverman, Vogel, Broverman et al., 1972). Recent research findings are less consistent. Some have found that doctors are more likely to diagnose depression in women compared with men, even when they have similar scores on standardized measures of depression or present with identical symptoms (Callahan, Bertakis, Azari et al, 1997;
However, no gender difference in the detection of depression and anxiety disorders by doctors was found in the multi-country WHO study of psychological problems in general health care (Gater et al., 1998). Detection or identification of psychological disorder is an important first step in improving the quality of care, but one which must be followed by effective treatment to have a positive effect on outcome.

Female gender is a significant predictor of being prescribed psychotropic drugs. It has also been reported that women are 48% more likely than men to use any psychotropic medication after statistically controlling for demographics, health status, economic status and diagnosis (Simoni-Wastila, 2000).

Gender differences exist in patterns of help seeking for psychological disorder. Women are more likely to seek help from and disclose mental health problems to their primary health care physician while men are more likely to seek specialist mental health care and are the principal users of inpatient care. Men are also more likely than women to disclose problems with alcohol use to their health care provider (Allen, Nelson, Rouhbakhsh et al., 1998). This suggests that gender based expectations regarding proneness to emotional problems in women and proneness to alcohol problems in men, as well as a reluctance in men to disclose symptoms of depression, reinforce social stigma and constrain help seeking along stereotypical lines.

Despite these gender differences, most women and men experiencing emotional distress and/or psychological disorder are neither identified or treated by their doctor (Üstün & Sartorius, 1995). An additional problem is that many people with psychological disorders do not go to their doctors. In a recent US study, almost three fifths of those with severe mental illness received no speciality care over a 12 month period (McAlpine & Mechanic, 2000). If help is not sought in the year of onset of a disorder, delays in help seeking of more than 10 years are common in many countries (WHO & ICPE, 2000). If there is significant unmet need, as well as poor identification of disorder in people who do go to primary care providers in relatively well-resourced developed countries, the situation is likely to be much worse in developing countries.

**Funding, organization and insurance**

The organization and financing of mental health care makes an important contribution to social capital, and is an indicator of access and equity in mental health care.

To reduce gender disparities in health care in relation to the disorders in which women predominate, requires that barriers to accessing care are lowered and patient preferences are heeded. Women's overrepresentation amongst those living in poverty, means that cost will be a significant barrier to mental health care. A “user pays” system where consumers either pay directly out of their own pockets for services or to cover the cost of health insurance, will further disadvantage poor women who are over represented amongst those experiencing depression, anxiety, panic disorder, somatization disorder and posttraumatic stress disorder.

Depending on the way mental health care is funded, medical insurance status can significantly predict access to speciality care. One US study reported that those with insurance were six times more likely to have access to care than those without (McAlpine & Mechanic, 2000). Lack of insurance interacts with other aspects of the socioeconomic disadvantage experienced by the severely mentally ill, in comparison with those with no identifiable mental disorder.

Both income level and the organization and financing of mental health can exert an influence on the likelihood of mental health services being utilized and the particular sector of service provision likely to be accessible. A three country study, using data from the 1990-1992 National Comorbidity Survey, the 1990-1991 Mental Health Supplement to the Ontario Health Survey and the 1996 Netherlands Mental health Survey and Incidence study, examined interrelationships between income, organization and financing of mental health care and differential use of mental health treatment. The three sectors of mental health care provision examined were the general medical, speciality and human services sectors. Ontario was the only place where income was unrelated to the sector of care for patients, indicating equity of access. In relation to human development, it is perhaps no coincidence that Canada also ranks first on the Human Development Index and the Gender Development
Index (UNDP, 2000). In the US, income was positively related to speciality sector treatment and negatively related to treatment in the human services sector. In the Netherlands, patients in the middle income group were less likely to receive speciality care and those in the high income group less likely to receive care from the human service sector (Alegria, Bijl, Lin et al, 2000).

If access to care is not blocked by cost considerations, those in greatest need are likely to seek treatment. Another Canadian study revealed that single motherhood status was the strongest independent predictor of mental health morbidity and utilization of mental health services. Low income was the next strongest predictor and of course, recall here too, that low income is interrelated with single motherhood status (Lipman, Offord and Boyle, 1997).

The trend to managed care in some countries, when associated with reductions in the intensity and duration of treatment, is likely to impact most on those with chronic disorders who are also most likely to be experiencing social disadvantage.

**Gender sensitive services**

To reduce gender disparities in mental health treatment, gender sensitive services are essential. If women are to be able to access treatment at all levels from primary to specialist care and inpatient as well as outpatient facilities, services must be tailored to meet their needs.

To ensure that the assistance available is also meaningful to those seeking treatment, the full range of patients’ psychosocial and mental health needs must be addressed. This involves services adopting a life course approach, by acknowledging current and past gender specific exposures to stressors and risks and by responding sensitively to life circumstances and ongoing gender based roles and responsibilities.

Gender sensitivity will not improve unless client based preferences inform models of treatment and the provision of care. For women generally, but especially low income ones, services have to be made genuinely accessible. This includes having access to services during the weekend or evening hours, short waiting times and locating services close to public transport routes. With regard to the doctor patient relationship, preferred health care providers are those who show a sense of concern and respect and are willing to talk and spend time with patients. Integrated services where social and clinical services are available on one site are also preferred by women (O’Malley, Forrest and O’Malley 2000).

Some women with mental illness or substance use disorders are also parents and carers. Services need to be aware of the impact of this role on women’s lives and their willingness to seek help, including fears that their children will be taken from them, if they do seek treatment (Mowbray et al., 1995). For women experiencing postnatal psychological disorder such as postnatal depression and postpartum psychosis, but also for women experiencing emotional distress, exhaustion and parenting difficulties, mother-baby units that allow joint admission can be useful. To reduce stigma, such units should operate as part of general maternity hospitals and services. Mothers and babies should not be sent to psychiatric hospitals.

Services that attempt to assist women with severe mental illness need to move beyond stereotypical assumptions and roles regarding women and not only provide access to living and social skills but also to vocational training and employment support.

**Violence and severe mental illness**

Violence-related mental health problems are poorly identified, victimization histories are not routinely taken and women are reluctant to disclose a history of violent victimization unless physicians ask about it directly (Mazza & Dennerstein, 1996).

At the same time, violent victimization, especially severe childhood sexual abuse (CSA), significantly predicts admission as an inpatient to a psychiatric facility during adulthood. A New Zealand study (Mullen, 1993) found women whose childhood sexual abuse involved penetrative sex, were sixteen times more likely to report psychiatric admissions than those who had been subjected to lesser forms of abuse. Given the significance of CSA as a predictor of inpatient admission, it is important that inpatient and residential services provide women with adequate safety and privacy. Even after controlling for the effect of coming from an unstable family home where one or both parents were
absent, had mental health problems or were in conflict. CSA remained a significant predictor of later psychopathology.

**Gender and risk**

Emerging evidence indicates that the impact of gender in mental health is compounded by its interrelationships with other social, structural determinants of mental health status, including education, income and employment as well as social roles and rank. There are strong, albeit varying, links between gender inequality, human poverty and socioeconomic differentials in all countries. Gender differences in material well being and human development are widely acknowledged. According to the 1998 World Health Report:

Women’s health is inextricably linked to their status in society. It benefits from equality, and suffers from discrimination. Today, the status and well being of countless millions of women world-wide remain tragically low (WHO, 1998: 6).

In every country, gender development continues to lag behind human development (UNDP, 2000) or as an earlier Human Development Report (UNDP, 1997) put it: “no society treats its women as well as its men”. Women constitute more than 70% of the world’s poor (UNDP 1995) and carry the triple burden of productive, reproductive and caring work. Even in developed countries, lone mothers with children are the largest group of people living in poverty (Belle 1990) and are at especially high risk for poor physical and mental health (Macran et al., 1996; Lipman, Offord and Boyle, 1997). Clearly, gender must be taken into account in looking at the way income disparities, inequalities and poverty impacts on mental health.

**Gender and rank**

There is a strong social gradient in health. Adverse mental health outcomes are 2 to 2 _times higher amongst those experiencing greatest social disadvantage compared with those experiencing least disadvantage (Dohrenwend 1990; Kessler et al., 1994; Kunst et al., 1995; Bartley & Owen, 1996; Macran et al., 1996; Stansfeld et al., 1998). Environmental stressors, including increased numbers of negative life events, experiences and chronic difficulties, are highly significant in accounting for the lower social class predominance of non-psychotic psychiatric disorders like depression and anxiety. Less control over decision making, the structural determinants of health and less access to supportive social networks correlate with higher levels of morbidity and mortality (Kessler et al., 1994; Turner & Marino, 1994; Brown, 1998).

While there is a large amount of evidence that confirms a strong relationship between socioeconomic status, position in the social hierarchy and mental health, most research has lacked a gender perspective.

Analyses of the social gradient in health have concentrated on the material indicators of inequality and social disadvantage. However, the social gradient in physical and mental health also operates on a symbolic and subjective level. Social position carries with it an awareness of social rank and a clear understanding of where one stands in the scale of things. The link between a sense of loss and defeat, entrapment, and humiliation denoting devaluation and marginalization, is strengthened by related research on social rank (Gilbert & Allan 1998). Depression is strongly related to several interrelated factors:

- Perceptions of the self as inferior or in an unwanted subordinate position, with low self confidence.
- Behaving in submissive or in non assertive ways.
- Experiencing a sense of defeat in relation to important battles, and wanting to escape but being trapped.

The very same qualities that characterize depression and low social rank, have been regarded as normal and desirable qualities of “femininity” and encouraged if not enforced through socialization, “tradition” and outright discrimination. By contrast, psychosocial resources, the wherewithal to exercise choice, having a confidant, social activities and a sense of control over one’s life, form critical bulwarks against depression regardless of a woman’s age (Zunzunegui et al., 1998). Feelings of autonomy and control significantly lessen the risk of depression occurring in the context of what might otherwise be considered as an important loss. Brown, Harris and Hepworth (1995) found
that when marital separation was initiated by the woman, only about 10% of such women subsequently developed depression. When the separation was almost entirely initiated by her partner, around half the women developed depression. Interestingly, the rate of depression increased again, if infidelity was discovered and not followed by separation.

Gender and work

Women in paid work receive significantly lower wages than their male counterparts. Relative income inequality penalizing women and favouring men is structurally embedded as women typically earn around two thirds of the average male wage and this disparity has persisted over time. The level of gender development in a country is strongly related to rates of pay. Between 1993-1995, less than 10% of women were in low paid work in Sweden, where the ranking for gender development is higher than for human development. In contrast, in Japan and the US where gender development rankings are lower than human development rankings, more than 30% of women were in low paid jobs (UNDP, 1997).

The weakening of worker protection laws to attract foreign investment and the employment of girls and women as "outworkers" or sweated labour in garment and footwear industries and in export processing zones (EPZ), as well as their overrepresentation amongst sex workers, represent significant threats to mental and physical health and violations of women’s human rights.

The workplace itself is another area where rank is predictive of depression and linked to gender. Work characteristics, especially skill discretion and decision making authority are closely allied to employment grade and make the largest contribution to explaining differences in well being and depression. The highest levels of well being and the least depression are found in the highest employment grade; the reverse is true for those in the lowest grades who have a higher prevalence of negative life events, chronic stressors and less social support. Women are more likely to occupy lower status jobs with little decision-making discretion (Stansfeld, Head and Marmot, 1998).

Research on the subjective correlates of events related to subordinate status or lower rank, complements earlier work that documented the relationship between various objective measures of rank and the increased likelihood of poor health, depression and anxiety. Rank related variables are found in clusters, rarely in isolation and combine structural, material determinants, rank and symbolic indicators of social standing and gender roles. The resultant mix is strongly predictive of the common mental disorders. It includes low educational status, unemployment, low employment status and pay, insecure, "casual" employment, single parent status, homelessness and insecure housing tenure and inadequate income, poor social support and diminished social capital (Belle, 1990; Macran, Clarke and Joshi; 1996, Brown et al, 1996; Kawachi et al., 1999).

Gender roles

Gender socialization, which stresses passivity, submission and lower rank, are not only reinforced for women by their structural position in paid employment – lower status, more "casual", part-time and insecure jobs and lower rates of pay - but by their much larger contribution to unpaid domestic and caring work in the home. Women of reproductive age may carry the triple burden of productive, reproductive and caring work. Not surprisingly, gender differences in rates of depression are strongly age related. The largest differences occur in adult life, no differences are found in childhood and few in the elderly (Vazquez-Barquero et al., 1992; Beekman et al., 1995; Zunzunegui et al., 1998).

Gender differences in mental health cannot be explained by relying solely on role analysis to examine women’s mental health and structural analysis to examine men’s mental health. Even so, when social role variables such as marital status, children and occupational status were matched between women and men who participated in the multi country WHO study on Psychological Problems in Primary Care, the female excess in depression was reduced by 50% across all centres in the study (Maier, Gansicke, Gater et al, 1999).

To fully understand gender differences in mental health, there is a need to integrate a gender role
analysis with a structural analysis of the determinants of health because gender roles intersect with critical structural determinants of health including social position, income, education and occupational and health insurance status. Role patterns of women are not evenly distributed across income levels. A French study found that housewives and lone mothers are more common at the bottom and middle of the income scale and working women without children, married or not, are more common at the top (Khlat, Sermet and Le Pape, 2000).

In addition, the measurement of women’s income is problematic. A significant amount of income data is missing for women in many large scale surveys (Macran et al., 1996). The substitution of “family income” or “total household income”, as a proxy measure of socioeconomic status has inherent problems. This proxy measure may bear little relationship to the way income is distributed within the household, especially in households where women are subjected to violence and experience high levels of coercive control over all aspects of their lives including the spending of money. To accurately assess women’s income, information is necessary on their levels of access to and control over income within the household. Assuming equitable access to and distribution of “family income” is unwarranted, but continues to be widely practiced (WHO & ICPE, 2000).

Numerous studies have reported that low income mothers, especially lone mothers, have significantly higher levels of depression than the general population (Macran & Joshi, 1996; Salsberry, Nickel, Polivka et al., 1999). Compared with the general population, poor women are exposed to more frequent, more threatening and more uncontrollable life events, such as the illness and death of children and the imprisonment or death of husbands. They face more dangerous neighbourhoods, hazardous workplaces, greater job insecurity, violence and discrimination, especially if they belong to minority groups (Belle 1990, Brown 1998; Patel et al. 1999). Other gender based experiences, such as having two or more abortions, or experiencing sexual abuse or other forms of violence and adversity in childhood or adult life also contribute significantly to poorer mental health (Bifulco et al. 1991; Fellitti et al., 1998). These factors, separately and together, work to reduce the degree of autonomy, control and decision making latitude possible for women on low incomes.

**Economic policies**

Current evidence on the consequences of globalization and restructuring indicates that socioeconomic deprivation is increasing and income inequality is widening within and between many countries (UNDP, 2000). Considerable evidence links rising income inequality to increasing rates of common mental disorders, like depression, anxiety and somatic symptoms (Patel et al., 1999), increased rates of mortality from physical conditions (Lynch, Smith, Kaplan, House, 2000) and increased mental health related mortality associated with substance use disorders and suicide (Lorant, 2000). In Russia, the predictors of significant falls in life expectancy include fast paced economic change, high turnover of the labour force, increased levels of crime, alcoholism, inequality and decreasing social cohesion (Walberg, McKee, Shkolnikov et al, 1998).

The impact of globalization and structural adjustment programmes is especially severe in the poorest nations. Moreover, it occurs in gender distinct ways because of the separate roles men and women play and the different constraints they face in responding to policy changes and shifts in relative prices (Kirmani & Munyakho, 1996). Cutbacks in public sector employment and social welfare spending can cause the costs of health care, education and basic foodstuffs to become unaffordable, especially to the poor, the majority of whom are women (Bandarage, 1997).

Evidence on the gender specific effect of restructuring on mental health is persuasive. Data obtained from primary care attenders in Goa (India), Harare (Zimbabwe), Santiago (Chile) and from community samples in Pelotas and O linda (Brazil) showed significant associations between high rates of depression, anxiety and somatic symptoms and female gender, low education and poverty (Patel et al., 1999). This study reveals how gender inequality accompanies but is also worsened by economic inequality and rising income disparity. The result of this interaction is a steep rise in the very mental disorders in which women already predominate.
Economic policies that cause sudden, disruptive and severe changes to the income, employment and living conditions of large numbers of people who are powerless to resist them, pose overwhelming threats to mental health. Disruptive, negative life events that cannot be controlled or evaded are most strongly related to the onset of depressive symptoms. An increase in the number of such events is paralleled by an increase in the numbers of women becoming depressed. The size of the contribution made by these events to common mental disorders is evident from a number of studies on women’s mental health carried out over recent years in a range of countries.

Based on research carried out in Great Britain, Brown, Harris and Hepworth (1995) calculate that 85% of women from the community (as opposed to a patient group) who developed “caseness” for depression in a 2 year study period experienced a severe event in the 6 months before onset. Depression was particularly likely to occur when a severe event (or events) was accompanied by vulnerability factors, especially those associated with low self-esteem and inadequate support. The matching of a current severe event with a pronounced ongoing difficulty was also critical to the onset of depression (Brown et al., 1990; Brown, 1998).

Severe, disruptive negative events could involve loss or danger but other features were more important in initiating depression. Most important of all was the experience of humiliation, defeat and a sense of entrapment, often in relation to a core relationship. Almost three-quarters of the severe events occurring in the six months prior to the onset of depression involved entrapment or humiliation whereas just over one fifth involved loss alone and only 5% concerned danger alone (Brown et al., 1995). Studies conducted in Zimbabwe at two different time points offer further insight into the strength of the relationship between the nature and frequency of severe events and associated rates of depression. In the first study, the annual incidence of depression was 18%, double that found in inner London (Abas & Broadhead, 1997). This increased to 30.8% in the second study (Broadhead & Abas, 1998). The excess of onset cases in the second study was primarily due to the increased numbers of severe and disruptive events and difficulties occurring in the intervening time period.

The severe events reflected, “the high levels of physical illness and premature death in family members, the predicaments associated with seasonal migration between rural and urban homes, problems associated with infertility and the large number of marital and other relationship crises” (Broadhead & Abas, 1998: 37).

Population based studies of women in Zimbabwe, London, Bilbao, the Outer Hebrides, rural Spain and rural Basque Country, Spain, found that women meeting the criteria for depression varied from a low of 2.4% in the Basque Country to a high of 30% in Zimbabwe. Negative, irregular, disruptive life events were found to trigger depression in all six sites. Taken together, these findings indicate that a strong linear relationship exists between the number and severity of events and the prevalence of depression (Brown, 1998).

Impact of gender-based violence on mental health

Where women lack autonomy, decision making power and access to income, many other aspects of their lives and health will necessarily be outside their control. In particular, gender differentiated levels of susceptibility and exposure to the risk of violence place stringent limitations on women’s ability to exercise control over the determinants of their mental health.

Social research indicates that depression in women is triggered by situations that are characterized by humiliation and entrapment and that this occurs in relation to “atypical events” (Brown, Harris and Hepworth, 1995). This view is challenged by evidence about the chronic nature of much gender based violence and its direct link to increased rates of depression.

The prevalence of violence against women (VAW) is alarmingly high (WHO, 1998). Women compared to men are at greatly increased risk of being assaulted by an intimate (Kessler, Sonnega, Bromet et al., 1995). Violence in the home tends to be repetitive and escalate in severity over time (AMA 1992) and encapsulates all three features identified in social research on depression in women: humiliation, enforced inferior ranking and subordination, and blocked escape or entrapment.
Violence – physical, sexual and psychological – is related to high rates of depression and co-morbid psychopathology, including posttraumatic stress disorder (PTSD), dissociative disorders, phobias and substance use and suicidality (Roberts et al. 1998). Moreover, psychological disorders are accompanied by multi-somatization, altered health behaviours, changed patterns of health care utilization and health problems affecting many body systems (Resnick et al., 1997; Roberts et al. 1998; Felitti et al., 1998). Being subjected to the exercise of coercive control leads to diminished self-esteem and coping ability.

Violent victimization increases women’s risk for unemployment, reduced income and divorce (Byrne et al, 1999). For this reason, gender based violence is a particularly important cause of poor mental health because it further weakens women’s social position by operating on the structural determinants of health at the same time as it increases vulnerability to depression and other psychological disorders.

The high incidence of sexual violence against girls and women has prompted researchers to suggest that female victims make up the single largest group of those suffering from post traumatic stress disorder (Calhoun & Resick, 1993). A nationwide survey of rape in the US, found 31% of rape victims developed PTSD at some point in their lives compared with 5% of non-victims (Kilpatrick, Edmunds & Seymour, 1992). PTSD also persists longer in women than in men (Breslau et al., 1998).

The mental health impact on the millions of women who are caught up in sexual trafficking has not been assessed. The trauma of repeated abuse and denial of any human rights is severe and ongoing. Mental health effects are likely to include all those previously identified in research on VAW and to parallel those experienced by other victims of torture. The likely causal role of violence in depression, anxiety and other disorders such as posttraumatic stress disorder is suggested by:

- Three to four fold increases in rates of depression and anxiety in large community samples amongst those exposed to violence compared with those not exposed (Mullen et al. 1998; Saunders et al. 1993).
- Severity and duration of violence predicts severity and number of adverse psychological outcomes, even when other potentially significant factors have been statistically controlled in data analysis. This has been found in studies on the mental health impact of domestic violence (Campbell & Lewandowski, 1997; Roberts et al. 1998) and childhood sexual abuse (Mullen et al., 1993).
- Marked reductions in the level of depression and anxiety once women stop experiencing violence and feel safe (Campbell et al., 1996) compared with increases in depression and anxiety when violence continues (Sutherland et al., 1998).

The evidence presented here indicates that the female excess in depression and other disorders reflects women’s greater exposure to a range of stressors and risks to their mental health, rather than an increased, biologically based vulnerability to psychological disorder.

**Implications for policies and programmes**

To reduce gender disparities in mental health involves looking beyond mental illness as a disease of the brain. This is not to deny that distress and disorder exist and require compassionate and scientifically based treatment nor that the stigma associated with all forms of mental illness must be eradicated. However, clinicians, researchers and policy makers also need to socially contextualize the mental disorders affecting individuals and the risk factors associated with them.

There is strong evidence that globalization and large scale restructuring have increased income inequalities and adverse life events and difficulties, with particularly severe impacts on women. Moreover this increase in gender based income disparities is associated with increasing rates of common mental disorders amongst women in a number of countries (Patel et al, 1999; Broadhead and Abas, 1998).

Governments need to monitor the mental health effects of their economic reforms and take urgent action to bring about a more gender equitable distribution of the benefits of globalization. Active measures need to be taken to protect social capital,
as this too, is powerfully related to how people rate their health (Kawachi et al., 1999). If gender based income inequalities are not reduced, the numbers of girls and women who are forced to rely on harmful and/or illegal activities for income, such as work in the sex industry, will continue to escalate.

Budgets for mental health will become rapidly depleted if funding is focussed on curative treatment and care. Medical treatment that is confined to the alleviation of presenting symptoms is at best a partial response. Such a response fails to address ongoing high levels of exposure to mental health risks or to reduce gender based levels of susceptibility. In other words, while improving identification and treatment of mental disorders is certainly necessary, it is clearly not sufficient to reduce their incidence.

Currently, the rates of detection, treatment and appropriate referral of psychological disorders in primary health care settings are unacceptably low. The high rates of depression in women and alcohol dependence in men strongly indicate a large unmet need for improved access, at a community level, to low or preferably no cost gender sensitive counselling services. Psychologists and social workers working in community based health services that are responsive to the psychosocial issues of those they serve, are well placed to provide cost effective mental health services.

All health care providers need to be better trained so that they are able to recognize and treat not just single disorders such as depression and alcohol dependence, but also their co occurrence. Clinicians need to be equipped to assess and respond to gender specific, structurally determined risk factors and to become proficient in providing much needed advocacy for their patients with other sectors of the health and social welfare system. Without these skills, rates of comorbidity among patients will compound. Skill in trauma focussed counselling is a priority for clinicians in all health sectors who encounter women (Acierno, Resnick and Kilpatrick, 1997).

Women’s overrepresentation amongst those with psychiatric comorbidity (Kessler et al., 1994) together with the heightened burden of disability associated with comorbidity indicates the need to clearly identify gender specific risk factors for comorbidity. In particular, the complex linkages between depression in women, multi somatization and psychiatric comorbidity in the context of a history of violent victimization need to be clarified.

Mental health care funding, too, must be responsive to the issue of psychiatric comorbidity. Clinicians need to have adequate consultation time with their patients to permit accurate diagnosis. Time and cost pressures on “throughput” may appear economic and efficient in the short term but are incompatible with providing patients gender sensitive, meaningful assistance with their mental health problems. Repeated utilization of the mental health care system consequent on the failure to accurately diagnose and treat is a far more expensive outcome in the long term.

