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HEALTH

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2001

Mental Health:
New Understanding, New Hope
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MESSAGE FROM THE DIRECTOR-GENERAL

Mental illness is not a personal failure. It doesn’t happen only to other people. We all remember a time not too long ago when we couldn’t openly speak about cancer. That was a family secret. Today, many of us still do not want to talk about AIDS. These barriers are gradually being broken down.

The theme of World Health Day 2001 was “Stop exclusion – Dare to care”. Its message was that there is no justification for excluding people with a mental illness or brain disorder from our communities – there is room for everyone. Yet many of us still shy away from, or feign ignorance of such individuals – as if we do not dare to understand and care. The theme of this report is “New understanding, new hope”. It shows how science and sensibility are combining to break down real and perceived barriers to care and cure in mental health. For there is a new understanding that offers real hope to the mentally ill. Understanding how genetic, biological, social and environmental factors come together to cause mental and brain illness. Understanding how inseparable mental and physical health really are, and how their influence on each other is complex and profound. And this is just the beginning. I believe that talking about health without mental health is a little like tuning an instrument and leaving a few discordant notes.

WHO is making a simple statement: mental health – neglected for far too long – is crucial to the overall well-being of individuals, societies and countries and must be universally regarded in a new light.

Our call has been joined by the United Nations General Assembly, which this year marks the 10th anniversary of the rights of the mentally ill to protection and care. I believe The World Health Report 2001 gives renewed emphasis to the UN principles laid down a decade ago. The first of these principles is that there shall be no discrimination on the grounds of mental illness. Another is that as far as possible, every patient shall have the right to be treated and cared for in his or her own community. And a third is that every patient shall have the right to be treated in the least restrictive environment, with the least restrictive or intrusive treatment.

Throughout the year, our Member States have taken our struggle forward by focusing on various aspects of mental health whether it be medical, social or political. This year WHO is also supporting the development and launching of global campaigns on depression management and suicide prevention, schizophrenia and epilepsy. The World Health Assembly 2001 discussed mental health in all its dimensions. For us at the World Health Organization and in the extended community of health professionals, this heightened and sustained focus is an opportunity and a challenge.
A lot remains to be done. We do not know how many people are not getting the help they need – help that is available, help that can be obtained at no great cost. Initial estimates suggest that about 450 million people alive today suffer from mental or neurological disorders or from psychosocial problems such as those related to alcohol and drug abuse. Many of them suffer silently. Many of them suffer alone. 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.

Major depression is now the leading cause of disability globally and ranks fourth in the ten leading causes of the global burden of disease. If projections are correct, within the next 20 years, depression will have the dubious distinction of becoming the second cause of the global disease burden. Globally, 70 million people suffer from alcohol dependence. About 50 million have epilepsy; another 24 million have schizophrenia. A million people commit suicide every year. Between ten and 20 million people attempt it.

Rare is the family that will be free from an encounter with mental disorders.

One person in every four will be affected