The concept of “meaningful assistance” in mental health care needs to be promoted. Meaningful assistance implies a patient centred approach. Gender disparities in mental health will not be reduced until women’s own mental health concerns and life priorities are taken into account in programme design and implementation (Avotri & Walters, 1999). Currently under diagnosed and poorly treated conditions, especially the combination of depression, violence related health conditions and significant psychosocial problems urgently require meaningful assistance.

Gender based barriers to mental health care, especially cost and access, bias and discrimination must be removed. Intersectoral collaboration across government departments and gender sensitive policy making in education, housing, transport and employment are required to ensure that the multiple structural determinants of mental health are facilitated to work in positive synergy, maintain social capital and support social networks (Kawachi et al., 1999). A free, universal medical insurance scheme is the only way to ensure mental health care will be accessible to the most socioeconomically disadvantaged group (Lipman, Offord and Boyle, 1997).

A public health approach to improve primary prevention and address gender specific risk factors for depression and anxiety disorders is indicated by a large body of evidence. Social safety nets and income security are especially important for women and their mental health. A public health approach necessarily broadens the notion of effec-
tive treatment. The most obvious way of reducing violence related mental health problems is to reduce women’s exposure to violence. Women who have been but are no longer being battered show significant reductions in their level of depressive symptoms, while those who continue to experience violence do not (Campbell et al., 1993). Providing access to refuges and alternative forms of safe housing is thus a powerful mental health “treatment”.

Better quality evidence needs to be collected that is informed by a gendered, social determinants, life course approach. Cross sectional research has revealed significant factors in the onset of depression but much more longitudinal research is required to understand how changes in social and household conditions mediate the course of depression and its chronicity (Bracke, 2000). If persistence in adversity is neither accurately measured nor disentangled from persistence in depressive symptoms, its role in the chronicity of depressive symptoms cannot be ascertained.

A priority for mental health promotion and intervention programmes is to incorporate a mental health focus in all programmes related to child health. The level of exposure to adverse childhood events has a strong graded relationship with all the major causes of adult morbidity and mortality and the behavioural risk factors associated with them (Felitti et al., 1999). Childhood sexual abuse, in particular, is predictive of multiple negative health outcomes including high rates of psychiatric morbidity as well as homelessness, prostitution, substance use disorders and suicidality. The earliest possible identification and protection of those exposed to adverse childhood events, and ideally the elimination of these events, is necessary to prevent re-victimization and arrest the progression and compounding of poor mental, physical, sexual and social health outcomes. Consequently, the goal of preventing childhood neglect and exposure to all forms of trauma and adversity must inform the design and implementation of maternal and child health, family violence services and social welfare and social security services.

At the same time, “zero tolerance” health education and promotion campaigns to reduce violence against women and children need to be designed using culturally appropriate formats in order to counter traditional beliefs and attitudes that condone and perpetuate violence.

**Conclusion**

To address gender disparities in mental health requires action at many levels. In particular, national mental health policies must be developed that are based on an explicit analysis of gender disparities in risk and outcome.

Effective strategies for risk factor reduction in relation to mental health cannot be gender neutral while the risks themselves are gender specific and women’s status and life opportunities remain “tragically low” worldwide (WHO, 1998). Low status is a potent mental health risk. For too many women, experiences of self worth, competence, autonomy, adequate income and a sense of physical, sexual and psychological safety and security, so essential to good mental health, are systematically denied. The pervasive violation of women’s rights, including their reproductive rights, contributes directly to the growing burden of disability caused by poor mental health.

Consequently, a rights framework needs to be adopted to improve the ethical and interpretative dimensions of research, mental health care practice and policy. Mental health research has scarcely begun to address the impact of patient and human rights violations on mental health. These include the psychological effect of failure to gain informed consent, denial of patient privacy and dignity, and the use of treatments that may successfully alter mood but neglect ongoing exposure to experiences that grossly violate the right to mental health such as living in safety and freedom from fear. This omission needs to be rectified.
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The discussions

Summary records of statements by Ministers
This section contains summaries of the statements made by the Ministers of Health participating in the round table discussions. The statements appear in alphabetical order according to country and regroup the participants of all four round tables.

**Angola**

Dr Hamukwaya described how the mental health situation in her country had been aggravated by internal conflict and its consequences. Political, social and economic stability and prosperity were essential to bring about improvements. She emphasized the importance of promoting healthy lifestyles and adopting psychosocial rehabilitation measures as part of a national policy to improve the mental and physical health of the Angolan people. She also reaffirmed her country’s intention to fight marginalization and social exclusion by associating its efforts with initiatives taken by WHO to promote mental health.

**Argentina**

Dr Lombardo traced the history of mental health care in his country from its origins in the 19th century, including the establishment in 1957 of the National Mental Health Institute, which had endorsed the approach of treating mental health disorders as health problems and not diseases. Nevertheless, developments in lifestyles, including the emergence of “modern” problems such as stress had led to the increased incidence of serious mental disorders. The treatment of such disorders had developed in parallel on an interdisciplinary and intersectoral basis, with recognition of the fundamental importance of community participation in health matters. Argentina currently had a high number of mental health specialists, comparable to the numbers in the most developed countries. Progress had also been made in the treatment of mental disorders with the emergence of new drugs in the second half of the twentieth century, while the development of new outpatient services had helped persons with mental disorders to avoid social marginalization and stigmatization. In that respect, he emphasized that the isolation of many adults in modern society was a basic reason for the development of mental health disorders.

Legislation placing emphasis on promotion and prevention was currently being adopted at various levels in Argentina. A National Primary Mental Health Care Act, the principal focus of which was on prevention, had recently been adopted and had been accompanied by legislation covering the treatment of various conditions related to mental health disorders. Similar legislative measures were also being adopted by the provinces. The mental health policy had been incorporated into the national health policy emphasizing the promotion of healthy lifestyles and including the prevention of substance abuse, and the development of a national programme to prevent depression and detect possible cases of suicide at an early date. The basic elements of the treatment of mental health disorders were: the elimination of stigmatization; the organization of multidisciplinary health services covering prevention, health promotion, care and rehabilitation; and the social reintegration of patients. Gender was another fundamental aspect of mental health problems, since more women than men suffered from mental health disorders. Attention therefore needed to be paid to problems of gender discrimination in modern societies. Finally, it was necessary to identify the socioeconomic elements that led to the development of mental disorders, including poverty and marginalization. Mental health patients needed immediate reintegration and assistance to promote their participation in the life of the community. He welcomed the initiative taken by WHO on one of the major health problems of the coming years.

**Australia**

Professor Mathews said that the rapid pace of social change, economic pressures, war and population movements and other factors had contributed to difficulties in recognizing and providing adequate support for mental health problems. That social change had also been accompanied by the loss of traditional family support in many countries. Transitional societies, such as indigenous Australians, were having difficulty with social adjustment, and they and other vulnerable groups were likely to suffer from drug and alcohol problems, and problems related to violence and suicide, which Australia, like other countries, was taking very seriously.
Stigmatization was still a problem, and new approaches to the philosophy of care and treatment were needed. The Australian National Mental Health Strategy sought to promote the mental health of the Australian community and to prevent the development of mental health problems and mental disorders; to reduce the impact upon individuals, the family, and the community; and to protect the rights of people with mental illness.

Particular emphasis had been placed on reducing stigmatization through programmes targeted at schools to increase awareness and understanding of mental health problems, engaging with the media to promote community understanding, and working with community groups, as well as the professional health sector, to promote acceptance. Australia had underpinned its work with legislative protection of the rights of people with mental illness and had developed community plans for mental health support involving specialist care and an interdisciplinary focus. Australia’s commitment to promotion and prevention had engaged the Commonwealth and state Governments and community organizations, as well as stakeholder groups, patient groups, and also the private sector. Australia fully supported the WHO mental health initiative and was committed to an interdisciplinary focus with a view to reducing stigmatization and recognizing co-morbidities, emphasizing mental health promotion and prevention and rehabilitation.

**Austria**

Professor Waneck said that WHO had successfully drawn public attention to mental health problems, which were often underestimated and misunderstood. Great progress had recently been made in the field of psychiatry and yet psychiatric disorders in the industrialized countries were increasing. A new consciousness had emerged, evidenced by the burgeoning number of self-help groups, as a result of which most people with mental illnesses were living within the community, able to make their own life choices. At the global level, however, much remained to be done. The Austrian health authorities vigorously pursued the WHO-advocated policy aimed at ending the exclusion of the mentally ill, particularly in the field of hospital psychiatric services, which had been decentralized and integrated, thus representing an important step forward in destigmatizing psychiatric disorders and those suffering from them. Self-help groups also played an instrumental role in the efforts to destigmatize psychiatric illness, as they provided vital back-up to the policy already in place.

To strengthen the Austrian mental health policy, a countrywide survey of mental health provision had been commissioned, bringing together, for the first time, data on psychiatric and psychosocial care for the benefit of the mentally ill, their families and those professionally concerned. Projects would be analysed and additional measures adopted in the light of the data produced by the survey, the second part of which was due at the end of 2001. Other important future objectives included the satisfaction of needs, the integration of basic care, quality assurance and the participation of patients and their relatives, care professionals, administrators and politicians. In conclusion, he hoped that the national and international efforts undertaken would improve the information available in the field of psychiatric care and that the stigma attached to psychiatric illness would diminish to the point where such health problems could be openly discussed without taboo.

**Bahamas**

Dr Knowles said that he had taken comfort from the realization that most countries had problems similar to those in his own country but was sad to hear that solutions were hard to come by, regardless of the size of a country’s gross domestic product.

The Bahamas, was a country of scattered populations, which hindered service delivery. In addition to the country’s usual array of mental health problems, it had suffered from being directly situated between the major cocaine-producing Latin American countries and the United States of America. The crack and cocaine epidemic of the 1980s had been closely followed by the AIDS epidemic and an upsurge in violent crime.

The Bahamas had recently reviewed its mental health services and was revising its mental health plan correspondingly. His country would welcome direction in its efforts to provide sufficient num-
bers of mental health workers, especially psychiatrists. That was not seen as a glamorous profession, nor did graduate nurses want to specialize in psychiatric care. He also asked for advice on the care of mentally ill patients in prisons, where the necessary psychiatric services were not available, and on the multidisciplinary care of mentally ill adolescents.

**Belarus**

Dr Zelenkevich said that it was time to bring the problem of mental illness out into the open. One of the principal challenges was how to ensure that such illness was allocated its proper share of the scarce resources available, and to that end, it was important to include mental health in all health plans and policies and to involve general practitioners. The change-over from institutionalized forms of care to care in the community, as well as the increase in the number of specialists in mental health being trained in medical schools, would contribute to a more efficient use of resources. Greater efficiencies could also be achieved by mobilizing other sectors to assist the health sector and by pooling resources. Nongovernmental organizations also had an important contribution to make.

**Belgium**

Mrs Aelvoet said that in her country, as in others, there had been an increasing demand for mental health treatment, despite a substantial economic upsurge, which indicated that wealth per se was no solution. Furthermore, stigmatization was still widespread; people with mental disorders were treated differently from those with physical illnesses and tended to be regarded as abnormal. During the past 25 years, there had been a trend towards encouraging patients to stay in their home environment, thereby enabling them to continue to work and function as usual. That had been achieved by the development of first-level care, home support services and home visits by doctors, in addition to outpatient and institutional care.

In 2001, a 10% increase in the health budget had been agreed, constituting the largest increase for any government department. The concept had been accepted that chronically ill patients, including those with mental disorders, should receive financial and institutional support. A system had also been developed to place a ceiling on the amount each patient should pay in any one year, anything over and above that amount being covered by a reimbursement system, taking into account personal socioeconomic circumstances.

In connection with gender specificity, it had been established that women were more dependent on legal drugs, whereas men tended to be dependent on alcohol. For issues of national importance, it had been stipulated that at least one-third of the members of all national committees should be women, including those concerning health.

**Benin**

Professor Ahyi observed that his country, like many others, had been slow in responding to mental illnesses, in part because of the belief, common in Africa, that they could be treated by traditional medicine. The recognition that many conditions did not respond to such treatment had forced a new approach and helped to raise mental health to one of the six top health priorities for Benin. With support from WHO the country had begun cooperation with Ghana and Mozambique on issues of health promotion, but that concept had rapidly led to issues of well-being and quality of life. A small national coordinating team had soon discovered that “health problems” were viewed in a prejudicial light, there being a major general confusion about illness and health: as soon as one talked about health promotion, that raised images of illness. Similarly, health centres and dispensaries were seen as focused on disease rather than on health. A conclusion was that, in Benin, the training of health care workers needed to be revised to correct those misperceptions. In the past two years there had been a move to educate the public at community level, for example by encouraging communication between generations. For instance, in one village a bench had been placed by a communal path, enabling older people to come out of their homes and be more integrated into community life. People stopped and talked, and perceptions and attitudes soon changed.
With regard to medicines, even generic drugs were rare in Benin. Moreover, those psychotropic drugs that featured on the essential drugs list were not ordered because the population was poor and the demand for such drugs was considered to be small. Further, the Bamako Initiative encouraged cost recovery. After the introduction of the health promotion policy, there had been a reduction in the number of patients and the rate of cost recovery had also declined. A contradiction became apparent: people preferred to have more patients so that there would be sufficient funds to maintain the existing system of health rather than reducing the number of patients. Health promotion had meant social mobilization in order to reduce costs. A further important point was the culture of health, not disease - and mental health was a case in point. The conclusion reached was that there was no development without health and no health without mental health. Mental health was the portal of entry for the development of developing countries. With democratization came decentralization, but that had posed various problems. For example, social mobilization had resulted in the multiplication of demands for the expansion of services based on the successes of pilot projects with the incorporation of mental health into primary health care.

**Bolivia**

Dr Cuentas-Yáñez observed that mental health programmes, whether against familial violence or alcoholism or for the administration of psychiatric hospitals, were based on a predominantly clinical vision. He advocated a more cultural approach to mental health, and recalled that Bolivia had been part of the Inca empire. At that time, some 400 years ago, itinerant “doctors” (cayaguayos) had dispensed basic mental health care. He argued that every mental health programme should take cognizance of the cultural heritage as well as of the epidemiological profile and the impact of poverty. The prevalence and incidence of mental illnesses were known to be associated with social groups; alcoholism was closely linked with intrafamilial violence, both of which were synonymous with the mechanisms of desperation during economic difficulties. Culture differentiated mental health from other health programmes, and people’s perceptions and cultural background needed to be accommodated.

**Bosnia and Herzegovina**

Mr Mišanović said that stigmatization was an important issue in Bosnia and Herzegovina. The stigma arose from the subconscious fear that anyone could fall victim, permanently or temporarily, to mental ill-health. Bosnia and Herzegovina was a post-traumatic society in transition. Half the population suffered from war or stress-related psychiatric disorders; the other half had dealt with the problem by referring to the sufferers as “broken” people, partly out of fear that psychological trauma could be passed on to the next generation. It was difficult to fight stigmatization in post-traumatic societies because stigma was used to deny people’s rights. Bosnia and Herzegovina needed a very different procedure for eradicating the problem of stigmatization. It needed extremely clear recommendations not only on how to eliminate stigma, but also on how to promote mental health and prevent mental disorders.

**Botswana**

Ms Phumaphi said that steps similar to those described by other speakers had been taken by Botswana in relation to patient integration, the setting up of community hospitals, and campaigns to reduce the stigma associated with mental illness. Two issues were of particular importance. First, it was essential to recognize that mental illness was a human problem as well as a medical problem, and to develop programmes aimed at particular social and economic groups. The power of peer groups could be harnessed to promote mental well-being. Secondly, her country attached importance to early intervention, which was a critical element in implementing mental health policies. She agreed that there was a need for research into mental illness and into the links between mental and physical health.

In Botswana, stigmatization corresponded to fear of those with mental illnesses. That was perhaps because their loss of control of their lives was associated in the minds of others with disruption to their lives. The response to the four questions
raised by their Chairman could be summed up in three words: information, education, communication. Botswana had medical-aid societies that did not provide adequate care for the mentally ill because of stigma; there was a high unemployment rate among the mentally ill because employers did not want to hire them; and insurance payments had been denied to the families of mentally ill patients who had committed suicide.

Consideration also had to be given to the plight of those who already had special needs in addition to suffering from the stigma of mental ill-health, for example, children in difficult circumstances, women, refugees and migrants, the elderly, conflict survivors, prisoners, and young people engaged in substance abuse. Those groups’ needs should be accommodated in appropriate legislation. It was also vital that patients be properly managed; to do so entailed removing stigma among health care workers. Consideration should be given to ways of countering the results of stigmatization by legislative means, such as regulations governing patient management that would help to eliminate stigmatization among health care workers.

Brazil

Dr Yunes said that mental health was one of his Government’s main priorities. Historically, it had been given a low priority despite the fact that mental disorders represented a heavy burden on the quality of life of patients and their families, as well as on the economy. In Brazil, as in many other countries, hospital-based care was still predominant, swallowing up most of the financial, technical and human resources available and limiting access to treatment. There was a need for strategies to enhance primary and community-based care.

A reform had been launched in the early 1990s aiming to decentralize the mental health care system and to redistribute resources from hospitals to community-based services; to disseminate information on the effectiveness of new models of treatment on patient rights and on the importance of combating stigma and discrimination; and to design and implement broad-based programmes for the social reintegration of long-term patients. The obstacles to the implementation of community-based mental health services in Brazil were the lack of trained health professionals, including general practitioners who could act as psychiatrists in remote areas, and the insufficient availability of drugs. His Government had introduced a programme to finance basic kits of psychiatric drugs for distribution, free of charge, at outpatient clinics, but since outpatient services were still insufficient the drugs were not yet reaching all those who needed them.

It had also addressed stigmatization and human rights problems by conducting regular inspections of psychiatric hospitals. Legislation had been adopted to protect the rights of mental patients and to promote their social integration, and services had been introduced to support women living in violent domestic environments.

Brunei Darussalam

Mr Matnor noted that WHO had not paid mental health the same attention as it had to other issues, and therefore needed to organize activities to promote awareness. In many countries, developments in the approach to mental health were guided by the outcome of discussions on the issue at international and regional forums. In his country, closed mental clinics within hospitals had been replaced in 1982 by a single specialist hospital providing outpatient care and counselling, and steps had been taken to decentralize primary health care so that it could be provided at community level. Brunei was able to provide free medical care and drugs because of its small population and land area.

One of the country’s approaches to the problem of stigmatization of mental illness had been to change certain names. For example, the term “ward 5” commonly associated with mental problems, and hence “bad” people, had been replaced by “psychiatric ward”, and the new hospital had comfortable rooms instead of the cages and bars formerly used to hold mentally ill patients. The Lunatic Law had been renamed the Psychiatric Act. The word “mental” was no longer used; the terms “stress” or “light depression” were more acceptable to young people and made them more willing to come forward for treatment. Because those identified as having mental problems often lost their jobs, the Government provided allowances to encourage them to undergo treatment. Brunei’s main problem was how to
encourage the formation of a nongovernmental organization to care for the mentally ill. The stigma attached to mental disease was apparently still too high for that to come about.

**Burkina Faso**

Mr Tapsoba described the evolution of mental health care in his country, which included decentralizing the health system and incorporating mental health care into the responsibilities of district level structures. Lack of coordination had resulted in a lack of adequate supervision, insufficient epidemiological data, lack of enough properly trained staff, insufficient financial and material resources for mental health services, and inequitable access to medicines owing to the slow introduction of cheaper generic psychotropic drugs. A national mental health programme had been formulated to meet the main areas of concern and would be implemented, despite financing problems, as part of the national development plan which extended to 2010.

In regard to gender issues, he drew attention to a particular problem in Burkina Faso, that of a category of woman known as the “devourer of souls”. These women, because they lived alone, were widows or had no resources, were often driven out of their villages although healthy in mind and body because they were alleged to be the cause of mysterious deaths. Eventually they either committed suicide, disappeared into the bush or suffered mental health problems. Only women – never men – were so accused. The public authorities and religious associations were aware of the problem but did not have enough resources to provide adequate support. He appealed for help from WHO.

**Canada**

Mr Rock, welcoming the exchange of views on common problems, said that his country’s experience was similar to that described by previous speakers. The Canadian Government had recognized the importance of integrating mental health into primary health care systems and had recently funded a pilot project to make mental health services available within the community. As almost 20% of primary health care patients presented with mental health problems, it had been considered important to ensure that the training of health professionals included the identification, recognition and treatment of such problems. The importance of early intervention in children to prevent more complex difficulties later on could not be overemphasized. Disease prevention was given high priority in Canada, and the development of a national approach towards early childhood development was encouraged. Thus, a “children’s agenda” had been created, covering prenatal nutrition for young mothers, programmes focusing on the crucial years of brain development between birth and the age of three years, early identification of signs of emotional maladjustment, and emphasis on the prevention of foetal alcohol syndrome and defects that limited personal development and led to social cost and disruption in later life. Many of Canada’s communities, especially those of indigenous peoples, were rural and remote and experienced harsh winter weather. Increasing and successful use had been made there of modern information and communication techniques, such as telemedicine, teleradiology and telepsychiatry. Rather than being a barrier to the personal relationship between therapist and patient, the televised connection appeared to facilitate full participation in the consultation.

A new approach to the organization, coordination and financing of health research, including mental health, had been adopted with the creation of virtual mental health research institutes consisting of networks of researchers. One such institute was devoted to mental health and involved researchers in clinical and biomedical fields, the provision of services, and population health and health determinants. By bringing those four perspectives together and substantially increasing the level of financing, Canada’s research enterprise was more effective and better use was made of its research funds. Investment in mental health was being increased to reflect more appropriately the importance attached to that area in the health system. Canada would be hosting the World Assembly for Mental Health in July 2001, bringing together people from around the world with valuable perspectives and insights into the ways in which national health systems could better organize, coordinate and deliver services for mental health, and he encouraged the involvement of all Ministers present.
Chad

Mrs Kimto recalled that her country had suffered many years of civil war. Added to that was a difficult economic situation and the fact that health coverage reached only 11% of the population. The need for mental health care was enormous, for instance, for children, people with HIV/AIDS, war widows, alcoholics, prisoners and refugees. Furthermore, mental disorders were traditionally considered as deriving from evil spirits or curses. At the time of independence in 1970 the country had one asylum in the capital, where patients were shut away and made the objects of curiosity and mockery. The building had been destroyed in the civil war. Currently the psychiatric unit of the main national hospital acted as a referral centre and provided an open service with care and treatment. The Government accorded mental health a top priority. The national programme of mental health had organized a consensus workshop in 1999 which had helped to identify the current situation, priority areas, strategies, interventions, funding and the main actors. To achieve social mobilization in favour of mental health issues, the Ministry of Public Health had involved traditional and religious authorities in the programme. The number of associations concerned with mental health had grown and were linked in a network. Every year a mental health day was celebrated on 10 October in order to mobilize public opinion and to raise awareness of the need to prioritize mental health, particularly as Chad was in a post-war situation. WHO’s World Health Day offered a good opportunity to undertake additional activities, for instance in communities and schools, including the use of mass media. A community, multidisciplinary approach was considered to be the most logical. Within the ministry an intersectoral, interministerial committee for mental health had been created, charged with the task of creating a coordinated mental health programme covering care, social reinsertion, awareness and information, and advocacy at the highest levels. The major role of traditional medicine in Chad justified cooperation with relevant structures and bodies.

Legislation enacted on mental health had been effective, but practical difficulties remained. Qualified staff, psychotropic drugs, infrastructure and funds were all lacking. The Government aimed to strengthen the national programmes for the promotion of mental health, to formulate a national plan for the distribution of drugs and to create referral centres. A new centre was being built in N’Djamena. The Government was also integrating mental health into the health activities of district health authorities.

Chile

Dr López stressed that close alliances between all those involved in treating and caring for people with mental illness, including their families, were needed in order to raise the profile of mental health and attract more resources. For the past 10 years, Chile had therefore been promoting the establishment of such groups at national and regional levels. The initiative had been accompanied by efforts to raise general awareness of the public health implications of mental health disorders and to improve the ability of local health services to respond to the problem. Chile had benefited from access to national and international epidemiological research studies that had enabled the scientific community and health professionals to develop better treatment and prevention strategies. As a result of its greater visibility, mental health was now regarded as an important component in Chile’s health reform programme.

The public sector had an important role to play in ensuring that psychiatric treatment was made available at the primary health care level to people with few resources. Indeed, the population should have access to the specialized services they required regardless of their ability to pay.

In addition to the type of mental health disorders prevalent in developing countries, Chile also had to contend with those associated with more developed countries, such as schizophrenia and bipolar disorders. Treating them was proving to be a considerable challenge and had led to the establishment of outpatient clinics and specialist units in general hospitals.

Depression was a major cause for concern, particularly among women. A programme designed to detect and treat depression was being developed at the primary health care level and 40% of general medical practices currently provided access to a psychologist. In addition, the new generation of
safer antidepressants was being made more widely available. Alcohol and drug dependence constituted another serious mental health problem which Chile was confronting through the development of a system to provide treatment to those in need with support from non-profit organizations. Other major areas of concern, about which more information was urgently required, included the mental health of schoolchildren and indigenous people, and work-related mental health problems.

In 2000, Chile had launched a national mental health plan, and additional resources had been made available that would increase the proportion of the total health budget allocated to mental health by between 1% and 1.4% in the first year.

China

Dr Peng Yu described how the transition to a market economy in China had been accompanied by an upsurge in mental health problems; for instance, mental disorders were the single most important factor in university student drop-out rates. While recognizing the need to adapt its policies and activities to reflect the new health situation, the Government had insufficient numbers of health professionals with adequate training in the diagnosis and treatment of mental disease. Although China had sufficient supplies of domestic and imported psychotropic medicines, limited funds in remote areas restricted the access of farmers and agricultural workers to the drugs they needed. The Government was focusing its efforts on providing basic and community-based training, delivered, in the case of remote areas, through the use of telecommunications.

In the 1990s, China had launched a programme aimed at assuring the rehabilitation of some 200 million persons and providing training in mental health for primary health care physicians. Its current goal was to reach as many as 400 million people nationwide, drawing on the help of WHO, among others, in order to launch pilot projects and honour its commitment to promoting mental health.

Croatia

Dr Gilić recalled that, more than 50 years previously, his countryman Dr Andrija Tampar, one of the founders of WHO, had proposed the inclusion of mental health among other components in the definition of health for the WHO Constitution.

Socioeconomic conditions were a prerequisite for mental health and welfare, as the example of Croatia illustrated. One in six of Croatia’s population had been displaced during the recent war. War damage had also had a dramatic effect upon productivity and unemployment, and had caused poverty and related mental health disorders. Although the new Government was addressing the ongoing effects of the war, in 1999, three out of every five cases of illness were associated with mental disorders, such as schizophrenia, alcoholism, and reaction to stress. The Croatian health authorities were giving effect to WHO recommendations such as the transfer of patients suffering mental disorders from hospitals to primary health care, the focus on community-based mental health care, emphasis upon training of mental health care workers, and seeking to prevent stigmatization and discrimination against mental health patients, so as to enable them to participate to the fullest possible extent in the life of the community.

In conclusion, with improving social and economic conditions in Croatia, a reduction in mental disorders was to be expected in the near future.

Cuba

Dr Dotres Martínez stressed the importance of providing adequate care to all patients with mental disorders and of considering mental health from the point of view of both health services and such social factors as poverty, inequity, violence and other risk factors.

In Cuba, where health care was universally provided free of charge, priority was given to mental health. The trends since 1995 had been towards community-based care mediated through training and education of families to enable them to live with sufferers. Thus, 137 municipalities had established community mental health centres. Work was under way to restructure psychiatric hospitals and
redefine their mission and functions both from the viewpoint of increasing primary health care coverage and of focusing attention on mental health.

Improvements had been made in information systems and in the identification of indicators to evaluate the impact of mental health measures. The identification of risk factors played a fundamental role in community-based care of patients with mental disorders and should be addressed as part of a preventive strategy that included family members and the community. In Cuba, the shift towards mental health had been carried out by training doctors, nurses and specialists at all levels. The country had a large number of psychiatrists providing care to adults and children, while mental health concepts had been incorporated into training of primary health care physicians and family health specialists.

The participation of communities and of community organizations in providing services and rehabilitation to patients was vital for the management of risk factors, and ensuring that the goals set could be achieved in a sustainable manner.

Legislation was important: public health law, the family code and even the criminal code should include provisions to protect psychiatric patients and all disabled persons. Those persons should be guaranteed social benefits, opportunities to participate in society and to gain access to employment and education, and thus to avail themselves of an integrated system of care. In that regard, one of Cuba’s greatest difficulties was that the economic embargo imposed on it by the United States of America restricted access by patients to the psychotropic drugs they needed. In spite of the difficulties, Cuba remained committed to community participation and health education as the best means of reducing the incidence of mental disorders.

Cyprus

Mr Savvides said that since the 1980s Cyprus had shifted the emphasis of its national policy away from outmoded mental asylums, characterized by stigmatization of the disease and violation of patients’ human rights, to community-based services and the integration of mental health care into primary health care. Most patients were now released into half-way houses or hostels and to their families, and only the oldest and most institutionalized of patients remained in the old-style institutions.

Among the measures introduced in the context of care in the community were the retraining of psychiatric nurses and establishment of community psychiatric services; the deployment of multidisciplinary teams at the community level; and collaboration with nongovernmental organizations and local authorities in setting up various centres, clinics, and types of accommodation. Although much had been achieved, significant problems remained, including a shortage of trained personnel, poor coordination with social services, inadequate coverage in rural areas, inadequate training of primary health care workers and poor information and communication systems.

Among the most important actions taken by Cyprus to counter stigmatization and human rights violations was the enactment of a law in 1997 for the provision of psychiatric treatment, which incorporated the 10 principles recommended by WHO. The media had been enlisted to draw attention to mental health issues, making patients more visible, emphasizing the availability of successful treatment and providing information and education to professionals and the public at large. The fact that World Health Day 2001 had been devoted to mental health had offered an opportunity to intensify efforts in that domain.

Since knowledge of the extent of mental illness and neurological problems in Cyprus was poor, an epidemiological study would be conducted in 2002 and the results would be used to direct policy. Future measures would include more training of professionals, greater multisectoral cooperation, public education, research and the removal of all barriers that prevented the full reintegration of patients into society.

Czech Republic

Professor Fíše welcomed the round-table discussion, particularly since psychological and psychiatric disorders were increasing in importance in his country. The highest prevalence rates were for neurotic disorders, affective disorders and schizophrenia. The number of suicides of men in the Czech
Republic was also increasing, while the suicide rate of women was decreasing. Although higher than the average in the European Union, the suicide rate of 15.5 per 100,000 population in his country was significantly lower than, for example, the countries of the former Soviet Union.

One of the most serious problems faced by his country in the field of mental health was the shortage of specialists in psychiatry; more were being trained in psychiatry, psychology and psychotherapy, although problems persisted in financing that training, and that of general practitioners and nurses in modern aspects of psychology and psychotherapy. Psychiatric patients were traditionally located in specialized institutions, which were very frequently isolated and oriented towards the long-term, and sometimes lifelong hospitalization of patients, thus underlining the segregation of the mentally ill and contributing to discrimination against both the discipline of psychiatry and against the patients themselves. In recent years, the number of places in institutions for the mentally ill had been increased by one-third. It was planned to organize psychiatry departments as sections of large hospitals, with modern equipment, designed for short stays with intensive diagnostics and treatment, to be followed by outpatient care. It would also be necessary to organize a system of care for chronic alcoholics and persons affected by other kinds of addiction. However, the necessary measures would require substantial funding.

Finally, he welcomed the possibility of cooperating, through his country’s Research Institute of Psychiatry and the Society of Psychiatry, with WHO and its office for Europe in the field of mental health.

Democratic Republic of the Congo

Professor Mashako Mamba said that mental health problems in his country had been neglected because of the prevalence of major factors affecting physical health, notably infectious and parasitic diseases. Such neglect also stemmed from the African belief that more emphasis should be given to concrete than to abstract health problems. The war that his country was experiencing, which had displaced and killed many people and split up families, had resulted in various kinds of depression and stress caused by psychological trauma. Another major problem was the abuse of psychoactive substances, particularly cannabis.

Faced with a lack of mental health institutions and specialized human resources, his Government had decided to integrate mental health into primary health care, although such integration raised the problem of adequate training. The community-based health care system reduced the risk of patient rejection or stigmatization, but treatment often required the prescription of psychotropic drugs, whose high cost placed them beyond the reach of most patients. In that respect, he appealed for a North-South partnership so that his country’s requirements for such drugs could be met.

Denmark

Mr Rolighed said that, in his country, all persons had free and equitable access to the health system irrespective of sex, age, social status and the problem from which they suffered. It was important to ensure that mentally ill patients were given appropriate treatment, and to that end the Danish medical authorities worked closely with research, education and quality assurance programmes.

Dominican Republic

Mrs Caba described how the traditional barriers to improving mental health in her country, such as attitudes of health workers and managers towards people with mental disorders, remained unchanged. The formulation of mental health services was thus restricted, particularly in general hospitals. Integration of mental health into primary health care needed money and time, the high cost of drugs forming part of the problem. As part of health sector reform, the Government was working on a subsystem of mental health care with community and nongovernmental organizations in order to strengthen the provision of services at different levels.

The theme of World Health Day 2001 had provided a unique opportunity to enlist allies in the process of improving mental health care. A campaign had been launched to strengthen the human rights of people with mental disorders, and to try
to improve the way they were treated. Its targets included people in the business sector and the workplace, where issues such as alcohol abuse and stress needed to be addressed. In addition her country was working to improve its present inadequate system of monitoring and record-keeping. Coverage of primary mental health care needed to be improved, too. Although for some 22 years there had been good results with community-based mental health care, the network was concentrated in the capital. Crisis care centres were urgently needed in hospitals, but that development had been thwarted by the resistance of health care personnel, often hospital administrators. The lack of a crisis intervention unit for children and young people presented a serious gap in the system. Rehabilitation and social reinsertion programmes were also needed.

With regard to gender issues, progress had been made through work with nongovernmental organizations, other ministries such as those for women’s affairs, the judiciary, and in particular the police. Campaigns had been run on prevention of and dealing with violence in the family, and “solidarity networks” for women had been established throughout the capital and in some other cities. The Government was trying to re-educate health personnel to have a more positive attitude to mental health care. In the education sector, considerable support in the early detection of the effects of domestic violence came from teachers. The current focus was on violence against women, children and young people, together with ensuring routine screening for risk factors of domestic violence. Refuges for the victims of such violence were planned.

**Ecuador**

**Dr Jandriska** drew attention to four issues associated with mental health problems in his country: the fact that Ecuador was located in a high-risk disaster area; the number of persons displaced as a result of the “Plan Colombia” strategy; the high levels of migration away from families in order to find work; and the level of political instability. It was important to analyse mental health in relation to society. To that end, his Ministry had set up a series of mobile units in poor areas from which wage earners were often forced to migrate and a psychologist had been attached to each unit to analyse the resulting community problems.

Since 1994, there had been greater awareness of mental health in Ecuador, and it was hoped that the draft legislation developed in that regard would enter into force as soon as possible. Ecuador faced a wide range of mental health disorders with prevalence of alcohol misuse particularly high in young people. A multifaceted approach was needed to ascertain the causes of substance misuse and violence, in particular violence directed at women. Ecuador and a neighbouring country planned to develop joint legislation on psychotropic substances.

Affirming the need to pay attention to indigenous populations, he said that his Government was taking steps to provide those in Ecuador with health care services of good quality based on local needs.

**Egypt**

**Professor Sallam** emphasized the importance of differentiating between mental health and addiction and between mental illness in children and criminals. Prevention of mental illness and rehabilitation were not high priorities in developing countries. Egypt had undertaken a major reform in that regard, and a Presidential Decree had been issued to the effect that, while psychiatric hospitals were still needed, the system should be reformed. Many speakers had advocated incorporating mental health care into primary health care; could WHO establish an agenda for that, according to the different countries’ needs?

There was an urgent need in developing countries to act promptly against early addiction. Ways should be sought of “immunizing” children against addiction with a service set up for people at high risk and for first-time users. Countries like his would greatly benefit from assistance from international donors for prevention of addiction and rehabilitation. Therapeutic measures such as music and agriculture could be helpful in transforming psychiatric hospitals into rehabilitation centres. Similar treatments could be applied to violent behaviours. That problem, linked to psychological depression, was affecting the entire world. He would welcome the introduction of a social component into mental health strategies. As things
stood, sufferers were often ignored by their relatives and friends; a change in attitude was the first step towards improvement.

**Fiji**

Mr Nacuva noted the need to consider mental health problems in the specific context of each particular country, taking into account changes such as the moves from colonial status to independence and from traditional societies to cash economies. In Fiji, the health budget was small and it was difficult to find the funds for mental health services. However, the sense of responsibility for caring for others was strong and it had therefore been possible to build on community involvement. The Ministry of Health had opted for a multisectoral approach involving all aspects of civil society in the promotion of mental health and the prevention of mental disorders. Fiji had one specialized psychiatric hospital. The emphasis on community-based services and vigorous clinical management had led to a dramatic decrease in the bed occupancy rate and length of stay despite an increase in the number of new cases. Relevant legislation was also being reviewed. It was vital to change social attitudes to mental health care and Fiji was addressing the problem in its own particular context and in spite of budgetary constraints.

**Finland**

Dr Eskola noted that WHO had been active in the mental health area since the 1970s. Although mental health had received a lower priority in the 1980s, it was a cause for satisfaction that greater emphasis was now being placed on it. As the Finnish approach to mental health was very similar to that described for Sweden, he focused on the reduction of the specific problems of suicide and depression in his country, areas in which considerable success had been achieved.

The rates of suicide in Finland had increased rapidly from the 1950s through the 1980s, rising from 26.5 to 41 per 100 000 for men, with a figure double that for women. A 10-year, nationwide suicide prevention strategy had been launched in the 1980s and had achieved a reduction of suicide rates of nearly 20% in relation to the peak period. An evaluation of the project had shown that the stigmatization of mental health disorders had been greatly reduced and on that basis a programme to address the problem of depression had been launched.

During its presidency of the European Union two years previously, Finland had identified mental health as the number one health problem. From that experience, his Government had concluded that clear changes were needed in mental health policies. First, mental health should be brought out of its political isolation into the broader sphere of public health. Second, instead of concentrating on mental health at the individual level, there was a need to strengthen the approach to mental health for the population as a whole, in particular as a means of promoting the integration of mental health into public health policies, strategies, and programmes. Third, emphasis must be shifted from the negative concept of mental disorders to a more positive mental health model. The key importance of mental health was encapsulated in Finland’s slogan: “There is no health without mental health.”

**France**

Dr Kouchner said that mental health was a concept with wider social ramifications than traditional psychiatry. Although the drugs developed over the past 20-30 years had allowed some progress in the treatment of mental disorders, they had also camouflaged the difficulties. People with mental health problems were always stigmatized. Furthermore, psychiatrists, psychologists and social workers did not agree on their practices or general objectives. The general medical community and psychiatrists disagreed about the extent of the mental health sector. Was social work a marginal component of the sector or was it fully integrated? Psychiatrists were unwilling to become involved in what they considered to be social problems, such as depression and suicides among young people. There was poor follow-up on the part of hospital emergency services and society in general of young people who attempted suicide. It was known that one in two succeeded on a second attempt and that half of those who had committed suicide had consulted a general practitioner the week previously. General practitioners did not have the training to deal with such problems.
There was insufficient communication between psychiatrists and social workers in developed countries. In France, the problem of drug addiction had initially been viewed as a psychiatric illness, whereas it was now considered a social problem. It appeared that 30% of prisoners suffered from mental illness, and 20% had been imprisoned for that reason. Were their mental health dealt with adequately? Were domestic violence and alcohol abuse psychiatric problems? Those problems remained unsolved because of a lack of understanding between social workers, general practitioners and psychiatrists.

Efforts had been made to close down psychiatric hospitals and provide care in small community structures in general hospitals, close to the patients' families and to patients' associations. However, some psychiatrists complained that they were swamped by social problems and that closure of the large psychiatric hospitals meant that no beds were available for patients with severe psychiatric conditions such as schizophrenia or manic depression.

**Georgia**

Dr Gamkrelidze said that the significant social, political and economic changes that had occurred in Georgia at the beginning of the 1990s had had a negative effect on the country's medical care system and particularly on psychiatric care. Owing to major shortages of psychotropic medicines and a drastic deterioration of the conditions in hospitals, patients had left, and the mortality rate in the institutions had increased. In March 1995, the Georgian Parliament had passed a law on psychiatric care which had become the legal basis for the State programme. Hospital and outpatient care was provided by a network of hospitals, regional clinics, psycho-neurological clinics and consulting units. The State covered the treatment costs of about 30,000 patients registered as suffering from schizophrenia, affective disorders, organic and symptomatic psychoses, post-traumatic psychoses and other psychiatric disorders. However, more than 70,000 patients registered in psychiatric institutions outside the public programme required professional psychiatric care. The budget of the programme was greatly in deficit. In order to function optimally, it would require US$ 4.5 million, whereas the actual allocation was about US$ 1.5 million.

Nevertheless, the Government had managed to extend its programme. Regional psychiatric clinics had been opened, and a programme of psychosocial rehabilitation for children and young people had begun functioning in 2000. A service for urgent psychiatric care was planned for 2002. In 2000, a national health policy had been developed in the Ministry of Health, in cooperation with the European Regional Office of WHO and the Georgian Society of Psychiatrists, with a strategic plan for implementation during the coming decade. The main strategic goals for development and reform of the psychiatric care system were:

- extension of the public programme of psychiatric care and a gradual increase in free medical care;
- creation of a system of social rehabilitation and social assistance to patients with mental disorders;
- creation of a system of psychiatric care for children and young people;
- a reduction of the suicide rate in the general population; and
- reduction of the incidence of psychiatric diseases due to social stress.

The plan envisaged the creation of five centres for the psychosocial rehabilitation of patients by the year 2009, in addition to the centre functioning in the capital; nine psychosocial assistance units had been opened in various regions of the country. The prolonged economic crisis did not permit full, regular financing of the state mental health care programme and made it difficult to ensure optimal functioning of the system of psychiatric care in his country.

**Ghana**

Dr Anane welcomed the choice of mental health as the theme for World Health Day 2001. In Ghana mental ill-health was typically regarded as aggressive or strange behaviour; general society did not consider the milder but distressing forms such as depression and anxiety as mental disorders. Mental health programmes had begun in 1888, with the enactment of the Lunatic Asylum Ordinance. That
Act had been improved in 1972 with a mental health decree, followed by upgrading of facilities, strengthening of personnel and an expansion of institutional care, with a decentralization policy leading to the setting up of mental health units in general hospitals. However, progress in that area had slowed sharply with the economic decline in recent years. Owing to financial constraints, institutions were not giving the required attention to the subject, professional development programmes were constrained and many trained staff were lured abroad to better paid jobs – the proportion had reached 30% of mental health care providers, nurses in particular, in the previous year. Currently, the country had one psychiatrist for 1.5 million population. Low pay and the stigmatization associated with mental illness did not encourage recruitment. Although the Ministry of Health had implemented a motivational programme for all health professionals, that step had been limited by financial constraints and offset by the increasing incidence of mental illness, especially depression, which might underlie the fatalism engendered by spreading poverty. Ghana therefore supported the view that coordinated global efforts to mitigate the ravages of poverty would be a major step to counter mental illness.

Ghana had set its priorities. The Government’s mental health policies stressed decentralization of mental health services, not only through the establishment of units in tertiary and regional hospitals but also through the integration of mental health into primary health care. Also, even with the current meager resources, model programmes for training of both medical and non-medical staff in prevention, identification and treatment of mental disorders had been drawn up. Major focuses were attitudinal change, particularly for senior health workers and policy-makers, and the need to ensure that all health professionals were knowledgeable about mental health. Finally, the focus should be on a biophysical model for mental health care, which recognized the biological, psychological and social roots of mental disorders. A purely medical approach would be bound to fail; a sector-wide approach including communities was needed for effective care. Prevention must be seen to be as important for mental health as for general health. Effective communication, including parenting skills, crisis management and the use of non-professionals in the community would be vital for prevention of mental health problems. Since 1978 Ghana had had a three-monthly training programme for community psychiatric nurses, who were subsequently placed in all districts.

He noted that gender issues might often be seen as mental health problems. Societal attitudes about expected gender roles, including the childbearing role of women, often caused intense stress: female infertility was an instance. As in other countries, more women reported depression than men.

In order to achieve success, mental health workers were needed to take the lead, but they were in short supply. He urged support for disadvantaged countries in training and retaining personnel.

**Greece**

Professor Spyraki said that the mental health system in Greece had significantly changed in the past two decades, including the introduction of a modernizing legislative framework. With assistance from WHO and with financial support from the European Union, Greece had reformed its system of mental health care, thereby gradually bringing about significant qualitative and quantitative changes. Legislation passed in 1999 had given priority to primary care, outpatient care, de-institutionalization, psychosocial rehabilitation, community care and the provision of information to the community; mental health services were to be decentralized and divided into sectors; social enterprises were being set up for persons with mental health disorders, and a committee had been established for the protection of their rights.

Within the framework of psychiatric reform, an action programme to develop mental health services throughout the country had been launched in 1997, which was reviewed and updated every five years. The recent creation of a large number of permanent government posts related to the programme, at a time of relative economic austerity, had been a measure of the priority assigned to the mental health care system by the Government. In the current year, a committee of persons working in the media had been set up for the purpose of increasing awareness of mental health issues through television, radio and other means.
Greece

Professor Spyraki said that fighting stigmatization was important not only to overcome mental illness but also to improve society. In response to the Chairman’s first question, about the measures put in place to fight stigma, he said that Greece had offered services for the mentally ill in psychiatric units in general hospitals and mental health centres; that had changed perceptions for both the patient and the relatives. Secondly, campaigns were important to teach children tolerance at an early age. Children had to realize that while mental illness had biological and genetic determinants, social disparities were also crucial factors. Everyone should ask themselves to what extent they were responsible for the mental illness of others and what they could do to help.

Grenada

Dr Modeste-Curwen said that her country had tried to fight stigmatization by shifting the emphasis from institutionalization of patients to the start of treatment in the community. However, because many of the mentally ill had never had a job or were unable to hold one, they returned to the institution shortly after being sent out to the community. Grenada had therefore started on a policy of industrial therapy to develop or teach skills, essentially in agriculture. She had recently toured an agricultural area in the presence of media representatives so that they would show mental health patients as productive rather than nonproductive or destructive persons. A multisectoral organization (involving health sector representatives and the community) was helping those with mental disorders by organizing activities such as sports meetings in which healthy members of the community participated alongside the patients. Recently, a long-term institutionalized patient had been helped to launch a book of poetry. The media had been extremely supportive throughout in promoting understanding of the productivity of the mentally ill.

Guinea

Dr Saliou Diallo said that his country had earlier introduced a mental health policy and programme with a strategy of decentralizing all the health structures that would facilitate referrals. That meant the integration of mental health into the basic minimum package of health activities, particularly in primary health care. That required changes in attitude and culture with regard to mental disorders by decision-makers, health care personnel and the general population, with promotion of healthy lifestyles. Unfortunately many obstacles were being met, such as the great gap between supply and demand, the paucity of trained staff, the high cost of drugs, the civil disturbances in Liberia and Sierra Leone with the resulting influx of refugees and incursion of rebels, all on top of poverty and exclusion. With a calming of tensions and the implementation of decentralization, Guinea looked forward to an improved situation.

Honduras

Dr Castellanos said that the prevalence of hurricanes on the Caribbean and Atlantic coasts and the Pacific Rim Fault, which gave rise to frequent earthquakes, were special factors affecting mental health in his country. They precipitated both economic difficulties for the country and mental disorders among the people. The most frequently diagnosed problems in Honduras included violence (30%), depressive illnesses (27%), epilepsy (11%), psychological disorders (6%), and behavioural problems beginning in childhood (5%). In 1975, the Ministry of Health had established a mental health department to deal specifically with such problems. Intensive work throughout the country had formed the basis for the mental health programme.

In 1998 Hurricane Mitch had killed three thousand people and wreaked extensive infrastructural and agricultural damage with lingering effects on the population. Following a detailed analysis of the general health situation, a poverty-reduction strategy had been devised that included a major primary mental health care component. Working directly with the victims of Hurricane Mitch, spe-
cific attempts had been made to enhance community participation through decentralization. A strong response had been received from both the people of Honduras and from such organizations as PAHO, WHO, and other friendly institutions and governments which had provided support. Currently under development was a strategy on mental health in disaster situations.

Gender issues figured largely in the efforts being made to bring about change in the country. Many women had been participating, particularly young single mothers from rural areas who were suffering mental disorders. In that connection, much had been done to enact laws against family violence and a special national institute for women's issues had been established. The Ministry of Health had devised a national sexual and reproductive health programme, and work was proceeding on a special law on HIV/AIDS. Destructive as it had been, Hurricane Mitch had strengthened the unity of the people of Honduras and had provided an incentive to confront mental health problems.

**Hungary**

Mr Pulay said that awareness-raising campaigns had targeted various groups, the first being decision-makers, including the Minister of Health. With a view to a better allocation of resources, it was important to convince ministers of finance of the significance of mental health problems. For example, in Hungary, it had been decided that new antidepressant drugs should be made available at affordable prices, since the chronically mentally ill were among the poorest members of society. Hence national insurance now covered 90% of the costs for such drugs. A second target group consisted of the patients themselves. Although they were insured, lack of objective information and fear of stigmatization prevented them from coming forward for treatment. Other targets had included primary health care workers, who were crucial in combating gender discrimination, and detecting violence and mental illness in the family and schools. As the Director-General had stated in her address to the current Health Assembly, it was essential to act now to create a better future for the children of the world.

**Iceland**

Mr Gunnarsson, noting that mental health was vitally important to the well-being of nations and to human, social and economic status, said that it had been included as one of seven target areas in Iceland's new health plan. In that connection, the specific objectives of his Government included the reduction, within the next 10 years, of suicides by 25% and of mental disorders by 10%. The action planned to attain those objectives included: better registration of mental disorders; better training for health care personnel; provision of better information to the public, in particular by enlisting the cooperation of the media; improvement of access to mental health care; the offering of more treatment options; and improvement of coordination between schools and the mental health services. The focus was on children, young people and the elderly, especially those in rural areas. It was hoped that the health plan would help to reduce the stigmatization of those suffering from mental health disorders and discrimination against them and their families.

Studies had shown that those suffering from mental disorders tended to be from the less well-off sectors of society and, despite the fact that Iceland had a strong social welfare infrastructure, steps were being taken to strengthen the system still further. Efforts were also being made to reduce gender disparity: the longevity of women as compared to men, together with other factors such as their greater exposure to stress, made it necessary to distinguish between the health needs of women and those of men and to take such factors into account when planning mental health care. In conclusion, he recalled that most mental illness could be treated and that many mental illnesses were preventable.

**India**

Dr Thakur said that mental health disorders had been treated in India by yoga since ancient times. India had launched a mental health programme in 1982. The integration of mental health in the public health programme had aroused criticism at first, but was currently recognized as having been correct. Efforts were being made to improve services
in mental hospitals in order to make them more patient-friendly. While he agreed with Professor Ladrigo-Ignacio that problems such as natural disasters and wars caused mental disorders, there were also area-specific problems. For instance, men from Kerala often worked in neighbouring countries, and their absence led to family problems, even suicide, while in poorer states such as Bihar the suicide rate was much lower.

With the development of genomic research, it would be possible to investigate whether some mental disorders were of genetic origin. The round table might identify the need for such a study, as gene therapy could then be used in treatment.

Mental disorders should not be considered as diseases but as part of life. It was his day-to-day experience in medical practice that many persons suffered from slight depression. Addressing their mental health would help them to function better. Efforts should be made to combat the stigma attached to mental deterioration.

**Indonesia**

Dr Sujudi said that, as a result of legislation passed in 1960, Indonesia had adopted a social approach towards mental health care offering more open and comprehensive facilities and services. In 1974, mental health care had been integrated into selected district hospitals and health centres. Inadequate results in the identification and care of patients had led to the introduction in 1993 of training in the diagnosis and treatment of psychiatric patients for substantial numbers of personnel in such hospitals and health centres. Subsequently, the detection of mental health disorders among outpatients had increased from 0.47% to 2.15%. Community mental health activities had been promoted on a nationwide scale; they would support the development of relevant policies and strategies for improvements at provincial and district levels. Much remained to be done, as indicated by the unsafe environmental conditions and unhealthy behaviour which prevailed, but Indonesia was seeking to adopt strategies that emphasized welfare-oriented and community-based mental health care, as well as the inpatient services, and promotion and prevention, activities which were important to enhancing the overall development of health.

**Iran, Islamic Republic of**

Dr Farhadi observed that the problem of the increasing gap between physical and mental health services was particularly acute in developing countries, owing largely to lack of awareness, low political commitment, an acute shortage of trained professionals, weak intersectoral collaboration and the absence of community services. All too often, mental health services were neither affordable nor accessible. The only way forward was to integrate mental health services into general and primary health care systems, thus ensuring the provision of the most basic level of services for the seriously ill.

Iran had taken that initiative following a pilot project in 1987, aimed at promoting awareness of mental health issues and making essential mental health care available to all. Following wide-ranging training programmes for medical personnel and community workers and the establishment of a large number of rural and urban mental health centres, mental health care was now available to 6% of the rural population and 12% of the urban population. In addition, innovative programmes had been developed, such as an urban mental health programme, the integration of a preventive programme for substance abuse disorders, within the primary health care system, a school programme and integration of mental health into the “Healthy Cities” project.

With a view to expanding mental health services in 2001 and beyond, Iran’s national mental health programme was being revised, a new mental health act was in preparation, and efforts were being made to increase inpatient and outpatient mental health facilities and counselling services.

**Iraq**

Dr Mubarak recalled that his country was experiencing a difficult situation in view of the sanctions imposed and almost daily bombardments. Cases of mental ill-health had increased, caused by the fear of air raids and the constant trauma of bombing attacks, which particularly affected children, women and the elderly. Those difficulties were well known; the lengthy duration of such problems was another source of trauma. The current situation meant that it was very difficult to measure the
social consequences of mental health problems, as it was impossible to obtain research data. Despite the signature of a memorandum of understanding, the measures taken under the pretext of protecting human rights, and particularly the positions taken by certain representatives on the United Nations Security Council Committee established by Resolution 661, made it difficult to achieve any progress in the health situation in Iraq. Close cooperation was required with WHO to develop better approaches to mental health disorders, particularly through hospital treatment.

It was difficult to persuade trained practitioners to work in the field of mental health. His Government did not have the capacity to provide them with scholarships to study abroad, and it was difficult to bring in qualified personnel to train health practitioners in Iraq. Measures adopted to encourage newly graduated health professionals to work in the field of mental health included the creation of training programmes and rotation systems for new graduates, including incentives for them to spend two years working in mental health. The sanctions meant that the drugs required to treat mental disorders were classified as non-urgent and were in very short supply.

Iraq’s situation was having a severe impact on society, and particularly on women. Frustration was coming to the surface and confrontations were developing between family members. Children experienced frustration when they saw toys advertised to which their access was restricted or prohibited, and women, confined to their houses, were experiencing depression. To relieve the situation, legislation had been adopted and other measures devised, including soft loans, to enable women to work from home. The Government was cooperating with nongovernmental and other organizations in civil society to deal with mental health disorders. Heavy penalties were imposed on institutions and enterprises discriminating against persons with mental disorders.

The treatment of mental health should be a subject of close cooperation between countries at regional and international levels and should not be treated as a political issue. Although there could not be one standard approach to mental health which would fit all countries, WHO should lead in developing action in that field.

Israel

Dr Leventhal said that the future of mental health lay not in hospitals, but in the community; it was the concern of society as a whole, not just of mental health professionals.

Israel had taken the opportunity provided by World Health Day 2001 to extend the event to a week of awareness-raising on mental health. He thanked WHO for providing excellent supporting material.

Mental health affected the whole community since virtually everyone experienced some form of mental health disorder at some point in their lives, although mostly to a very minor degree. The problems associated with mental ill-health were part of living in a modern society. Prevention of those problems and mental health promotion were important at all levels. He regretted the shortage of material available for preventive activities and asked WHO to provide leadership in that field; such material would have the added advantage of ensuring that the public was well informed.

In conclusion, he commended the admission of a former prime minister of Norway that he too had suffered from depression, thus highlighting the fact that such issues affected privileged as well as disadvantaged members of society.

Dr Leventhal considered that the present round table and the World Health Day campaign were part of the fight against stigmatization. Society could only fight stigmatization if the health sector played a leading role. The health sector should be reoriented to incorporate consideration of mental health issues in physical health. It had to set a good example. However, the fight against stigmatization concerned not just the health system but also the education and welfare systems. All should contribute to the fight against stigmatization.

In answer to the Chairman’s fourth question, violence had in the past been associated with mental illness because mental health institutions had once been considered prisons. To avoid that, patients should now be given access to health services before their illness reached the point where they required institutionalization. In Israel’s experience,
only the courts could strike the balance between respect for human rights and enforced admission to a mental health institution. Since Israel had adopted the policy of using the courts, more people were reflecting on the question. Health professionals were in effect asking society as a whole to share in taking such decisions, which resulted in a better balance.

Italy

Dr Oleari said that the Italian experience in the area of mental health dated from the 1978 law to reform psychiatric services and specifically to eliminate institutionalization. However, institutionalization could continue as a problem, even in the absence of psychiatric hospitals, just as stigmatization and marginalization could still occur, unless the patient was treated as a full citizen. What was needed was a network that included health, social and community services.

Many problems had been encountered after the adoption of the 1978 law, in particular in connection with specific mental health programmes involving the participation of associations of the families of psychiatric patients, which was considered to be essential. Treatment necessarily involved inpatient mental health centres, care for acute patients in general hospitals, and residential structures that were conducive to the reintegration of the patient into society.

Many national health services had encountered the problem of how to finance social and health services. Such economic difficulties had not yet been fully surmounted in Italy also. Mental health funding was not related to expected outcomes, and an effort was being made to weight the per capita contributions through which health services were funded, by taking into account such sex-related factors as neonatal mortality and infant mortality, rather than purely socioeconomic criteria. Much more remained to be done along those lines. In Italy, 5% of the health service budget was currently allocated to mental health.

All psychiatric hospitals had been closed, and general hospitals had been given responsibility for treating acute patients. He considered that the Italian approach was both positive and in line with the experience of other countries, and expected future efforts to place emphasis on the rights of mental health patients as citizens and on the prevention of mental health problems.

Japan

Mr Kondo said that the competition inherent in a free-market economy had resulted in rising incidences of stress, distress and mental disorders in his country, underlining the importance of placing mental health high on the agenda. He welcomed the decision to devote World Health Day 2001 to that problem.

Until recently, Japan had placed considerable emphasis on the hospitalization of psychiatric patients. The results were too many long-term patients, and the raising of several human rights concerns. Currently, efforts were being made to ensure that patients acquired greater autonomy as part of their reintegration into society. The Ministry of Health, Labour and Welfare now focused on community-based care, and adequate support mechanisms were being set up, including employment opportunities for patients with mental disorders. Suicide was a significant social problem in Japan, often caused by financial difficulties. Adequate services to improve the social environment should be provided at the regional and workplace levels to prevent such difficulties. It would also be important to conduct research into the causes of depression.

As in other countries, stigmatization of patients with mental disorders was a major problem. Measures were being taken to eliminate prejudice and achieve social integration of sufferers through education and information campaigns, such as those carried out by and through WHO.

Jordan

Dr Kharabseh explained that his country faced two obstacles to the improvement of mental health care provision: lack of resources and a shortage of specialized workers in the mental health sector. Those two barriers were the result of war, human rights violations and other injustices.
He emphasized the importance of integrating mental health and general health programmes, and of making treatment affordable in order to care for the poor properly.

**Lao People’s Democratic Republic**

Dr Boupha congratulated WHO for highlighting mental health and bringing that important topic to the attention of Member States.

Among its strategies for addressing mental health, her country had promoted a series of activities using video productions and school contests within a community-based approach, as part of a deliberate strategy to tackle mental health issues.

She stressed that mental health factors relating to women had generally been overlooked. There were some 75 million unwanted pregnancies in the world each year. Unwanted pregnancies could have tragic consequences for the women, their families and society as a whole. The issue was one of empowerment: women should be allowed to decide when and whether they wished to become pregnant. A great deal of distress and depression could thus be avoided. She urged WHO and the authorities in each country responsible for mental health programmes to take into consideration the problems related to women’s health.

**Lesotho**

Mr Mabote said that, historically, mental health services in Lesotho had been marginalized, as was reflected in both legislation and budget allocations, with stigmatization and discrimination rife. Mental ill-health accounted for a significant proportion of DALY’s lost, with the largest proportion of the burden due to epilepsy and depression, the latter being more common in women than in men. Substance abuse, especially of alcohol, was rising and his country recognized the need for vigilance in that area. For many years, mental health services had failed to pay sufficient attention to emerging gender-related issues and violence. The Government was now giving serious attention to gender-sensitive policies and a specific ministry was dealing with the question. Moreover, an association of women lawyers was playing a leading role in raising private and public awareness of gender issues in many areas. Mental health policy was being revised to incorporate contemporary gender-related issues, such as the effects of unemployment, and to encourage disclosures concerning violence and emotional abuse. In addition, public awareness campaigns, seminars and workshops were providing a strong foundation for policy formulation concerning effective prevention of gender-related mental health problems. Preventive measures included poverty-reduction strategies involving income-generation projects. Training was needed to sensitize health care workers and others, such as the police, to the mental health consequences of gender-related violence, and to the need to provide tactful counselling and support.

**Madagascar**

Professor Ratsimbazafimahefa observed that mental health was an integral part of WHO’s definition of health, although it had long been overlooked in the developing countries because of the priority given to control of communicable diseases. At Madagascar’s present stage of epidemiological transition, the number of mental disorders and disabilities, the legal battles concerning people with mental problems, the increasing number of suicides and of patients who remained hidden away, unable to face the difficulties of adapting to life in society, all served to highlight mental health as a top priority.

The celebration of World Health Day 2001 had further widened the country’s understanding of the issue by seeking to redefine mental health and its implications for quality of life. It had also underlined that mental health was a means and an indicator of economic, social and cultural development so that failings in mental health led to poverty at every level. Thus her country had attached particular importance to the management of mental illness, which was handled chiefly by the public health system. Severe cases could be referred to provincial psychiatric centres, but otherwise mental health was part of primary health care. However, deficiencies both in number and quality of personnel had led to the appointment of a mental health coordinator to review the national mental health policy. That policy would include prevention and treatment of mental illness with social
reintegration, and would especially emphasize the development of human resources with training for mental health nurses and psychiatrists. Doctors working in primary health care had training guides to teach them about mental health. The lack of international solidarity on mental health issues was to be deplored. She asked WHO to seek ways of developing partnerships to give fresh impetus to that new world priority.

Malaysia

Mr Chua Jui Meng recounted a visit to a mental institution that had a clock tower with no clock; that had brought to his mind the thought that, on entering the place, there was no time, no reality and, for many inmates, no hope – they had been marginalized and stigmatized by society and, worst of all, by their own families. For the whole of the previous year, the Government had run a healthy lifestyle campaign in the mass media on the theme of mental health, including prevention. He echoed the description by the delegate of Trinidad and Tobago of the mass media as allies; every year, Malaysia, had given awards to journalists for the best writing on HIV/AIDS, as well as to the newspapers they worked for. As poor or unbalanced reporting about mental health issues could spark fear and discrimination, he proposed that similar awards be given to the journalists and the mass media which projected a more positive picture of what mental illness meant; that would be a start.

Maldives

Mr Abdullah welcomed WHO’s initiative to place mental health actively on the global agenda. Awareness-raising on behalf of the complex and forgotten issue of mental illness could be just as successful as that on behalf of HIV/AIDS. WHO should vigorously persuade Member States to dedicate a significant part of their national health budgets to improving treatment and facilities for the mentally ill, thereby enabling a large number of people to return as productive contributors to the mainstream of society. He called upon his fellow ministers to attach greater importance to mental health and to step up their contributions to it.

Mauritius

Mr Jugnauth, speaking as a lawyer rather than as a medical doctor, asked why it had taken so long for governments and international organizations to recognize the issue of mental health. What were the problems, and the related solutions, in the field of mental health? In response to those questions, he said that the key words were: recognition, identification, and treatment. Because those suffering from mental illness often attempted to hide their problem, such illness was both denied by the affected person and unrecognized as a real illness by their families. Accordingly, those who needed help were excluded from treatment.

Barriers to implementation of mental health services included public attitudes, resulting in a fear among individuals which prevented them from coming forward with their problems. A centrally-based institution in Mauritius had been constructed in a remote area as a high-security hospital for disruptive psychiatric and acute psychiatric patients, with different rules and regulations from those applied to general hospitals. Those admitted to that institution could not receive relatives or close friends.

The main barrier had been the failure to recognize mental illness, which was essential if the necessary treatment were to be provided. To achieve such
goals and overcome such barriers, he suggested that countries might follow the example of Mauritius in adopting a mental health act that clearly identified the fundamental freedoms and basic rights of those affected by mental illness, and provided for the protection of minors suffering from mental illness, life in the community and their rehabilitation in society. Other provisions of the act included the determination of mental illness, medical examination, confidentiality, the role of the community and culture, standards of care and treatment on a basis of equality with other patients, conditions in mental health facilities, resources for those facilities, admission principles, review bodies, procedural safeguards, access to information and equal treatment of criminal offenders.

Decentralization of mental treatment had been moving forward but with acute patients remaining in the psychiatric hospital. Wards for psychiatric patients in the regional hospitals were situated so as not to affect the rest of the patients.

Although Mauritius had eradicated malaria, poliomyelitis and tuberculosis, about 30% of the population still suffered from some kind of mental illness. Decentralization had been essential to reach those people and to make mental health services more available; to assure cost-effectiveness of services; to promote greater awareness in the community; and to suppress stigmatization of mental and psychiatric problems.

The main problems were societal, but there were also financial constraints, particularly in African and other developing countries, which made it difficult to decentralize. Another problem involved shortages of medical personnel, owing particularly to the emigration of trained medical personnel.

Mexico

Dr Frenk Mora underlined the double burden of disease that was afflicting developing countries. They faced mental health problems linked to backwardness and poor hygiene, such as epilepsy and mental retardation, as well as new types of mental disorder more commonly associated with developed countries, such as depression and psychosis. Moreover, current epidemiological and demographic trends, such as population ageing, indicated that the burden of mental disease was set to increase in the future in all countries.

Mental health problems served to magnify existing deficiencies in the overall health care system in respect of quality of treatment and care, respect for the human rights of people with mental health disorders, and fairness in financing, including the lack of health insurance cover for the mentally ill. Consequently, mental health should be treated as a priority in efforts to reform health systems. An important first step in increasing awareness of the problems associated with mental disorders was to document the scope of the problem. In that respect, Mexico had carried out several surveys which, in conjunction with WHO's ATLAS project, should provide scientific evidence for treating mental health as a priority area.

The public sector had a vital, proactive governance role to play in articulating the importance of mental health, protecting the human rights of those suffering from mental disorders and combating the stigma attached to mental illness. In Mexico, priority had been given to devising new mental health programmes, in particular to tackle alcohol and drug dependence, depression, schizophrenia, dementia, psychological disorders in children, and epilepsy. New pilot projects were under way to introduce innovative approaches that included the integration of prevention and treatment of mental health disorders in general health care systems; early detection of learning disabilities and social rehabilitation of patients in half-way houses, sheltered workshops and residential accommodation to facilitate their gradual reintegration into the community.

He agreed with Dr López on the need to focus special attention on the mental health of indigenous people, taking into account their particular cultural circumstances.

Mongolia

Professor Nymadawa observed that, while mental disorders were increasing in all Member States, they were a particular problem for countries in transition. In the previous 10 years, Mongolia had undergone drastic socioeconomic changes in its efforts to build up a multiparty democracy and a market economy. That difficult task had rendered
social problems more acute, resulting in increased prevalence of depression, alcoholism, accidents, suicide and crime, especially among the poor. According to a recent study, 51% of the adult population used alcohol and the suicide rate had risen five-fold between 1989 and 2000. The Government had introduced several measures to promote stabilization and provide social protection. Since 1990, cost-sharing mechanisms had been introduced into the previously universally free health service and a social health insurance scheme had been set up in 1994. However, the costs of treatment for chronic mental health conditions continued to be met by the State in the same way as some other priority health services such as immunization programmes and pregnancy and childbirth care.

He expressed appreciation for WHO’s support in coping with the mental health problems arising from economic transition. Mongolia faced a severe challenge from increasing mental health disorders, especially alcoholism and depression, and hoped to learn from the experience of other countries with different conditions and structures.

**Mozambique**

Dr Ferreira Songane described the development of his country’s mental health programme in 1990, based on prevention, training and partnership, in a multisectoral approach. Although Mozambique’s psychiatric hospitals had largely become redundant, it lacked the resources to eliminate the stigmatization of the mentally ill. In practice, many sufferers were simply left on the streets to die.

Since it had insufficient specialists and wanted to decentralize services, Mozambique was providing psychiatry training for doctors at the middle level of the system, including a significant public and social health component. The physicians worked closely with traditional practitioners who also had expertise in the use of drugs, and who thus could help overcome social resistance to seeking treatment.

The streets of Mozambique revealed children as young as five years of age who were forced out to work or to seek food and were deprived of the education and care they needed to enjoy mental health in later years. His Government hoped that, with the help of WHO and through its highly effective Regional Office for Africa, such phenomena could be effectively eradicated.

**Morocco**

Mr El Khyari observed that lack of knowledge was hampering efforts to tackle mental health problems, many of which were influenced by complex social factors. Moreover, the financial and human resource costs of long-term treatment and support for those with mental disorders were beyond the reach of many developing countries. Many were experiencing economic transition and its consequences, such as the splitting of families and decreasing belief in traditional medicine, at the same time as undergoing severe resource constraints. Mental health disorders required the involvement of several different ministries and many different aspects of civil society; they called for solutions that went beyond the conventional health care framework. He therefore welcomed the interest being shown by the international community through WHO.

**Myanmar**

Mr Ket Sein described how the launch of his Government’s mental health programme in 1998 had started to break down the misconceptions previously attached to mental health disorders. Awareness had been enhanced by the activities of health education teams and projects. Community participation in activities designed to provide moral support for sufferers had also been important in improving acceptance by the community and in encouraging community-based care. The engagement of well-known artists and cartoonists to open and promote exhibitions of paintings and drawings by people with mental disorders had contributed greatly to the change in people’s perception of mental illness and to minimizing discrimination.

The community-based approach to mental disorders covered the training of basic health care workers. New care guidelines had been issued, and the supply of basic psychotropic drugs had improved.
Nongovernmental organizations were encouraged to promote mental health activities, including the prevention of substance abuse among young people. Health education activities had been introduced in schools and in the community. A maternal and child welfare association had started to promote health and well-being, including programmes for education and income generation. National committees for women’s affairs had sponsored the establishment of counselling centres for victims of violence.

At the national level, a concerted effort was being made as a result of the mental health theme for World Health Day 2001 to secure adequate supplies of affordable, good quality psychotropic drugs. Meditation, which was already part of Myanmar’s culture, continued to be encouraged for the harmonious mental state that it promoted.

### Namibia

Dr Amathila, noting that the stigma of mental illness had been eclipsed in Namibia by that associated with HIV/AIDS, said that gender disparities had been actively addressed in her country, and that no health service excluded women. As far as mental health was concerned, women in Namibia appeared to be stronger than men; however, the level of violence against women was increasing. The health authorities had set up centres for women and children who had been abused, and in the previous year, an organization entitled “Men against violence against women” had been set up by men to provide counselling to abusive men.

Unemployment, poverty, alcoholism and HIV/AIDS were important factors in the rise in mental instability in Namibia, especially among young people. The refugees from neighbouring war-torn Angola also experienced mental health problems. It would therefore be important to create employment opportunities where possible, and to improve the country’s economy. HIV/AIDS had resulted in an increased incidence of depression and suicides; counselling services were not always accessible to the young, and immediate, confidential support, which should also cover mental health issues, should be provided. Traditional healers were now based at rural clinics to deal primarily with mental illness. Pensions for persons aged 60 years and over had helped to reduce depression among the elderly. However, the elderly were having to take care of an increasing number of AIDS orphans, and additional steps should be taken to support them in that regard.

Namibia currently had only one psychiatrist, and there was a clear need for additional investment in human resources and training to improve care for those with mental illness. Some 15% of the gross domestic product was devoted to health services, and it was important to ensure that due attention was given to mental health.

### Nepal

Mr Tamrakar observed that further study was needed in order to determine whether certain behaviours and lifestyles might be conducive to mental illness, and to investigate the mitigating influence of spiritual aspects of individuals’ lives, such as meditation. His country had adopted a national mental health policy. In the past, the size of the problem had not been recognized, owing to the stigma attached to mental disease, as well as to the shortage of trained personnel. A community-based pilot project was gradually being introduced, involving traditional healers and civil society as a whole in an awareness-raising campaign. However, it was difficult to allocate adequate resources in that area, and Nepal would welcome support from WHO to find funding for mental health projects and to provide drugs for a limited period.

### Netherlands

Dr Borst-Eilers said that her country had also seen a growing demand over the past 10 years for help for mental disorders, due to the increasing incidence of such problems and to the fact that help was being sought at an earlier stage, largely as a result of de-stigmatization. The change had undoubtedly been promoted by well-known personalities who had openly admitted to suffering from certain disorders. The availability of effective treatment for mental health problems such as anxiety and depression in primary health care centres, by family doctors, psychiatric nurses, social workers or primary care psychologists, was also responsible for the growing demand.
Like France, the Netherlands had also begun to shift from institutional to community care, where patients received support and various kinds of ambulatory treatment. In order for the shift to be successful, budget cuts were inadvisable, as community care was not necessarily cheaper than institutional care in view of the personal support required. It was also important not to push the concept further than the community could tolerate. Some vulnerable patients with chronic psychotic conditions and those who posed a threat to others needed the protected environment of an institution and should not be exposed to life in a community. One of the most important aspects of community care was the building up of broad public support by making it clear to the local community that professional help was readily available in the event of a disturbance. Community care had been introduced into a number of cities in the Netherlands with great success.

Niger

Mr Adamou said that, since the independence of his country, mental health care had been provided at the national hospital in the capital and at three hospitals that had psychiatric units; however, with waning funds and resources, their performance had deteriorated. On the occasion of World Health Day 2001, WHO had provided certain psychotropic drugs, which had enabled the country to resume its activities in that field. Clearly, in a country as vast as Niger, three hospitals were insufficient to cover all mental health care needs. The mentally ill, whether hospitalized or not, were rejected by their families and were looked after by the State. In his country, traditional medicine existed side-by-side with modern medicine. The traditional healers were not witch doctors and did cure some mentally ill people. The intention of the authorities was to promote primary health care for mental disorders and to decentralize that care through personnel training and the provision of sufficient drugs. Niger’s mental health programme was new, and there was need still to formulate policy, coordinate the activities of all those involved in mental health care and to raise awareness. All that was needed was financing. He had found the round table useful and would make good use of some of the suggestions that had been made.

Nigeria

Professor Nwosu commented that in Nigeria mental health care had initially been the responsibility of families and communities, and had then been transferred to hospitals before being restored to the community. The disintegration of the extended family system in Africa had placed an enormous burden on the community for the management of mental health care. In that regard, poverty alleviation was a crucial instrument for integrating mentally ill patients into society and giving them adequate care. While traditional healers played a major role in treatment, the community also needed education and awareness programmes so that traditional care would be effectively integrated into the orthodox health care system.

She asked that WHO devise a special programme on postpartum psychosis, a neglected area of mental illness.

Norway

Mr Tønne said that as a result of a study conducted a few years earlier, which had led to some shocking conclusions about the state of the mental health care system in Norway, his Government was working on a long-term plan to bring the system up to acceptable standards. In reply to the third question put by the Chairman, he said that openness and inclusion were two of the key issues being addressed. The history of mental health care in Norway, as in many other countries, had been one of non-information, lack of openness, closed institutions, stigmatization, exclusion, shame and fear. The reform of that situation had been a long process which had required changes in culture, attitude and behaviour amounting to a complete re-education of society. The second key issue, inclusion of those afflicted and affected, was closely connected to the first, because it could not be attained without the active participation of patients and their families. That implied participation in the development of the mental health care system and treatment offered, participation in the design and performance of information and education programmes, and, perhaps most importantly, individual participation in self-help and self-treatment.
Research in Norway indicated that 20% of the population suffered from mental illness at least once during their lifetime, and that mental illness was a growing factor in causing school drop-outs, unemployment and absenteeism. In the debate on mental health some difficult and controversial questions had arisen, for example the question of whether a general recognition of mental health problems as illness might not entail the risk of lowering the threshold of illnesses requiring treatment, thereby reducing the capacity of individuals to cope with their own problems.

**Norway**

**Mr Tønne** said that the broad answer to the Chairman’s four questions was that information, in the sense of education of society as a whole, was the best remedy. All efforts to fight stigma had actively to involve everyone who suffered from mental health problems and stigmatization.

With regard to the comments made by the delegate of Israel, it was important to distinguish between mental illness and the mental problems that arose in normal society. Care had to be taken that efforts to promote mental health did not produce stigma by turning normal problems into illnesses and disorders. Thresholds should not be lowered; rather, work should continue on education and information.

**Pakistan**

**Dr Kasi** related that recent studies carried out in rural areas and urban slums in Pakistan had shown a high prevalence of neuropsychiatric disorders. Mental health had also been identified as a main priority area in the national health policy. The Lunacy Act of 1902 had recently been replaced by the National Mental Health Ordinance 2001 which provided a balanced framework for protecting the human rights of mentally ill people and their families. The national mental health programme had established pilot projects at local level to provide mental health care as a component of primary health care. The media and nongovernmental organizations were supporting efforts to promote public awareness and understanding of mental illness by tackling traditional myths and superstitions. Other public sectors, in particular the Department of Education, were actively involved in the mental health programme, and mental health education was being introduced in private and state-run medical schools. Psychiatric nursing courses were also being offered by nursing schools. Mentally ill people and their families were eligible to receive grants, as well as social and disability pensions. Most health care services for the mentally ill were provided by the public sector, although the private sector was rapidly emerging as a new player in that area. As yet, no policy existed to regulate private sector providers and health insurance was not available, although the Government had recently submitted an ordinance on the regulation of private hospitals, including mental health institutions.
Panama

Dr Gracia García said that he had found the round table highly instructive. It would be important to determine to what extent mental health systems had been affected by the economic and social policies and crises imposed by the current development model. Panama resembled other Latin American countries in experiencing increased poverty, greater unemployment and a resultant rise in disease in general and in mental illness in particular. One immediate effect of an unstable economy was decreased spending on health and education.

In 2000, Panama had made mental health a priority and had implemented four programmes. The first had focused on obtaining accurate epidemiological data on the real impact of mental illness on society. The second had ensured early diagnosis and treatment of mental illness in a national care system through promotion campaigns and education programmes for patients, their families and general practitioners. Joint public-private sector support groups for patients and their relatives had been established to eradicate stigmatization of mentally ill patients by their families and society, so that the patients could be reintegrated into society as rapidly as possible. A community pharmacy programme had been established that gave patients access to high-quality drugs at reasonable prices. The possibility of State subsidies for drugs in the event of economic necessity was being studied.

Papua New Guinea

Mr Mond described his country’s 10-year action plan for social change and mental health. The main challenges were: the need to increase public awareness and involvement; the limited financial resources; poor service coverage; inadequate training of staff, community, and home care providers; a lack of psychiatrists and psychiatric nurses; a neglect of forensic psychiatry; poor intersectoral collaboration; and, finally, insufficiently developed data and evaluation indicators. To respond to those problems, month-long awareness campaigns and training seminars were held for skills development, and a community-based psychosocial health care centre had been established. Pocket-sized standard treatment manuals were being prepared for general practitioners, nurses and other health care professionals, to help them deal with mentally ill patients in the hospital setting.

The Government’s mental health policies were linked to social change, and included free psychiatric care and rehabilitation as an integral part of the public hospital system and the establishment and support of community-based treatment and psychosocial rehabilitation, carried out in collaboration with nongovernmental organizations and other such groups.

Peru

Dr Pretell Zarate said that developing countries, with their many priorities and scant resources, needed more information on mental health in order to raise awareness of the problem. The first step should be to carry out national epidemiological studies. He appealed to WHO to support countries in carrying out surveys on mental health at country level, in order to provide more accurate data on the prevalence and epidemiological profile of mental disease. Such surveys would permit an assessment of requirements in terms of human, professional, and family resources, and of mental health care provision. They would also support the development of appropriate models for developing countries to deal with mental health problems. He applauded the pragmatic efforts of many countries in providing psychiatric training for health care workers, but he wondered what results had been obtained from such training in terms of quality of care, prevention, diagnosis and referral to other levels. Secondly, he enquired what experience had been gained in mobilizing families and communities, particularly in rural areas, to avoid isolation, discrimination and stigmatization in respect of the mentally ill. Lack of resources and failure to prioritize mental health were problems shared by all developing countries, and it was therefore of vital importance to conduct a global survey on mental health.
source of great expense to the State. It would therefore be very useful to wage a major educational campaign showing the scientific progress made with regard to the causes of many of those problems and the existence of new and more effective methods of treatment and rehabilitation. For example, the World Summit for Children's global campaign to iodize salt was an effective, cheap and easy means of preventing damage to the brain and mental disease.

**Poland**

Professor Opala said that the Polish Ministry of Health and Social Welfare had approved a new mental health programme in 1994 with the aim of ensuring improved access to appropriate health care and support for those with mental disorders. The implementation of the programme and the mental health of the population were being monitored. A recent study of mental health had revealed that the number of people with a positive assessment of their lives had increased but feelings of happiness and satisfaction had declined. Higher mental well-being was associated with broader social support, increased income, participation in religious practices and marriage, whereas a lower sense of mental well-being affected in particular the elderly, the unemployed, those with a lower income and those suffering from loneliness. The highest risk for mental disorder was found in persons over 65 years old, 51% of whom (88% in women) admitted to feeling sad and depressed. The Council for Mental Health Promotion had drawn attention to some of the risk factors for mental disorder and measures had been introduced to monitor and promote mental health, including the identification of risk groups, the introduction of educational programmes for families, the implementation of school curricula to develop skills in problem-solving and coping and the establishment of various forms of psychological counselling and intervention for people in emotional crisis. Such measures would be included in the national mental health programme.

**Portugal**

Mr Boquinhas said that his Government had approved a national mental health plan in 1996 and in the last five years had ratified a new mental health act and organized new mental health services around hospital and community care. Intersectoral cooperation was being promoted. Other legislation, concerning collaboration between the health sector, social services and non-governmental organizations in the development of psychosocial rehabilitation programmes had also been approved. For example, the national council for mental health and a number of regional councils had been established, and a hospital referral network put in place. The integration of mental health services into the national health service ensured their greater accessibility and adequacy. In-patient treatment was now provided in general hospitals. Local services had been developed to replace psychiatric hospitals, and new psychiatric services were being funded at the community level, including services for children. Drugs for the treatment of severe mental illness were partly subsidized.

There was nevertheless a marked lack of progress in some areas. Stigmatization persisted, little attention was paid to preventive programmes and there was a lack of community-based facilities to bridge the gap between hospital and home care. There was also a lack of epidemiological data on psychiatric morbidity and mortality and use of the available facilities. There was a particular need for monitoring and assessment of the national mental health policy, its implementation and the quality of care. Efforts were being made to promote mental health by investing in community-based facilities for long-term patients, developing a national plan to create other facilities such as day care and continuity of care on medium-term and long-term bases. Epidemiological and economic studies were being planned at the local and national levels, and an ongoing monitoring and assessment programme had been established to ensure quality of service.

**Republic of Korea**

Dr Lee said that, until the mid-1990s, his Government's policy had been geared to long-term hospitalization of mentally ill patients. However, with the enactment of the Mental Health Act in 1995, there had been a trend towards a community-oriented approach, concentrating on early
detection, early treatment, rehabilitation and integration in the community. Considerable improvements had been achieved. About one million persons were currently receiving treatment, representing 2.7% of the total population. A large-scale epidemiological study on mental illness was underway. Measures had been put in place to provide support for families, appropriate jobs for those able to work, and entitlements to disablement benefits. The Government was committed to combating social stigma related to mental illness through public campaigns and community-based projects. Mental Health Day 2001 had been celebrated with the design of a special emblem to draw attention to the importance of mental health and the organization of academic seminars and rallies for mentally ill patients.

Romania

Dr Bartos explained how she had learned early in her medical career the true importance of adequate mental health services. The lack of such services allowed many persons with mental disorders to hide behind real or virtual barriers, some of which were presented by prejudice and intolerance. In her country, despite the important social changes that had occurred, violence, unemployment and a rapid deterioration in economic conditions and living standards were all affecting the mental health of the population. The Government believed that health care was a collective social good to which everyone should have free and equitable access. Better health in Romania would be achieved through a strategy of correcting the excessive orientation towards hospital services which was detrimental to outpatient and community care.

The Ministry of Health and the Family had submitted a bill to promote mental health and the protection of persons with psychological disorders, to ensure that they were treated in a manner that fully respected their dignity, without discrimination and, in so far as possible, in the community. WHO had supported the preparation of that bill and had also contributed to the evaluation of mental health at the national level. Romania needed a national mental health plan based on: the determination and evaluation of the real dimension of the problem; the reform and effectiveness of the system of mental health services; and integrated, interdisciplinary and intersectoral programmes to promote mental health. Family doctors needed to be involved to a greater extent as “gatekeepers” and special assistance would have to be provided to vulnerable and high-risk groups. The Ministry was also coordinating a project financed by the World Bank for the establishment of a mental health centre. She welcomed the support provided by WHO and its initiatives to raise awareness of mental health problems, which had prompted several new activities, which she hoped, would reduce certain obstacles to mental health service reform, including traditional attitudes and inertia. In transition countries, such as her own, one of the most difficult reforms had concerned hospitals, in which most mental health services were located and the call for emphasis to be given to outpatient and community services. Such a course of action was hard, given the lack of information on the real dimension of the problem. She therefore welcomed the round table which, even if it did not knock down existing barriers, would nevertheless weaken them.

Russian Federation

Professor Krasnov stressed that the rise and spread of mental health problems were characteristic of all societies, rich, poor, or in transition. It was wrongly assumed that poverty eradication was the prerequisite to the reduction of prevalence of mental health problems; however, those problems were themselves factors of social and economic development.

Any long-term strategy of care and prevention required greater integration of psychiatric services into the general health system, with families and even former patients contributing their unique experience, skills and advice on how to overcome certain problems. The task could not be left to specialists alone; it required the participation of all members of society, and of primary health care workers in the first instance. Although his country had limited experience in that domain, it had organized local polyclinics facilitating early intervention through offering access to services that communities would otherwise shun if provided by large institutions.
He suggested that a global appraisal be made of experience in mental health care in different countries in order to develop effective health care models. WHO was uniquely positioned for such a task. Many participants had described community-based mental health care policies, but there were as many interpretations of the term “community” as there were regions, countries or towns. Whereas most villagers knew one another, in large urban apartment blocks people rarely knew their neighbours. Effective community-based care should be predicated by a definition of “community”.

Rwanda

Dr Rwabuhihi noticed that the date for World Health Day, devoted to mental health, had been 7 April. However, that day was one of mourning in Rwanda to commemorate the tragedy of 1994, where in the space of only 100 days one million Rwandans had been killed by other Rwandans. The significance of that date would prevent Rwanda from celebrating World Health Day for many years to come. Mental health programmes in Rwanda were being decentralized in order to help to cope with the healing of an entire society. It was not a question of healing a few groups on the margins but of instituting a mental health programme for the whole population. The need was more readily understood when set against the backdrop of the more-than 120 000 persons still in prison on suspicion of having participated in the massacre of their compatriots. One survey of 3000 children in 12 provinces had revealed that over 90% had been in danger of being killed and more than 95% believed that they were dead, even though they were living. Those factors gave an indication of the enormity of the task being faced with very few resources. Rwanda had chosen a participatory form of justice in which people who had witnessed the massacres for three months would be able to tell the truth about what had happened. That was the reason to ask everyone to participate, including the traditional health systems, the district hospitals and the health centres, in order to seek the truth and assist in the healing process. The traditional healers were needed because there was a desperate shortage of so-called modern medical personnel. There were fewer than 200 doctors in Rwanda as compared with more than 10 000 traditional healers. He thanked all those who had helped Rwanda, especially in training. He expressed his particular appreciation to Switzerland for its cooperation in training doctors and mental health specialists.

San Marino

Mr Morri said that mental disorders should receive greater attention. Since 1955, patients in San Marino had enjoyed free, direct access to medical care, including care for mental and neurological disorders. As San Marino had no psychiatric hospitals, patients requiring admission were referred to institutions in other countries. In addition, relevant legislation was being reviewed to respond to new needs, including support to care providers.

San Marino had always attached importance to caring for patients with mental disorders through social and community-based services, and strategies had been improved to enhance quality of life. Rehabilitation was individually tailored, and included access to half-way houses for reintegration into the community, occupational rehabilitation workshops and special training contracts. Private companies could enjoy reductions in their social contributions if they employed certified disabled persons and were required by law to employ one disabled person for every 20 employees. Those and other administrative and social measures were effective in preventing the stigmatization of persons with mental disorders.

Voluntary assistance contributed significantly to the services provided by the State, and some voluntary associations were actively promoting information on mental disorders, supporting rehabilitation, and encouraging the involvement of the mentally and physically disabled in sport.
Current commitments would need to be sustained, through, inter alia, investment in human resources and the implementation of preventive programmes targeted at all social groups, and the provision of effective and individually tailored care. It would also be essential to improve understanding between patients with mental disorders and doctors.

**Senegal**

Mr Diop, describing the experiences in his country, said that particular stress was being laid on raising public awareness of mental health matters. Through the national health education system, mental health experts were promoting a programme in the mass media, using all the Senegalese languages. In 2001, particular emphasis was being given to epilepsy, prevalence of which was 8% to 11%. An information programme was being developed to induce traditional practitioners to refer patients with mental disorders to specialized care services. So far, participation by the State in care for patients with mental diseases was still very low, although the Ministry of Health was currently developing a national programme in that regard. The strategies were aimed at reducing stigmatization and exclusion and encouraging family participation in caring for patients with mental health problems. Some patients were cared for in psychiatric villages, staffed by carers from the same region. Elsewhere specialized teams were being set up to visit patients in their own environment. An attempt was being made to integrate mental health care into the basic health care programme, which involved training health workers at all levels and improving prevention, screening and treatment. Traditional practitioners were also becoming increasingly involved in mental health care alongside professional health workers.

**Sierra Leone**

Dr Jalloh welcomed the decision to focus on mental health for World Health Day 2001 and to include the subject on the agenda of the current Health Assembly.

The Ministers of Health of Uganda and the Democratic Republic of the Congo had raised the issue of civil strife as a factor in mental health problems. It was important for countries that had undergone war to share their experience of the relationship between war and mental health. On 6 January 1999, rebels had invaded his country’s capital, Freetown, and had carried out widespread and barbaric attacks on the civilian population, including arbitrary executions, abductions, single and gang rapes, amputations, arson and looting. At least 10,000 people were alleged to have died and at present some 150,000 were displaced from their homes.

While most medical personnel acknowledged that gross atrocities had been committed, they knew little or nothing about post-traumatic stress disorder, which was difficult to define both conceptually and operationally. It was a unique diagnosis, in that an exposure or criterion stressor was an integral part of the disease. The criterion stressor required that a person had experienced an event that was outside the range of usual human experience. Although specific criterion stressors might be difficult to define, participation in war was generally deemed to be such an experience.

The concept of post-traumatic stress disorder should be considered with care, as not all disorders arising after traumatic events fell into that category. To overcome mass traumatization, as in the case of Sierra Leone, the healing capacity of family community systems should support people in coping with severe stress and with more severe mental health problems. The number of traumatic experiences and their duration were important risk factors in the development of post-traumatic stress disorder. Sufferers from traumatic stress often had physical complaints, the so-called psychosomatic stress symptoms, although they were often misdiagnosed by medical practitioners who were not psychiatrists. It was important to consider not only conventional forms of depression and schizophrenia, but also the stress disorders that arose as a result of war.

**Singapore**

Professor Ee Heok Kua said that it was important to convey a positive message indicating that many people did recover from mental health problems. To that end, Singapore’s health authorities worked closely with nongovernmental organizations, held
public forums every two months on common mental illnesses including depression and anxiety, and collaborated with the mass media to destigmatize mental illness and to ensure that correct information was provided.

It was important for governments to ascertain the extent of mental health illnesses in order to plan service. Following a national survey in Singapore, action had been taken in three areas: teachers and counsellors had been trained to recognize and manage mental health problems in schoolchildren; personnel and managerial staff had also been taught to recognize the common signs of mental illnesses in the workforce, as well as counselling techniques; and retired professionals had been trained to provide counselling support to the elderly. In all cases, if a problem could not be managed, the individual concerned was referred to a specialist.

He hoped that mental health would remain a focus of attention for WHO, and that, in the future, the Organization would coordinate programmes and make sure of their effectiveness.

Slovakia

Mr Hlaväčka said that because mental health care was dominated by medical specialists the related strategies did not involve other professionals, such as social carers, patients and families. The role of the family was crucial, not only in terms of diagnosis (as the family was often the first to identify the problem), but also in enhancing access. The family could bring the patient for treatment and assist in reintegration. Thought should be given to a social environment that optimized the ability of the family to care for the patient. Often, the problem was not one of education or understanding, but of the economic ability to care.

Like other countries, Slovakia had formulated a mental health strategy. The difficulties lay in monitoring implementation and in establishing indicators of performance. Evaluation of treatments tended to be based on costs, the number of drugs used and the number of treatment centres available. However, there were few indicators to measure responsiveness of care. The views of the caregivers, the families and the individual patients should be sought on how to improve the service.

There was also a place for the type of benchmarking that WHO was carrying out. Finally, as to the role of WHO and other international organizations, the causes of mental illness, such as poverty and stress, must also be tackled.

Slovenia

Mr Murašič said that alcohol consumption and suicide each accounted for 30 deaths per year per 100,000 population. The current national health programme contained little on the subject of mental health, so a national mental health programme and national legislation on alcohol and tobacco consumption were currently in preparation. Primary prevention had already been introduced into the work of general practitioners, who were required to put questions to their patients concerning their mental well-being. Those with the highest risk factors were then involved in group therapy. A programme to encourage healthy schools and workplaces had also been launched. In order to reduce stigmatization, a patient advocacy act that stressed the need to protect the human rights of those with mental disorders was under discussion. The third and final reading of that act was to take place in the near future.

South Africa

Dr Tshabalala-Msimang said that one of her Government’s objectives was to promote an integrated approach to health care. Health care was not regarded as being the responsibility of the Department of Health alone and it had been possible to achieve an increase in social spending in recent years. A mental health bill, to be submitted to Parliament in the near future, would provide a framework for the delivery of care at all levels of the health system and would promote rights for those disabled by mental illness. South Africa was also finalizing a special training instrument to improve the skills of staff. An important challenge was the provision of appropriate services for people emotionally traumatized as a result of, for instance, rape, child abuse and family break-up. Prevention of mental disorders was crucial and often involved intersectoral collaboration. South Africa had initiated a programme aimed at the prevention of violence in schools and projects
along the lines of the WHO parent-child bonding programme. The next step was to improve primary mental health care. One-stop centres had been established for abused women, and health workers were being trained to deal with basic problems, to counsel on victim empowerment, and to recognize the need for referral. Future activities should include expansion of the network of referral centres and attention to the needs of health workers who took care of people with mental disorders.

Recent research had indicated that high blood alcohol levels were associated with well over half of all non-natural deaths including homicides and traffic accidents. Greater emphasis should be given to reduction of demand and supply of alcohol; prevention work in that area would have many human and financial advantages. The spread of HIV/AIDS among psychiatric patients was also a serious concern. A project aimed at developing comprehensive life skills in schools, which covered HIV/AIDS and substance abuse prevention, had been introduced under the WHO/UNDCP Global Initiative on Primary Prevention of Substance Abuse. Lastly, she drew attention to the need to develop appropriate community services and to shift budget resources accordingly.

Sri Lanka

Mr Seneviratne said that, although his country had achieved high levels of health with a relatively small financial investment, developments in mental health had lagged behind other aspects. Sri Lanka was facing high suicide rates and psychosocial disabilities related to stress, in connection with the socioeconomic effects of the war in the northern and eastern areas of the country. Lack of awareness of mental disorders, social stigma and the low priority attached to mental health continued to obstruct the development of mental health services. A series of measures had been taken in recent years to develop mental health services and to decentralize mental health care. The greatest problems faced by Sri Lanka were the lack of qualified psychiatrists, which he hoped would be alleviated by the training of medical officers; and the high rate of suicide among the young, which he hoped could be addressed through research conducted in cooperation with other countries.

Sweden

Mr Engqvist said that, in 1995, Sweden had challenged the traditional views of mental health services, shifting from large-scale institutional psychiatric care towards municipality-based rehabilitation and integration programmes. The aim was to ensure that people with mental health problems were closer to the main stream of health services. Despite major investment and a positive response to the structural changes introduced, however, the professional and other available resources had not met the required high standards of care. A national centre had therefore been established to provide support for individuals suffering mental or functional impairment and to ensure maintenance of their dignity and respect, in which connection personnel training was important. Moreover, a national action plan presented in 2000 would substantially increase health care funding and focus efforts on improving primary health care and care for the elderly and the mentally ill. The important role and the responsibilities of general practitioners in prevention and early intervention were equally underlined. Under Swedish legislation (compliance with which was annually monitored) patients had the right of access to information, as well as the right to a second opinion and a voice in their care and treatment. Special attention was devoted to patient empowerment and the valuable assistance of patient organizations was recognized, both in the development of legislation and guidelines and in the evaluation of reform and other changes.

Although mental health conditions had generally improved in Sweden, mental ill-health had increased at an alarming rate, particularly among teenagers and young women. Special measures would therefore be taken. Mental illness was strongly connected to poverty and substance abuse. Notwithstanding the significance of genetic factors in many conditions, social support systems were crucial in diminishing the consequences of mental illness, in which context he highlighted the advantage of multiprofessional approaches and the importance of cooperation between the different actors, including nongovernmental organizations.

Together with a well-developed preventive health system, a proper education system was the key to
providing the basic conditions needed to ensure that young people developed self-esteem and adopted healthy lifestyles. In that context, encouraging progress had been recorded in Sweden’s efforts to tackle domestic violence, including the development of a new training programme for professionals in the fields of health, social services and law enforcement. Sweden had also investigated gender differences in the provision of health care and was endeavouring to eliminate conditions attributable to gender discrimination.

Switzerland

Ms Dreifuss, responding to the Chairman’s second and third questions, suggested that the prime responsibility of the public sector was to ensure that everyone had access to care. In Switzerland, that meant that mental health was covered by health insurance on an equal footing with physical health. However, access to mental health care was hampered by the public’s poor level of knowledge of mental disorders. A second responsibility of the public sector was therefore to promote understanding of how mental disorders evolved in order to allow early intervention. Whereas certain issues such as drug dependence, because of their effect on public order, were well known and tackled, such disorders as depression quietly took hold before treatment could be delivered and before the community or the family became aware of their existence.

It was also the State’s responsibility to develop and to ensure good quality mental health care, to conduct epidemiological studies, research and training, and to safeguard the human rights of patients with mental illnesses as persons fully integrated into society.

The approach to mental health problems should target different segments of society. Young people’s problems, as manifested in drug abuse, suicides and depression, differed from the problems of the very old, characterized by serious depressions, and the problems of work-related stress and the workplace in general. Those approaches needed to be adjusted to take account of differences between men and women. Switzerland had had to develop specific responses to the problems of migrants and displacement. Caring for refugees and the particular traumas they brought with them required a different perspective on diagnosis. In summary, she stressed the need for widespread information, but also a targeted approach according to population groups, in order to promote understanding of mental health.

Thailand

Dr Winai Wiriyakitjar remarked that his country had experienced two major crises in the past decade: HIV/AIDS and the economic recession. There was an increasing number of mental health problems, including suicide: the annual rate had increased from 7.2 to 8.6 per 100 000 population over the past five years. The Government had tried not to cut health expenditure but to use the economic crisis as an opportunity to review its health strategies.

The World Health Day theme and related activities showed that discrimination and access to mental health care were major concerns in most countries. Thailand’s experience with psychotropic drugs was that side-effects increased stigmatization and reduced compliance. Newer drugs had fewer side-effects but were more expensive. For that reason he proposed that access to such drugs should be given high priority in the WHO revised medicine strategy. Also, he wanted WHO to consider recommending that Member States ensure that such drugs were appropriately represented on essential drug lists. He concluded by expressing the hope that the output of the round tables would be more than a report; he expected a concrete result that would improve mental health and alleviate the suffering of those with mental disorders.

The former Yugoslav Republic of Macedonia

Dr Nedzipi said that mental health care in his country was inadequate, and lack of resources for hospital and community care deprived many mentally ill persons of their basic human rights. With WHO’s support, however, the Ministry of Health had elaborated a master plan to improve human resources and had proposed new legislation to enhance patients’ rights and combat stigmatization.
Community mental health services had been set up in three pilot areas in partnership with three European municipalities. Day-care centres, protected homes, social enterprises and social clubs were supported by the public service and by nongovernmental organizations, in a multisectoral approach. Mechanisms were in place to ensure the sustainability of the community-based approach, and initiatives had been taken to increase the resources of the project and replicate it in other pilot areas.

Trinidad and Tobago

Dr Parasram said that, after a long period of neglect, mental health had become an integral part of his country’s health sector reform programme. The new mental health plan currently being implemented took into account the relationship between mental health, social pathology and other exacerbating conditions and sought to provide a range of integrated services, with the emphasis on primary care of the individual within the community. It also comprised activities such as a legislative review, restructuring, an assessment of health needs and human resources, training, health promotion and the development of regional plans in association with provider agencies. Approval had been given for the establishment of a suicide-prevention task force; the current system of drug procurement and distribution was under review; and new generations of drugs were available at public mental health care institutions. Such policies and reviews, however, were insufficient in themselves to reverse the stigma of mental illness and related problems, a process which demanded continuous efforts. In his country, fruitful forums had been held with the media. That group could serve as an important ally in overcoming the challenges entailed in moving the mental health care agenda forward. On that score, he looked forward to the continuation of national, regional and international action aimed at improving the quality of mental health for the world’s citizens.

Tunisia

Dr Abdessalem said that mental health had long been neglected for a number of reasons. Once independent, Tunisia had immediately tackled such scourges as infant mortality and had embarked on a countrywide immunization campaign. Since 1990, it had included mental health in its general health strategy, with emphasis on legislation, organization and human resources.

The first major component of that strategy had been the integration of the mental health programme into existing structures dispersed throughout the country, to take those services closer to the users. The second component, still being finalized, was the establishment of the structures necessary for the various categories of mental health care. Counselling units had been set up in secondary schools, higher education establishments, and in some small hospitals. A decision had yet to be taken with regard to voluntary and involuntary hospitalization. A third important measure was to attack the myriad risk factors for mental disorders through education, affording all children the opportunity to continue their studies and the fight against poverty with the creation of jobs for young people. Action was being taken to protect vulnerable groups, particularly children and the elderly, especially with respect to violence against women and children. The authorities were also endeavouring to ensure that persons who were or had been mentally ill were reintegrated into the country’s social and economic systems.

He endorsed the view expressed by many speakers that legislation on its own did not provide effective mental health care. A change of mentality was required among all persons involved in mental health care, including psychiatrists, who were sometimes unwilling to share their power and knowledge. It was equally important to train social workers, specialized nurses, psychologists and psychiatrists, and to provide psychiatric training for general practitioners. In short, Tunisia’s strategy focused on prevention and reduction of risk and affording its citizens better access to proper care in decentralized clinics, sponsored by university faculties of medicine and psychiatry.

Uganda

Dr Kiyonga had seen evidence in his country that stigmatization could be overcome. When he had been a medical student in the late 1970s, no student would have dared to admit to being near a mental hospital, yet when a psychiatric clinic had
recently been closed in town and mental health patients had been asked on radio to go to an out-of-town hospital for treatment, the reaction had been good. Furthermore, people were now contacting physicians about mental illness. In two further major developments, former sufferers from schizophrenia had formed an advocacy group to eliminate stigmatization of the disease, and the parents of epileptic children had created an association to seek care for their children and to promote the message that epilepsy was a manageable condition.

In order to give people confidence, the health sector had to demonstrate that treatment worked and that people got better. Sufficient confidence had to be generated in the population that people could be treated before legislation was adopted. Such legislation should be timed to coincide with an improvement in care and not be rushed through.

Lastly, was there any evidence that the extended family structure prevailing in most African States offered an advantage in mental health care? Could it be shown, all other things being equal, that countries with an extended family structure stood a better chance of dealing with mental illness than developed countries that did not have such a structure?

Uganda

Dr Kiyonga, noting the trust placed in traditional healers by the general population in his country, expressed interest in views on the role that traditional medicine could play in mental health care. His country gave a high priority to the treatment of mental illness as the HIV/AIDS pandemic and protracted civil strife had increased the incidence of such illnesses. Uganda, in common with other sub-Saharan countries, suffered from high rates of unemployment and poverty. The public sector was therefore seen as the key to tackling mental health problems and to raising public awareness so as to reduce stigmatization and to encourage the mentally ill to seek help. A loan recently granted by the African Development Bank would be used to reform national institutions responsible for health care delivery and to integrate the delivery of mental health and general health care. The training of health workers was currently being reviewed, in order to facilitate recognition at primary health care level of conditions likely to affect mental health and to avoid over-specialization.

United Arab Emirates

Mr Al-Madfaa, concurred with previous speakers on the importance of eliminating discrimination and stigmatization in regard to the mentally ill. His country took account of the psychiatric causes of certain illnesses, and was making efforts to raise awareness of mental health issues among students in universities and training institutes. The need for interaction between various ministries was recognized, and the ministries of health and education in his country were working together to combat psychological disorders among schoolchildren. He emphasized the importance of awareness-building, of the role of the family, of research, and of the use of the media in order to target areas for mental health action more successfully.

United Kingdom of Great Britain and Northern Ireland

Ms Hutt said that the National Assembly for Wales was aware that all the policy areas for which it was responsible, namely health and social services, housing, environment, economic development and education, were relevant to the improvement of health and well-being and to tackling mental health problems. It had also become clear to that Assembly in the two years of its existence that a national strategy for mental health was essential, with priority funding. Such a strategy would provide for local delivery and local management of services through primary care and community health development.

Every effort was being made in Wales to ensure that people who had used mental health services or were suffering from mental health problems were involved in policy development, both in their local communities and in the National Assembly.

In developing community services, it was essential to have plans and funds in place before closing existing institutions. It was equally important, with one in four people likely to experience mental distress at some time, either in their families or in their communities, to ensure that the community was able to address their needs.
Ms Abdallah observed that some 85% of the population of her country lived in rural areas where there were practically no mental health services apart from traditional healers. In most cases mental illness was associated with curses or supernatural causes. Her Government had developed a mental health policy, but traditional practices still needed to be integrated into modern medicine. She requested assistance from WHO in that area.

Specific causes of mental disorders in her country included the rapid breakdown of traditional psychological support systems and social norms, poverty and rural-urban migration in the absence of social skills and strategies to adapt. A second cause was the long-term presence of refugees, whose settlements were breeding grounds for mental disorders. In surrounding areas there had been increases in crime, resulting in insecurity among the indigenous population. Mental health services thus needed to serve local populations as well as refugees.

Mr Thompson, responding to the second question put by the Chairman, said that it was the responsibility of governments to disseminate information on mental health as widely as possible in order to combat the suspicion and scepticism that surrounded the subject. In the United States, one seventh of gross national product was spent on mental and physical health combined, and in all countries mental illness was among the five leading factors contributing to low productivity, absenteeism and suicide. The United States was spending more than US$ 1 000 million on research into mental health, as a result of which great progress was being made.

Two of the most difficult problems in the field were suicides among young people and discrimination against women. More needed to be done to reach out to young people and to try, through the education system, to reduce the number of suicides and eventually to prevent them. There was no doubt that certain mental illnesses were more prevalent among women than men, a difference that should be reflected in research and in expenditure on services. His Government intended to give mental illness a higher priority than in the past, and to ensure that it was treated on a par with physical illness.

Dr Touyá said that a process of de-institutionalization of mental health care had begun in 1986, with much of the responsibility passing to the community. That had resulted in fewer and shorter hospital stays, thereby improving patients’ quality of life in their family environment. Psychiatric care could not fail to improve with increasing knowledge about brain function. Nevertheless, the risks for mental disorders were increased in a civilization that pushed people increasingly towards self-destruction. The most positive approaches were prevention and protection, to which end WHO should firmly support countries that set examples of strong family bonds, which were known to reduce poverty and violence. The media should be used to raise awareness.

Dr Urbaneja Durant reported her country’s experience in carrying out extensive political and institutional changes that had enabled progress by ensuring that universal rights such as the right to health were met. That right must include the right to mental health, and health must be seen as an integral part of well-being and development. Obstacles to those goals were often related to poverty and inequality. Venezuela had worked out three strategies to try to overcome those obstacles: incorporating guarantees for rights in the country’s constitution; ensuring application of the constitutional provisions through governmental policies; and health system reform.

Venezuela’s constitution enshrined health as a basic right, without any discrimination on grounds such as mental ability or gender. It included respect for diversity and differences between individuals, which demanded a major change in attitudes.

Promoting health was essential for guaranteeing overall rights. That meant intersectoral approaches, improved access to more effective and appropriate services, tackling discrimination, and provision of
decent living conditions for health. Gender differences were recognized, for instance in access to health services, discrimination and quality of life. The National Women’s Institute had designed specific policies and strategies together with national plans in that regard. A council for the protection of children and young people had been established to ensure shelter, proper nutrition and feeding, and access to education, especially for street children. For disabled people there was a national committee for disabled persons and legislation for improved protection was being enacted. Steps were being taken to improve the living conditions for indigenous people whose rights were guaranteed in the constitution. Laws were in place to guarantee individual rights in times of emergency and disasters.

Her country had changed its model of health care, emphasizing health, rather than disease, as the starting point. Prevention and health promotion formed critical strategic elements for health care workers; they needed to understand that in integrated health care, health must be promoted in places regularly frequented by people, such as schools, sports venues, and outpatient clinics. In parallel, the profile of a health worker was being changed in favour of that integrated health care approach. That would help to remove the stigmas that blocked access to the mental health care which people needed; otherwise mental health problems and stigmatization would be exacerbated.

Specifically with regard to psychiatric care, she was convinced of the need to care for both acute and chronic cases, with involvement not only of patients but also of their families and communities. That would ensure proper treatment, both in hospitals and in communities, with rapid reintegration into society.

**Viet Nam**

Professor Pham Manh Hung informed the meeting that, like many developing countries, Viet Nam had seen an increase in the incidence of mental and brain disorders. The Government was dedicated to poverty reduction and had made considerable progress in the past five years. Priority had been given to programmes with a strong commitment to the provision of equitable health care services for the poor, including priority allocation of expenditure for health in poor areas. Health workers in the mental health field were encouraged by additional allowances equivalent to 20% of their salaries, a seven-hour working day and early retirement.

Improvements had also been made in hospital care, and the number of mental health departments in cities and provinces had been increased, as had the number of psychiatrists. More recently, mental health care had been integrated into the general health service, with emphasis on community-based services. Most districts currently had a mental health consultancy, responsible for the care and follow-up of patients.

Community awareness of mental health problems had increased. Nevertheless, and despite the considerable progress made in providing mental health care, poor people continued to suffer. Limited government expenditure on health and the lack of well-trained psychiatrists on the one hand, and poverty, social discrimination and prejudice, a lack of information and superstition on the other, were major obstacles to the provision of mental health care and information on preventive treatment.

To counteract that situation, the Government had approved a five-year plan for development of the health sector with the aims, inter alia, of expanding health care centres to a further 50 communes, expanding community-based mental health services to other provinces, providing community-based management and improving cure and rehabilitation rates. A notable result was that 50% of the country’s community health centres now had at least one medical doctor.

**Yemen**

Dr Al-Munibari agreed with earlier speakers that warfare and violence were among the major causes of mental illness. He also pointed out that smoking had a deleterious effect on mental health, and emphasized the importance of sporting activities in overcoming mental health problems. It was essential that the subject of mental health should remain on the agenda of future round tables.
Yugoslavia

Dr Kovac said that in the past 10 years the population of his country had experienced the traumas of war, sanctions, and consequent impoverishment. That had occurred at both family and community levels, and materially as well as spiritually, through the collapse of traditional social and cultural values, and the loss of hope. Mental health was impaired as never before. The incidence of classical mental disorders had increased, as had conditions such as post-traumatic stress syndrome, anxiety, neurosis, substance misuse and marked depressions with psychosomatic symptoms. Those were reactive pathologies to which people were not susceptible in normal conditions. The consequences were increased social pathologies, evidenced as greater delinquency, crime and violence. The presence of large numbers of refugees, with associated mental disorders, posed an additional problem. Children, many orphaned or living in collective centres, constituted the most vulnerable population. Some had experienced traumas at an early age.

The past 12 months had seen considerable improvement in mental health. The Ministry of Health and Social Policy was finalizing a multidisciplinary project to reduce and eliminate suffering and to facilitate treatment. The support of WHO in those efforts would be welcomed.

Zambia

Mr Mumba observed that mental health problems continued to have a considerable negative impact on his country's health status. While Zambia had done a great deal to upgrade the quality of mental health care in recent years, there had been a significant erosion of the human resource base, in particular, front-line mental health workers. Health infrastructures and equipment were in a deplorable state, and essential psychotropic drugs were only intermittently available. Zambia had established a post of mental health specialist, and some progress had been made. A mental health situation analysis had been undertaken; a draft bill had been submitted to the Ministry of Legal Affairs; mental health had been integrated into the essential health care package at community level, with the possibility of referrals; and mental health had been accorded its place among public health priorities. Zambia's participation in international forums and projects had led to the establishment of key links with a broad spectrum of mental health experts. As a member of the International Consortium for Mental Health Policy and Services of the Global Forum for Health Research, Zambia was pursuing ways of securing WHO support, and was participating in the WHO/UNDCP Global Initiative on Primary Prevention of Substance Abuse. At the local level, partnerships had been established with communities, giving them a central role in realizing improvements in mental health care. His Government was committed to developing a mental health policy, providing human resources for mental health, reviewing relevant legislation and upgrading health infrastructure and equipment. New international networks would also be developed that would benefit the local mental health programme. Zambia viewed the stigmatization and marginalization of people with mental health problems as an inappropriate legacy from the past. Mental health services were a crucial component of primary health care that would enable people to work productively and fruitfully. The inclusion of mental health in WHO's public health agenda underscored the commitment of governments to the development and improvement of national mental health services in line with relevant resolutions adopted by the World Health Assembly, the WHO Regional Committee for Africa, the United Nations General Assembly and UNDCP.

Zimbabwe

Dr Stamps said that, after achieving independence, his country had totally recast its Mental Health Act, so that it was currently dedicated to the needs of the patient rather than to the needs of society for protection. The Government had formulated its policy on mental illness, on the basis that psychiatric events were never due to a deliberate act on the part of the patient, so that all treatment, including the provision of drugs, was free. There was, however, a severe staffing problem. Nurses were being trained but, on qualifying, often went to more attractive posts abroad. The lack of trained staff meant that passive disorders were diagnosed a long time after the first symptoms appeared.
He drew attention to the increasing use of drugs in treating mental disorders, including the administration of stimulants and sedatives to children aged between two and four years.

The use of psychedelic substances to ensnare youth, for the purpose of commercial gain, was a matter of great concern. Although the worst problem was that of alcohol, dangerous drugs were readily available to young patrons of night clubs. The involvement of community leaders had been very effective in confronting such trends. He appealed to all to work together to bring about a more spiritual approach to living, in order to reduce temporary or permanent mental disability.
Report by the secretariat
This section contains a synthesis of the main issues raised by the Ministers during the four round tables.

**World health ministers call for action**

Ministers unanimously agreed that it is time to feature mental health on the world health agenda and to consider the huge burden of mental health problems as priorities for national action. The fact that countries have to face other health problems and that their health budgets are limited can no longer be deterrents to action. Mental health problems are significant contributors to the global disease burden, have huge economic and social costs, and cause human suffering. New developments persuasively indicate that cost-effective solutions are possible in all contexts. Many strategies, approaches and interventions have been identified and are being used in numerous small projects around the world. These need to be evaluated and the results disseminated widely to include them in national mental health programmes. The Ministers expressed their commitment to addressing the pressing mental health needs of their populations and called for international support and action.

**The current social context of mental health**

Ministers expressed the importance of contextualizing mental health since it is determined by a variety of challenges faced by their countries. Much of the world is facing rapid economic reforms and social change, including economic transitions that are linked to alarming rates of unemployment, family breakdown, personal insecurity and income inequality. Poverty remains a reality for much of the world, with women constituting a majority of those affected. Many countries experience political instability, social unrest and war. There are large populations of traumatized refugees and internally displaced persons who must be resettled, often in countries with limited resources to do so. The spread of HIV and AIDS has had a major social and economic impact on many countries, leaving large numbers of survivors in need of care and support. Women face great pressures with a range of gender-based disadvantages and huge numbers experience physical and sexual violence resulting in high rates of depression and anxiety disorders. Young people, particularly street children and those exposed to violence, are at high risk for substance misuse including alcohol. Indigenous people and other groups are undergoing social upheaval that is accompanied by climbing suicide rates. In many parts of the world, mental health systems are poorly funded and organized.

Taken together the above concerns cast a broad framework for discussing mental health problems since they are squarely placed at the heart of the social changes of our era. Ministers also brought up some of the more positive effects of change which include a steady increase in awareness, weakening of stigma, and the development of global approaches to mental health problems and prevention. They referred to the enthusiastic engagement of governments and communities alike in the celebrations of World Health Day 2001 dedicated to mental health.

**Overcoming stigma and human rights violations**

The ministers repeatedly made urgent calls for action to further reduce stigma, discrimination and the violations of rights of persons with mental illness since these affect the whole continuum of care. It was noted that the discrimination between coverage of mental and physical illness by health insurance schemas is fed by stigma. There is need to address the institutionalized stigmatization of persons with mental illness, a process exacerbated by the placement of psychiatric hospitals in far out places away from public scrutiny. Shifting mental health services to general hospitals and community clinics has helped in mainstreaming mental health problems; this must be pursued. Efficiency can be gained by recycling the infrastructure of mental hospitals to serve general health care purposes. Enforcing minimum standards in infrastructure, and in the provision of high quality care, coupled by the support of updated legislation, is a critical step in protecting the rights of persons with mental illness. Most importantly, addressing stigma amongst all health professions, including mental health workers, was considered necessary.
Since much of the stigma related to people with mental illness results from lack of information on the causes, the frequency and treatment possibilities, accurate information and education should be provided to politicians, decision makers, service providers, the general public and the media as a primary means to reduce stigma. The media can either reinforce or reduce stigma powerfully. It needs to be involved in campaigns designed to eradicate negative stereotypes and promote attitudinal change. The role of consumers, families and their organizations as well as visible role models in stigma reduction efforts was considered pivotal. Educational campaigns must be accompanied by the development and upgrading of services.

Sensitization on mental health issues, removing ignorance, superstitions and false traditional beliefs, requires multisectoral approaches and should include, among others, schools, criminal and judiciary systems, employment agencies, and housing and welfare systems.

## Improving mental health policies and services

### Shifting to community-based care and integrating mental health within Primary Health Care

Ministers discussed strategies to advance mental health care beyond the recognition that there must be parity between care for physical and mental disorders. There was agreement that mental health care should be intimately integrated into the general health care system. It was repeatedly noted that Primary Health Care (PHC) has a significant role to play in mental health services delivery, including in countries with highly specialised care. Integration into PHC is in line with the global movement in which many nations are engaged in the provision of mental health care shifting it from psychiatric hospitals to the community. For this shift to occur, budgets must be maintained or even increased; mental health teams, with multidisciplinary representation, must be developed; the needs of especially vulnerable groups must be met through supervised care; communities must have access to crisis centres for the management of acute conditions; and broad public support for community care must be secured. Shifting the location of care also facilitates collaboration with non-governmental organizations, social services, and other community agents, many of which are motivated to fill some of the service gaps.

### Treatment costs

Mental health treatments should be affordable for all those in need. Given that poverty is a risk factor for mental disorders, the principle of equitable treatment for the poor must be preserved. Concern was expressed that access to basic psychotropic drugs, especially in rural areas, was a crosscutting problem and that strategies to reduce costs should be considered by regions and by groups of countries, amongst them the bulk purchase of essential psychotropic drugs.

### Financing of care

Financing community-based mental health care is a challenge for all nations, especially the provision of comprehensive care to all those in need. Since mental health problems have intersectoral ramifications, it was suggested that financing of services should be intersectoral as well; ways to overcome the barriers in this regard ought to be devised.

### Human resources

Many ministers noted that the human resource base for mental health care is limited partly due to the brain drain. Therefore, attention has to be given to sustainable training programmes in mental health care at various levels of service provision. However, there are unsolved issues in this regard such as who should be trained and what should be the content of that training. Identifying categories of health workers who can be trained in the delivery of psychotropic drugs and psychosocial interventions with reasonable quality of care standards, is critical. Protecting mental health professionals working under adverse conditions was considered important to prevent the high rates of staff burnout. Special mention was made of the need to build capacity in research training in developing countries.
Traditional and faith healers

The reality in many countries is that traditional and faith healers provide much of the mental health care in communities because of traditional beliefs and because these practitioners outnumber those within formal health systems. There is a lack of adequate information on the practices of faith and traditional healers, and few programmes that articulate collaborative linkages between traditional and modern medicine systems. Research into these aspects is urgently needed along with inquiry into the effectiveness of traditional practices. In the meantime there is need to inform traditional healers and co-ordinate them with the general health care system through some form of regulation for consumer protection.

Consumer and family involvement

To help families in their role as primary care givers, they must have full access to systems of support including education and training. Consumers/users and their organizations can be most valuable in providing patient education, peer support and policy input.

Services for the special needs of women

All agreed that gender issues are pertinent in mental health care. Service provision has to take into account women’s health and mental health needs resulting from widespread discrimination. In particular, the mental health needs of victims of domestic and sexual violence requires special interventions. To properly address this problem, special training must be provided to health workers. The reduction of two frequent factors, alcohol and drugs, that facilitate violent behaviour among men, demands preventive interventions.

Country strategies

Ministers reported recent developments and approaches in mental health care in their countries. These included:

Decentralization of mental health services:
- Downsizing of mental hospitals and establishment of community mental health services including beds in general hospitals.
- Establishing proper funding for community services.

Integration of mental health care in primary health care:
- Training health care professionals and paraprofessional workers.
- Training traditional healers in mental health care.

Improvement of mental health services:
- Incorporating a gender approach in mental health policies.
- Using mobile mental health units to serve remote and rural areas.
- Integrating a mental health component in essential packages of care.
- Using telepsychiatry to train and consult with mental health workers in rural areas and where populations are dispersed.
- Monitoring quality of care and human rights violations.

Legal provisions for mental health care:
- Revising legal provisions for care of persons with mental illness.
- Decreasing stigma around persons with mental illness.
- Involving the mass media.
- Encouraging self-help, consumer/family groups, and NGOs in mental health advocacy.
- Replacing stigma-generating labels with stigma-free denominations.

Implementation of multisectoral approaches for mental health:
- Collaborating with education, employment, social welfare, and other sectors.
- Building partnership with private enterprises and labour unions.
Creating employment opportunities for women to empower them economically and reduce stress levels.

Integrating mental health programmes with violence prevention initiatives.

Meeting the needs of special groups

The following population groups were especially mentioned by many ministers since they require immediate mental health action in their countries:

Rural, remote and dispersed populations

The unmet needs and difficulties in providing adequate health services to rural and dispersed populations were noted.

Services for children and adolescents

A focus on the needs of children emerged. Attention to maternal nutrition, and the pre and post natal multiple needs of mothers and their infants is vital for the normal health and mental health development of children. School aged children constitute a group that is readily accessible for mental health services. School-based mental health activities serve to promote mental health, channel preventive interventions, and educate on the understanding of mental disorders and those affected by them. Bringing health care workers into schools also provides an opportunity for early detection and treatment of childhood and adolescent psychiatric disturbances that often remain undiagnosed. Additionally, children and adolescents are at high risk for substance misuse and suicidal behaviour for which sustained prevention and education are needed. Addressing the special needs of street children and those orphaned by AIDS was considered critical.

Refugees, displaced, indigenous and disaster-stricken populations

Wars, disasters and displacement have left huge population groups with serious mental health problems which countries are unable to address because of limited resources and untrained staff.

Social and economic change is having destructive impact on the mental health of indigenous populations which countries acknowledge but are unable to fully address.

Areas for WHO support and collaboration

Ministers identified ways in which WHO could provide technical support to countries at global, regional and country levels.

At the global level, WHO should:

- Continue global awareness-raising and advocacy campaigns.
- Provide gender disaggregated estimates of incidence and prevalence rates, and on the burden of mental disorders.
- Carry out studies on the determinants of mental health problems and the factors that influence mental health outcomes, including spiritual support systems.
- Promote and support programme evaluation.
- Produce information (particularly for politicians and decision makers) on the burden, determinants and solutions to mental health problems.
- Update guidelines and materials for prevention, treatment and care of mental disorders.
- Include more psychotropic drugs in the essential drug list and devise strategies to ensure the continuous supply of these essential drugs at affordable prices.
- Establish regional and global networks.
- Mobilize funding support for mental health programmes.

At the national level, WHO should:

- Support the development of national databases on mental disorders that can inform policy and service development.
- Provide materials and guidelines for community education, awareness raising, and anti-stigma campaigns.
Collaborate with countries in the implementation of programmes to repair the psychological damage of war and conflict.

Provide technical expertise for capacity building in research and evaluation.

Assist in the formulation of mental health policy and plans, and training of different cadres of health professionals in mental health care.

Ensure supply of essential psychotropic drugs.

Assist in addressing harmful traditional practices.

Assist in mobilizing resources for national programmes.
Speech to the plenary

A new beginning

Senator the Hon. Phillip C. Goddard
Minister of Health
Barbados
Mr. President, Director-General, colleague Ministers, ladies and gentlemen, I have the honour and pleasure to share with you the salient points of the Ministerial Round Tables on Mental Health that were held on Tuesday, May 15th.

First let me say that Ministers spoke with great unanimity on the importance of mental health to health and human development and the relative under investment in this area of health services. In the words of one of our peers, “for too long we hid this subject”. Another said “our concern for infectious diseases should not deter us from dealing with mental health problems”. Yet another stated, “we must find a share for mental health out of our limited budgets”.

Given this response, it is not surprising that all Ministers expressed appreciation to the World Health Organization for placing this subject on the world health agenda. The overriding theme that emerged from the discussions was that mental health affected all spheres of human endeavour and that there is no health without mental health.

Ministers agreed that raising the level of awareness was the first priority. Policy makers in government and civil society need to be sensitized about the huge and complex nature of the economic burden of mental illness and the need for more resources to treat mental illness. To quote another Minister, we must “dispel the unjustified pessimism about the treatment of mental disorders”. Indeed, it was recognized that new technologies were available that are based on scientific evidence. Many of these are within the affordable range of most countries today.

We must also recognize the reinforcing loop between poverty and mental disorders. While poverty is often a powerful determinant of mental disorders, it is equally true that mental disorders could deepen poverty. Many families without support could fall into the abyss of poverty from which it would be difficult or impossible to extricate themselves.

Ministers agreed that the stigma associated with mental illness was a severe stumbling block because, among many other reasons, it prevented people from seeking help. Health professionals are not immune from the impact of stigma, which they need to overcome to effectively manage the care of their patients. Stigma can also have an insidious effect on health policy, such as health insurers denying parity for the care of mental disorders. An understanding of mental health has to start early in life, and one Minister commented on the need for mental health to be placed in the schools’ curricula to help change attitudes.

Ministers discussed the need to move mental health care from outdated centralized institutions to community-based alternatives. “For too long, mental health institutions were placed in remote locations, out of site and out of mind” said one Minister, “they need to be brought back into population centres”. Furthermore, he noted “services located in general hospitals and clinics do not bear the stigma of the old mental hospitals”.

Of course this transference of care into the community requires new structures and the appropriate training of mental health care providers. It was recognized that evidence-based interventions in the community require proper knowledge and new skills. This massive effort, that entails the engagement of primary health workers to deliver mental health care, poses a challenge for which Ministers would like to have the support of the World Health Organization, particularly in training rural health care providers.

There was general agreement that the steady supply of psychotropic drugs was of fundamental importance if proper care is to be provided. Many ideas were floated in this regard; one of them was joint purchase of drugs by regional entities to reduce the cost to individual countries. It was also recognized that in many countries, faith and traditional healers outnumbered mental health workers, and treated large segments of the population. Not much was known about their effectiveness, however, and particularly so where traditional and modern methods of treatment coexist. The World Health Organization was asked to devise methodologies to study these phenomena and to assist in conducting the necessary research. Another area mentioned in this context were studies to provide national epidemiological data and evaluation of services including customer satisfaction.

Ministers from war torn countries and regions raised the need to involve the World Health Organization in restoring the mental health of
traumatized populations. Strategies and techniques to deal with large numbers of displaced victims of violence are needed along with the assistance to implement the appropriate remedial actions.

Sadly, violence afflicts those countries at peace as well. It was recognized that there was an alarming increase in violence against women in many countries. Ministers often mentioned that domestic violence should be considered an epidemic that ought to be eradicated. In addition to the physical damage and injury caused by domestic violence, there was also a significant impact on mental health that was often more damaging and long-lasting than the physical injuries. This was evident in the high rate of depression and anxiety disorders among women. Ministers wanted to better understand the gender-based mental health issues. They were all agreed that there was a need for short-term and long-term strategies to curtail violence against women, their families, the fabric of the communities and ultimately their nations.

The Round Table discussions were at times lively and informative. They generated much interest. A complete report of the issues highlighted during the course of the discussions is contained in the report which I invite you to take back with you.

Finally, I conclude by saying that Ministers share the universal concern of listening to people, and commit to strengthening the pivotal role the patients and families play in the treatment of mental illness. I would further remind you of the powerful presentation in the opening Plenary session made by a mother who related her real life experience of living with her son as she struggled to cope with the effects of his schizophrenia. We walked with her as she described his trauma and his slow recovery. We rejoiced with her as together they began the process of recovery and the joy of his first job.

Madame, I am sure that I can now say on behalf of us, your message has been heard.
Regional statements

Renewing commitment to mental health
The mental health situation in Africa is a very serious one indeed. It is recognized that poverty, civil strife, armed conflict, alcohol and drug abuse, among others, stand out as the main causes of mental problems which are a major concern of a number of countries in our Region. Needless to say, the HIV/AIDS pandemic is worsening the situation, adding considerably to the already existing psychosocial problems and creating unprecedented need for support, counselling and care for those affected.

In Africa, political turmoil deserves special mention as a causative factor of mental problems. As we observe World Health Day today, more than 20 of the 46 countries in our Region are experiencing one form of civil disturbance or other. This has created at least 10 million refugees and more than 30 million internally displaced persons. All these people, especially women, children and the elderly among them, are invariably severely stressed physically, psychologically and emotionally.

Also in Africa, as elsewhere, mental problems remain a hidden burden. Consider some of the economic and social costs: lost production from premature deaths (e.g. suicide); lost productivity of the mentally ill who are unemployed, underemployed or unemployable; lost productivity of family members providing care; the cost of accidents by people who are psychologically disturbed; direct and indirect costs for families caring for the mentally ill. If we add to these the in calculable emotional burden and the diminished quality of life for family members of people with mental illness, the magnitude of the problem becomes easier to appreciate.

In most countries of the African Region, mental health programmes are limited to curative health care of poor quality, usually provided in decrepit hospitals located far away from residential areas. These conditions create a serious problem of access to and acceptability of the treatment.

Hence, dropout rates are very high, and follow-up treatment as an outpatient is seriously hampered. In those countries where some services are provided, these are mainly for adults with major psychiatric disorders, the needs of children not being catered for.

Also, the pervasive effect of social exclusion resulting from stigma and discrimination prevents people from acknowledging their mental health problems, disclosing them to others and seeking treatment.

This situation is not helped by weak or total absence of policies, programmes and legislation to deal with the problem in many of our countries.

For example, a recent survey in the 46 countries of our Region indicates that only half of them have mental health and substance abuse policies.

Although 74% and 71% respectively of the countries have mental health programmes and legislations, these were developed relatively recently – only in the last five years. Some of the most distressing statistics emerging from the survey relate to financing: 84% of the countries spend less that 1% of their total health budget (usually 10% or less of the national budget) on mental health.

However, on the positive side, the report indicates the existence of drug policies and updated lists of essential drugs in 93% of the countries; 64% of the countries also have included drugs for the treatment of conditions like epilepsy, depression and major disorders like psychosis. Unfortunately, most people who need these drugs cannot afford them because the costs are prohibitive. The situation is particularly serious in rural Africa where antidepressants, anticonvulsants and antipsychotic drugs are rarely available. In relation to the issue of access, it is pertinent for countries to make overall treatment for mental illness available to the general population. Therefore, mental health needs to be integrated into general health, especially primary health care.

All these show very clearly that our countries need to rank mental health higher on their scale of health priorities by providing the necessary funding as well as appropriate policy and legal frameworks to deal with the problem.

We therefore appeal to individuals, families, communities and Governments to use this year to
rededicate themselves to raising the profile of mental health, and to creating a solid basis for changing the present scenario regarding mental health in our Region.

A real beginning was made in Windhoek in 1999 when our Health Ministers adopted the Regional Strategy for Mental Health.

This Strategy serves as a tool to be used by Member States to identify priorities and develop and implement programmes at various levels of the health system, with particular emphasis on action at the district and community levels.

The aim of the strategy for mental health and the prevention and control of substance abuse is to help prevent and control mental, neurological and psychosocial disorders, thus contributing to the improvement of the quality of life of the populations. This can be achieved through the formulation and strengthening of national mental health policies and the development and implementation of programmes in all the Member States in the African Region.

While adopting and implementing the regional strategy, all Member States should integrate mental health and the prevention of substance abuse into their national health services. This will lead to:

- a reduction in the incidence and prevalence of specific mental and neurological disorders (epilepsy, depression, mental retardation and psychosocial disorders due to man-made disasters) and other prevalent conditions;
- equitable access to cost-effective mental, neurological and psychosocial care;
- progress in the adoption of healthy lifestyles; and
- improvement in the quality of life.

Today, thanks to advances in science and medicine, mental disorders can be correctly diagnosed and treated with medications or short-term therapy or a combination of approaches.

It is therefore the collective responsibility of all, particularly Governments, to take appropriate measures to increase access to care; to improve public awareness of effective treatments; to popularize the use of effective community-based services; to ensure the existence of conducive socioeconomic environments for our people to live in, and to factor mental health into general health programmes.

We, at WHO, pledge to continue to respond to these challenges by assisting Member States to develop evidence-based policies and effective strategies that will help our populations achieve the highest possible state of health.

**Stop exclusion. Dare to care.**

This is the ultimate challenge!

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**Regional Office for the Americas**

**Dr George Alleyne**
Regional Director

**Dr Caldas de Almeida**
Coordinator, Program on Mental Health

The Pan American Health Organization, WHO’s Regional Office for the Americas (PAHO/WHO) and the countries of the Americas have been working together for decades to promote mental health and improve mental health care in the Region.

These efforts have led to significant advances, particularly following the 1990 Caracas Declaration. These advances include the establishment of national mental health policies, plans, and legislation in several countries; the development of innovative experiences of community mental health services; and the promotion of specific programs for the treatment of the most prevalent disorders.

Although these advances represent important milestones, we recognize that much more must be done in order for mental health to recover from the historical neglect to which it has been subjected worldwide, and to meet the mental health needs of all populations in the Americas. Many problems remain.

For example, in the last few years spectacular progress has been made toward understanding mental health problems, as well as toward the development of new and more effective treatments. Yet, despite the availability of effective treatments for most mental disorders, millions of people suffering from depression, schizophrenia, epilepsy, and other disorders with devastating con-
sequences still do not have access to these treatments.

Similarly, although comprehensive community services have proven more cost effective than the older centralized models, and are preferred by patients and families, in most places mental health care continues to be centered in old institutions separated from the general health system and the community.

The recognition of these realities, together with recent data showing the true magnitude of the impact of mental disorders, has led to an increased awareness of the need to mobilize all of civil society, including policy makers, professionals, users, families, and NGOs, to change the situation.

WHO initiatives and events dedicated to mental health in 2001 have begun this urgently needed process of mobilization at the global level and have already elevated mental health on the global political agenda.

PAHO/WHO, and the countries of the Americas, have collaborated enthusiastically in these initiatives and, taking advantage of the unique opportunity created in 2001 by the World Health Day, the World Health Assembly, and the World Health Report, are strongly committed to reinforcing technical cooperation in mental health.

Based on an evaluation of the current situation, the following objectives have been defined for priority attention in the Region:

- implementing national mental health policies and plans ensuring: (a) the restructuring of mental health services, leading to the development of comprehensive community-based services and integrating all necessary facilities and programs to meet the different needs of the populations; (b) the provision of essential treatments for the most prevalent mental disorders, in particular depression; c) the development of preventive and health promotion interventions;

- creating/revising mental health legislation integrating the key elements of mental health policy, and providing basic guidance to protect the rights of people with mental health problems;

- reducing inequity and addressing issues of parity to ensure that: (a) disadvantaged populations, refugees, and victims of disasters have access to services that meet their specific needs; b) parity of mental health services with other types of services is achieved;

- promoting mental health training for health professionals;

- improving monitoring and evaluation of the implementation of mental health plans; and

- increasing the participation of users and families in mental health care.

To attain these objectives, the following actions are specifically being emphasized in technical cooperation with countries:

- collection and dissemination of information on mental health;

- development of country capacities to plan, manage and evaluate mental health services; and,

- dissemination of guidelines on cost-effective interventions and development of innovative experiences.

The establishment of partnerships in the areas of training, research and policy development is also a key element of the defined strategy. The conference “Mental Health in the Americas: Partnering for Progress”, planned for November 2001, will seek to promote these partnerships, taking advantage of the momentum created by WHO initiatives.
The selection of mental health as the theme of the year 2001 is a reflection and recognition of the increasing importance of the role mental health plays in the everyday life of human beings. We would like to take this opportunity to dispel a common misconception that mental health is restricted to the treatment of mentally ill persons. Mental health is concerned with all aspects of our daily life, be they emotional, intellectual or behavioural. The quality of relationships we develop and maintain with fellow human beings, our familial bonds, the nurturing milieu we provide for our children to develop their potential, societies where individual members are respected and cared for, civil societies tolerant of dissent, are all dependent on mental health. Mental health thus encompasses, and interacts with, cultural life, traditions, religious aspirations and spiritual life of a population.

The countries of the Eastern Mediterranean Region of WHO are blessed with the existence of strong family ties, cohesive social institutions and the presence of spiritual and religious beliefs having the potential to positively affect the mental health of the population. However, the Region also faces a number of issues which can adversely affect mental health. Our population is very young and is faced with uncertainties about its future. Young people receive many conflicting cultural messages requiring reconciliation of traditions with the new trends, causing insurmountable stress in many instances. Waves of migration and unplanned urbanization, bringing in their wake poverty and loss of social capital, are placing heavy stress not only on the infrastructure but on the coping abilities of individuals as well. A number of countries of the Region face war, occupation, sanctions and internal conflicts, and millions of refugees in different parts of the Region are straining the social fabric of the societies they live in as well as facing the burden of nonassimilation in an alien culture.

There are also existing and emerging issues of the elderly, women and children, who are “doubly vulnerable” to develop mental health problems.

As far as diseases are concerned, the Region is particularly faced with issues of depression, epilepsy, management of the chronically ill and suicide, the incidence of which is on the rise in many parts of the Region. Substance abuse is a major mental health and development problem in the Region with grave public health consequences such as increasing the risk of HIV and other blood-borne infections.

In the past 15 years, the countries of the Eastern Mediterranean Region have adopted national programmes of mental health as a method of meeting the needs of the population. The main strategic approach of all these programmes is integration of mental health within the existing health systems, including primary health care. Accordingly, the objective of the almost all of the national programmes of mental health that are developed in collaboration between WHO and Member States is to develop proper systems for the realization of such integration. Such programmes that have specifically been put to experience in the countries of the Eastern Mediterranean Region of WHO during the last decade have been blessed by a number of opportunities and struggled with a number of constraints. Thus, the future success and/or failure of such programmes would depend on the correct understanding of these opportunities and constraints and on finding ways to deal with them.

In some countries, such as Bahrain, Cyprus, Islamic Republic of Iran, Pakistan, Saudi Arabia and Tunisia, mental health needs are addressed through integration of mental health into existing general health systems in more than one area of the country or on a nationwide basis. Other countries, such as Egypt, Jordan and the Republic of Yemen, have well sustained projects of integration of mental health in some areas. There are good examples of school mental health programmes in Egypt, Islamic Republic of Iran, Pakistan and Tunisia. Pakistan and Tunisia have also modernized their legislation.

Sudan has worked on both modernizing the mental health programme and utilizing the traditional healers. Cyprus, Lebanon and Morocco are examples of effective use of NGOs. In Afghanistan a three-month diploma course was coordinated by
WHO/EMRO in collaboration with the two neighbouring countries of Islamic Republic of Iran and Pakistan. This model has been recently used to train a new group, this time using the trainers trained, in a move towards self-sufficiency. The experience of Afghanistan can be utilized for countries with similar conditions.

At the regional level, the Region held a major advocacy event for mental health connected with the Region’s ministers of health or their representatives, and signed a declaration in support of mental health during the Regional Committee of 1997 in Teheran, Islamic Republic of Iran. As a follow-up to this event, a 10-item programme for development of mental health was proposed and Member States asked to choose from among a number of activities and start implementation in their respective countries.

As we enter the new millennium, developing countries face a number of burning issues and challenges that affect all aspects of health, including mental health. Population explosion, unplanned urbanization, scarcity of human resources, reliable data and systematic approach to health delivery and referral and a number of cultural issues are among these. On the other hand, it is fair to say that since the middle of this century the general attitude towards mental health has been changing in both developing and developed countries. Reasons for this change include the coincidence of many factors like scientific and technological advancements and socioeconomic changes. The introduction of a more accurate and holistic definition of mental health, new scientific discoveries regarding the etiology and treatment of mental illnesses and their treatment, and the possibility of returning a considerable number of patients to their homes and the community are among these factors. One of the major by-products of these developments is the introduction of much better coordination between the general and mental health services. Integration of mental health within primary health care systems is a major product of this coordination.

Let us conclude by pledging to continue to develop mental health in the Region and collaborate with Member States to provide the minimum necessary mental health care for all. Let us also note that at this stage of the development we need to realistically assess our programmes and determine what challenges we face, what assets and opportunities we have and what constraints are ahead of us. Only through such a comprehensive approach and true understanding of the real needs and specifications of each country and community can we develop the capacity to provide an acceptable level of mental health for our people.
Studies have shown that in Western Europe one in four persons needs psychiatric treatment during their life-time, in some countries, this figure is one in three. Among adolescents, about 15-20% have mental problems. However, mental problems are not necessarily accurately reflected in the number of health service contacts since most of those requiring mental health care do not use the services.

As in other WHO regions, many European countries spend less than 3% of their health budgets on mental health care, although mental ill health can easily amount to one third to a half of all health care costs.

**Mental health services development and obstacles for implementation**

More than 50% of all patients in some Eastern European countries continue to be treated in large mental hospitals. Stigma and discrimination with regard to mental illness makes early intervention extremely difficult, especially in rural areas. However, there is consensus among most Member States on the need to shift from psychiatric hospitals to community-based services and on the involvement of personnel in mental health care.

Obstacles in Europe are often found in outdated legislation concerning the rights of doctors and patients and in the lack of or limited insurance coverage for outpatient care. Also, the transfer of inpatient services to outpatient settings has proved to be complex especially from the stand point of financing.

Sizable minorities in European countries are affected by poverty and deprivation creating large numbers of people with increased vulnerabilities to mental and behavioural disorders. Since it is not only the degree of poverty but the increasing gap between the richest and poorest in society which act as powerful determinants, many people are at risk of mental problems in the unequal societies in Europe. Overcoming poverty might contribute to improve mental health but it will not be enough; a more equitable distribution of wealth remains a challenge for all countries.

**Stigmatization and human rights violations**

In some countries positive changes have been made over the years to reduce stigmatization and human rights' violations of people with mental illness including legislative reforms. Such reforms take into account the right to freedom and autonomy as well as the right to health and treatment. These efforts have been potentiated by the extensive celebrations of World Health Day 2001 throughout Europe. Mass media initiatives aimed at raising awareness and improving the quality and quantity of information on mental health issues have intensified everywhere and it is expected that the momentum generated will be sustained over the next years.

**WHO/EURO response**

In order to address the finding that about 40% of European Member States have no government-sanctioned national mental health plan, WHO/EURO is assisting many of its Member States to establish or strengthen their national mental health plans. The regional office is actively pursuing technical collaboration activities with member states to reduce premature mortality in countries undergoing rapid transitions and those facing conflicts, address and eradicate stigma and human rights violations, control the rise in depression and suicides, and, buffer the effect of gender disparities in mental health. An area of special focus is to assist countries in pursuing psychiatric reforms through the establishment of community-based mental health services and the utilization of the primary care system with the active involvement of consumers and families.

Mechanisms for collecting reliable country information, promoting and carrying out research and establishing programmatic guidelines on various aspects of mental health have included the setting up specific Task Forces such as the ones on Premature Mortality, National Assessments and Mental Health Audits and Destigmatization. The work of these Task Forces will help to assess the situation in countries, identify the key determinants of mental problems in various population groups and assess their impact, analyse the obstacles to service improvement, design appropriate interventions and strategies and monitor the implemen-
tation and follow-up of national programmes on mental health. Another objective of the Task Forces is to evaluate different models of interventions for promotion, prevention and care and to disseminate evidence-based information on successful strategies and approaches to Member States.

An example is provided by the heavy toll of mental health problems associated with violence, alcohol addiction and suicide in men. WHO/EURO is documenting this trend and designing appropriate intervention strategies based on different models. Also being investigated are the factors that protect females in times of change and transition and which lead to better coping by women. The ability of women to engage in social networking to keep a sense of control of their lives and to ask for help in time of need may provide a useful resource model for men.

Similarly, research generated in Western European countries is being used to assist East European countries to understand the complex socio-psychological processes currently being experienced by their populations. Promoting the practices of maintaining strong family ties, cohesive networks of families and friends, and spiritual and religious beliefs will hopefully protect some of the socially distressed societies from major mental health problems. EURO will continue to promote bilateral and multilateral collaboration including exchange of experience between Eastern and Western European countries in a mutually respectful way.

A European Ministerial meeting will be convened in the near future to provide further direction and guidance to EURO’s mental health programme and to reach consensus on its broad strategic directions.

Regional Office for South-East Asia

Dr Uton Muchtar Rafei
Regional Director

Dr Vijay Chandra
Regional Adviser for Mental Health

Populations of Member Countries of the World Health Organization’s South-East Asia Region have suffered for ages from many communicable diseases. Some have been successfully controlled, while others continue to be serious public health problems. However, it is now increasingly clear that noncommunicable diseases, including mental and neurological disorders, also cause untold suffering and death in the Region. Worldwide, an estimated 450 million people suffer from mental and neurological disorders or from psychosocial problems related to alcohol and drug abuse. Our Region accounts for a substantial proportion of such people. Thus, the Region faces the double burden of disease—both communicable and noncommunicable. Moreover, with the population increasing in number and age, Member Countries will be burdened with an ever-growing number of patients with mental and neurological disorders. As stated by Dr Gro Harlem Brundtland, the Director-General of WHO, “Many of them suffer silently, and beyond the suffering and beyond the absence of care lie the frontiers of stigma, shame, exclusion and, more often than we care to know, death.”

In SEAR Member Countries, mental health programmes have generally concentrated on hospital-based psychiatry. However, there is increasing awareness in these countries of the need to shift the emphasis to community-based mental health programmes. The WHO Regional Office for South-East Asia is concentrating on supporting Member Countries to develop community-based mental health programmes and also programmes for prevention of harm from alcohol and substances of abuse. The programmes will be gender-appropriate and culture-sensitive and reach out to all segments of the population, including marginalized groups.

There are many barriers to the implementation of community mental health projects and pro-
While some countries have developed mental health policies, there has not been adequate implementation. Governments urgently need to be sensitized on the importance of mental health and on clearly defining the goals and objectives for community-based mental health programmes. Mental health services should be integrated into the overall primary health care system. At the same time, innovative community-based programmes need to be developed and research into relevant issues and traditional practices promoted.

Communities have to be educated and informed about mental and neurological illnesses to remove the numerous myths and misconceptions about these conditions. But most important, the stigma and discrimination associated with mental illness must be removed.

The Regional Office is developing strategies for community-based programmes based on five “A”s: Availability, Acceptability, Accessibility, Affordable medications and Assessment.

**Availability**

Services to address at least the minimum needs of populations in mental and neurological disorders should be available to everyone regardless of where they live. The key questions are: what are the minimum services needed and who will deliver them?

**Acceptability**

Large segments of populations in the countries continue to perpetuate superstitions and false beliefs about mental and neurological illnesses. Many believe that these illnesses are due to “evil spirits”. Thus, even if appropriate medical services are made available, they would rather go to sorcerers and faith-healers. Populations need to be informed and educated about the nature of neuropsychiatric illnesses.

**Accessibility**

Services should be available to the community, and at a time convenient to them. If a worker has to give up his daily wages, and travel a substantial distance to see a medical professional who is only available for a few hours a day, he/she is unlikely to seek these services.

**Affordable medications**

Frequently, medications are beyond the reach of the poor. Every effort should be made to ensure an uninterrupted provision of essential medications, at a reasonable cost. Thus, government policies in terms of pricing and the role of the pharmaceutical industry in distribution and pricing become critical.

**Assessment**

Being new, these programmes need to be continuously assessed to ensure appropriateness and cost-effectiveness. Changes in the ongoing programmes based on impartial evaluations are essential.

Mental health care, unlike many other areas of health, does not generally demand costly technology. Rather, it requires the sensitive deployment of personnel who have been properly trained in the identification of illnesses, use of relatively inexpensive drugs and psychological support skills on an outpatient basis. What is needed, above all, is for everyone concerned to work closely together to address the multifaceted challenges of mental health.
Mental health is the foundation of all health. Scientific evidence and research today underscore the inseparable links between mental and physical health. But while physical health has improved in the Western Pacific Region, mental health has declined over the last 50 years.

Social and economic factors have had a significant negative effect on the level of mental health. Mental and neurological disorders include common disorders such as depression, anxiety, and substance abuse and dependence; less common but disabling conditions such as schizophrenia; epilepsy and dementia; and intellectual disability. Suicide is an important problem closely linked to mental health.

According to some estimates, the burden of mental disorders is higher in the Western Pacific Region than in some other parts of the world. In the relatively affluent countries of the Region, mental disorders accounted for 27% of the disease burden in 1999, and in the other countries the figure was 15%.

The obstacles to improving mental health range from poverty, family disruption, uncontrolled urbanization, disasters and armed conflict, and problems resulting from the situation of refugees and displaced persons, to community attitudes and knowledge, insufficient attention to healthy policies, low priority for services, and outmoded and inadequate service provision aggravated by weak links to community resources.

In the Western Pacific Region, two key strategic directions are proposed to improve mental health. First, the application of the public health approach to mental health promotion and the prevention and treatment of illness. This includes intersectoral approaches to mental health promotion (including legislation, policy and workforce training), gathering and disseminating the evidence of the effect on mental health of decisions in these areas, more specifically, prevention of disorders among groups at high risk (such as those with harmful use of alcohol and new mothers with a history of depression), and organization of acceptable, accessible and effective health services.

Second, the integration of mental health services into general health services and the wider community. Integrated services of a good standard will provide for (a) early recognition and treatment of mental health problems and mental disorders, and (b) continuity of care close to home, family and employment for those with persisting disabilities.

Providing quality service will require improving community awareness and reducing the stigma and discrimination affecting those with mental disorders and their families; easy and quick access to treatment and care; improved provision and organization of mental health services; appropriate legal protection; workforce training in mental health skills; service standards and accreditation; inclusion of support for consumers and families, self-help and advocacy associations in treatment and planning; a culture of service and programme research and evaluation; and attention to the psychosocial aspects of health care.

It is recognized that to improve mental health and address the challenges posed by mental disorders, WHO/WPRO and its partners will need to take concerted action. Action is needed at several levels – awareness, policy and intervention – and in developed and developing countries alike. WPRO will, therefore, work with countries and other partners to:

- analyse the situation and develop policies and programmes that reflect emerging perspectives in mental health;
- develop the technology needed for prevention, treatment and rehabilitation programmes;
- integrate mental health care into general health care;
- reorient services from hospital-based to community mental health care;
- develop a culture of research and evaluation; and
- include mental health in health promotion programmes.

WHO/WPRO is committed to using the framework of an agreed mental health strategy to work with Member States and other partners to translate these elements into action.
Epilogue

WHO’s response to the Ministers call for action

Benedetto Saraceno
Director
Department of Mental Health and Substance Dependence
World Health Organization
Geneva
It is with a deep sense of satisfaction that we are witnessing the emergence of a phenomenal movement for improving mental health at international and national levels. This movement is the result of a series of events that unfolded progressively throughout 2001 in WHO and countries around the world. Never before did Mental Health receive such central focus during a single year, nor was there ever before a stronger sense of solidarity and mobilization of people around this critical health concern. Non-governmental organizations, private sector entities, academics, professional groups, and the media have expressed eagerness to team up with governments and civil society to increase access and means of addressing the mental health needs of all people.

Key amongst the recent events that have led to this global response for mental health is undoubtedly the consensus reached by more than one hundred Ministers of Health on the need to prioritize the mental health needs of their populations since this was threatening the wellbeing of large segments of their populations and compromising the socioeconomic development of their nations. They made clear their beliefs by stating that the round tables on the theme of mental health were “long over due” and “historic” because “for too long we hid the subject”, and that “our concern for infectious diseases should not deter us from dealing with mental health problems... ...we must find a share for mental health out of our limited budgets”. This new political commitment provides an important platform for scaling up action in mental health.

The reasons that have propelled WHO to bring mental health into the limelight are multiple and well described in the different sections of this book. On the one hand there is the alarming epidemiological burden and projected increases in incidence and prevalence of mental, neurological and behavioural disorders, the vast treatment gap and, the epidemic stigmatization and human rights violations of people with mental problems. On the other hand, there is the solid scientific evidence that provides us with strong basis for action. Psychotropic drugs with less adverse side effects are now available to treat different crippling disorders, such as schizophrenia and depression. The mechanisms of their action are better known and indications for their proper use have been systematized and made available for specialized and non-specialized medical personnel. Psychological interventions for depression have been researched and their success rates documented. The effect of modifying the family environment to reduce negative outcomes in some disorders such as schizophrenia, have been carefully tested. We have also made huge advances in identifying the best channels for delivering these treatments to people in the context of the primary health care and as close as possible to communities where people live.

Indeed, evidence is replacing ideology or tradition and all this new information is persuading many that the practice of mental health care can now have a scientific anchor. But progress in actually making the shift from knowledge to action is slow and uneven in countries. Recent surveys carried out by WHO Department of Mental Health show that no more than one third of persons with schizophrenia receive any treatment. It is likely the treatment gap is much higher since the basis for the calculations world-wide were studies carried out in countries where mental health care was more readily available. The case of epilepsy also illustrates well the treatment gap. Between 60 to 90% of treatable patients with epilepsy receive no care, 5% or less of people who have depressive disorders have access to treatment in resource poor countries. Moreover, even when treatments are accessible, people do not seek care for long periods of time because of the fear of being stigmatized by health workers, community and society at large. And, the prevalence rate of mental disorders cannot be reduced without reduction in the treatment lag.

These facts beg an appropriate response by governments. The reorientation of services, the use of available technologies and the promotion of healthy public policies can make a difference. It was time therefore for WHO to stimulate and catalyse a collective response for mental health action by taking the evidence to the international community, governments and the public. This is what we tried to achieve through the messages of the World Health Day (7th April) which reached all sectors of society.

This is also what we tried to achieve through the Ministerial Round Tables in the World Health Assembly this year by arousing the interest and motivation of health ministers to place mental health...
squarely on the health and development agendas of their countries. The results of the Assembly Round Tables have been very encouraging. 132 Ministers of Health from all parts of the world came together and collectively expressed their political commitment for addressing people's needs in this area. They highlighted their strengths as well as their shortfalls in so doing during their discussions. They also made a strong call for international support specifying WHO's intensified technical support in priority areas. Based on these requests, we are proposing a global mental health strategy to ensure that WHO at headquarters, regional and country levels can assist countries effectively in achieving their national mental health goals.

The strategy consists of the following four pillars:

1. generating information and disseminating it widely;
2. supporting countries in developing their policies, programmes and services;
3. promoting research and building national research capacity;
4. strengthening advocacy and protection of human rights.

The first pillar addresses two essential elements: one which aims at increasing significantly the quantity and quality of information available to policymakers and service providers on the science and programme experience related to mental health care, promotion and prevention. We believe that even if a small fraction of what is known can be made available to those who plan and provide services, it will have a large impact. The second arm addresses the existence of tremendous gaps in knowledge about the state of mental health in countries as well as lack of information on countries' capacity to address the factors affecting mental health. Intensified support to countries will need to be provided for building national information systems for the collection of reliable data relating to mental health systems and their monitoring, the evaluation of service delivery, and the collection of basic epidemiological information. Particular attention will be given to ensure these efforts are compatible with and linked to broader health sector information systems.

The second pillar of the strategy will redress the current situation in which 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. Providing a comprehensive package of support to countries to develop capacity for policy and service development in prevention, treatment and surveillance of mental disorders is therefore a much-needed activity. The development of the package would be accompanied by technical assistance to countries, upon their request, for planning and financing of comprehensive mental health systems. Essential elements will include legislation, service planning especially the integration of mental health into the larger public health system, human resource development, services for especially vulnerable populations such as women, children, elders, refugees, adolescents and those with chronic physical illnesses and/or disabilities, and quality of care.

The third pillar of the strategy addresses research and country support for building research capacity. The impetus for considering research one of the four pillars of our strategy is driven by the understanding that there is currently very limited research capacity in most countries and a serious lack of trained researchers, especially in low and middle income countries. Yet this is a critical and essential element of health system development. Most current research on mental health is conducted in a few wealthy countries and we know that the relevance and transferability of findings from wealthy countries to poorer countries remains questionable. This is a serious contributing factor to the lack of locally relevant and evidence-based mental health policies and practices based on operational research findings. Encouraging and supporting countries to build the necessary infrastructure to sustain research capability, in particular applied research, is essential for improved efficiency and effectiveness of services as well as for extending knowledge about the causes, preventive measures, and the possibilities of treatments.

The fourth pillar pertains to the critical role of sustaining advocacy for mental health at the international, regional and national levels. Through the use of partnership relationships with governments, NGOs and community groups, countries will be
supported in developing their important advocacy sector in order to position mental health on the public agenda, to promote a greater understanding and acceptance of those affected by mental illness, to promote legislation for the protection of the human rights of people with mental illness, to reduce the pervasive effects of social exclusion resulting from stigma and discrimination and the out-dated nature of many mental institutions. Less exclusion, less discrimination will help those afflicted and their families to lead better and more productive lives and encourage those in need to seek treatment.

The systematic process of awareness raising and advocacy launched through the World Health Day campaign “Stop exclusion. Dare to care”, will continue to provide the platform for generating enthusiasm, inspiring people to represent the needs of families and consumers in policy, legislation and service delivery; and ensuring that the response of the mental health system matches the real needs of people with mental illness.

While beneficial results of this strategy are already evident, we expect much more substantial impact within the next three to five years. In order to better assess the impact of these activities, a systematic and in-built mechanism of evaluation is being put in place. We believe that we can optimally target our limited resources only through a continuous evaluation of the results of what we do, whether the area is research, policy/programme/service development or advocacy. The same applies for countries.

In conclusion, WHO wishes to pay tribute to the Ministers of Health who iterated a strong call for mental health action during the World Health Assembly of 2001. In aligning our strategic directions with their expressed concerns and priorities, we want to ensure that our vision and goals are collective and that they follow pathways that are realistic as well as achievable. We appeal to all who share this vision to join us in improving access and quality of mental health care for all those who have waited far too long.
Annex

List of participants of the round tables
# ROUND TABLE - Room VII

<table>
<thead>
<tr>
<th>Country</th>
<th>Representative</th>
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<tbody>
<tr>
<td><strong>Chair</strong></td>
<td>Mr Phillip Goddard (Barbados)</td>
</tr>
<tr>
<td><strong>Facilitators</strong></td>
<td>Professor Jill Astbury (Australia)</td>
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<td></td>
<td>Professor Arthur Kleinman</td>
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<tr>
<td></td>
<td>(United States of America)</td>
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<tr>
<td>Belgium</td>
<td>Mrs Magda Aelvoet</td>
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<tr>
<td>Burkina Faso</td>
<td>Mr Pierre Tapsoba</td>
</tr>
<tr>
<td>Cameroon</td>
<td>Mr U. Olanguena Awono</td>
</tr>
<tr>
<td>Chile</td>
<td>Dr Carmen López</td>
</tr>
<tr>
<td>Denmark</td>
<td>Mr Arne Rolighed</td>
</tr>
<tr>
<td>Dominica</td>
<td>Dr John Toussaint</td>
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<tr>
<td>Ecuador</td>
<td>Dr Patricio Jandriska</td>
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<tr>
<td>Ethiopia</td>
<td>Dr Menilik Desta</td>
</tr>
<tr>
<td>Fiji</td>
<td>Mr Pita K. Nacuva</td>
</tr>
<tr>
<td>Germany</td>
<td>Mrs U. Schmidt</td>
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<tr>
<td>Hungary</td>
<td>Mr Gyula Pulay</td>
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<tr>
<td>Lesotho</td>
<td>Mr T. Mabote</td>
</tr>
<tr>
<td>Mexico</td>
<td>Dr Julio Frenk Mora</td>
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<tr>
<td>Mongolia</td>
<td>Professor P. Nymadawa</td>
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<tr>
<td>Morocco</td>
<td>Mr Thami El Khyari</td>
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<tr>
<td>Namibia</td>
<td>Dr Libertina Amathila</td>
</tr>
<tr>
<td>Nepal</td>
<td>Mr Ram Krishna Tamrakar</td>
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<tr>
<td>Oman</td>
<td>Dr Ali Bin Mohammed Bin Moosa</td>
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<tr>
<td>Pakistan</td>
<td>Dr A.M. Kasi</td>
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<tr>
<td>Paraguay</td>
<td>Dr Martin Chiola</td>
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<tr>
<td>Poland</td>
<td>Professor Grzegorz Opala</td>
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<tr>
<td>Qatar</td>
<td>Dr H.A.H. Al-Bin-ali</td>
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<tr>
<td>Republic of Korea</td>
<td>Dr Kyeong Ho Lee</td>
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<tr>
<td>Saint Kitts and Nevis</td>
<td>Mr Earl Martin</td>
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<tr>
<td>San Marino</td>
<td>Mr Romeo Morri</td>
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<tr>
<td>Senegal</td>
<td>Mr Abdoul Aziz Diop</td>
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<tr>
<td>Singapore</td>
<td>Professor Ee Heok Kua</td>
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<tr>
<td>Slovenia</td>
<td>Mr Dorjan Marusic</td>
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<tr>
<td>South Africa</td>
<td>Dr M.E. Tshabalala-Msimang</td>
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<tr>
<td>Turkey</td>
<td>Professor Orhan Canbolat</td>
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<td>Zambia</td>
<td>Dr L. Mumba</td>
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## ROUND TABLE - Room XII

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<tr>
<th><strong>Chair</strong></th>
<th>Mr Lyonpo Sangay Ngedup (Bhutan)</th>
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<tbody>
<tr>
<td><strong>Facilitators</strong></td>
<td>Dr J. López-Ibor (Spain)</td>
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<td></td>
<td>Dr Sylvia Kaaya (United Republic of Tanzania)</td>
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<tr>
<td>Angola</td>
<td>Dr Albertina Hamukwaya</td>
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<tr>
<td>Belarus</td>
<td>Dr Igor Zelenkevich</td>
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<tr>
<td>Bosnia and Herzegovina</td>
<td>Dr Zeljko Misanović</td>
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<tr>
<td>Botswana</td>
<td>Ms Joy Phumaphi</td>
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<tr>
<td>Brazil</td>
<td>Dr João Yunes</td>
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<tr>
<td>Brunei Darussalam</td>
<td>Mr Ahmad Matnor</td>
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<tr>
<td>Democratic Republic of the Congo</td>
<td>Professor Mashako Mamba</td>
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<tr>
<td>Gabon</td>
<td>Mr Faustin Boukoubi</td>
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<tr>
<td>Greece</td>
<td>Professor Christina Spyraiki</td>
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<tr>
<td>Grenada</td>
<td>Dr Clarice Modeste-Curwen</td>
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<tr>
<td>Guatemala</td>
<td>Mr Mario Bolaños Duarte</td>
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<tr>
<td>Haiti</td>
<td>Dr Henri-ClaudeVoltaire</td>
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<tr>
<td>Israel</td>
<td>Dr A. Leventhal</td>
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<td>Jordan</td>
<td>Dr S. Kharabseh</td>
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<tr>
<td>Lao People's Democratic Republic</td>
<td>Dr Boungnong Boupha</td>
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<tr>
<td>Liberia</td>
<td>Dr Peter S. Coleman</td>
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<tr>
<td>Madagascar</td>
<td>Professor Henriette Ratsimbazafimahefa</td>
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<tr>
<td>Maldives</td>
<td>Mr Ahmed Abdullah</td>
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<tr>
<td>Nicaragua</td>
<td>Dra Mariánges Argüello</td>
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<td>Norway</td>
<td>Mr Tore Tønne</td>
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<tr>
<td>Peru</td>
<td>Sr Dr Eduardo Pretell Zárate</td>
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<tr>
<td>Rwanda</td>
<td>Dr Ezéchias Rwabuhhi</td>
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<td>Samoa</td>
<td>Mr M. Siafausa Vui</td>
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<tr>
<td>Sierra Leone</td>
<td>Dr I.I. Tejan Jalloh</td>
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<td>Slovakia</td>
<td>Mr Svätopluk Hlavacka</td>
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<td>Sri Lanka</td>
<td>Mr W.D.J. Seneviratne</td>
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<tr>
<td>Switzerland</td>
<td>Ms Ruth Dreifuss</td>
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<tr>
<td>Uganda</td>
<td>Dr C. Kiyonga</td>
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<tr>
<td>United Arab Emirates</td>
<td>Mr Hamad Abdul Rahman Al-Madfaa</td>
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<tr>
<td>United States of America</td>
<td>Mr Tommy Thompson</td>
</tr>
<tr>
<td>Yemen</td>
<td>Dr Abdul Nasser Ali Al-Munibari</td>
</tr>
<tr>
<td>Chair</td>
<td>Mrs Annette King (New Zealand)</td>
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</tbody>
</table>
| Facilitators              | Professor Julian Leff (United Kingdom of Great Britain and Northern Ireland)  
 Dr Lourdes Ignacio (Philippines) |
| Algeria                   | Dr M. Abdelmoumène             |
| Bahamas                   | Dr Ronald Knowles              |
| Bangladesh                | Mr Sheikh Fazlul Karim Selim   |
| Canada                    | Mr A. Rock                     |
| China                     | Dr Peng Yu                     |
| Côte d’Ivoire             | Professor Raymond Abouo N’Dori |
| Cuba                      | Dr Carlos Dotres Martínez      |
| Cyprus                    | Mr Frixos Savvides             |
| Egypt                     | Professor Ismail Sallam        |
| France                    | Dr Bernard Kouchner            |
| Gambia                    | Mr Y. Kassama                  |
| Georgia                   | Dr A. Gamkrelidze              |
| India                     | Dr C. P. Thakur                |
| Iran (Islamic Republic of) | Dr Mohammad Farhadi            |
| Japan                     | Mr Jungoro Kondo               |
| Mali                      | Dr Fatoumata Traoré Nafo       |
| Mozambique                | Dr Francisco Ferreira Songane  |
| Myanmar                   | Mr Ket Sein                    |
| Netherlands               | Dr E. Borst-Eilers             |
| Niger                     | Mr Assoumane Adamou            |
| Nigeria                   | Professor A.B.C. Nwosu          |
| Panama                    | Dr Fernando Gracia García      |
| Papua New Guinea          | Mr Ludger Mond                 |
| Portugal                  | Mr José Manuel Boquínhas       |
| Russian Federation        | Professor V.N. Krasnov         |
| Saudi Arabia              | Dr Mohamed Abdullah Al Shawoosh |
| The former Yugoslav Republic of Macedonia | Dr Muarem Nedzipi |
| Tunisia                   | Dr H. Abdessalem               |
| United Kingdom of Great Britain and Northern Ireland | Ms Jane Hutt |
| Uruguay                   | Dr E. Touyá                    |
| Viet Nam                  | Professor Pham Manh Hung       |
| Zimbabwe                  | Dr Timothy J. Stamps           |
### ANNEX

#### ROUND TABLE - Room XVIII

<table>
<thead>
<tr>
<th><strong>Chair</strong></th>
<th>Professor M. Eyad Chatty (Syrian Arab Republic)</th>
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</thead>
<tbody>
<tr>
<td><strong>Facilitators</strong></td>
<td>Dr Vikram Patel (India) Ms Paula Mogne (Mozambique)</td>
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<tr>
<td>Argentina</td>
<td>Dr Hector Lombardo</td>
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<td>Bolivia</td>
<td>Dr Guillermo Cuestas-Yáñez</td>
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<td>Chad</td>
<td>Mme Fatimé Kimto</td>
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<td>Colombia</td>
<td>Sra Sara Ordoñez Noriega</td>
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<td>Dominican Republic</td>
<td>Sra Angela Caba</td>
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<td>Finland</td>
<td>Dr Jarkko Eskola</td>
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<td>Ghana</td>
<td>Dr Richard W. Anane</td>
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<td>Dr Mamadou Saliou Diallo</td>
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<td>Dr Achmad Sujudi</td>
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<td>Iraq</td>
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<td>Jamaica</td>
<td>Mr John Junor</td>
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<td>Malaysia</td>
<td>Mr Chuajui Meng</td>
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<td>Mr Ashok Kumar Jugnauth</td>
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<tr>
<td>Romania</td>
<td>Dr Daniela Bartos</td>
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<td>Saint Lucia</td>
<td>Mrs Sarah Flood Beaubrun</td>
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<td>Sudan</td>
<td>Dr Ahmed Bilal Osman</td>
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<td>Sweden</td>
<td>Mr Lars Engqvist</td>
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<tr>
<td>Thailand</td>
<td>Dr Winai Wiriyakitjar</td>
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<td>Tonga</td>
<td>Dr V.T. Tangi</td>
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<tr>
<td>Trinidad and Tobago</td>
<td>Dr Rampersad Parasram</td>
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<tr>
<td>United Republic of Tanzania</td>
<td>Ms Anna M. Abdallah</td>
</tr>
<tr>
<td>Venezuela</td>
<td>Dra María Lourdes Urbaneda Durant</td>
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<tr>
<td>Yugoslavia</td>
<td>Dr M. Kovac</td>
</tr>
</tbody>
</table>
Mental health is the capacity of the individual, the group and the environment to interact with one another in ways that promote subjective well-being, the optimal development and use of mental abilities, the achievement of individual and collective goals consistent with justice and the attainment and preservation of conditions of fundamental equality.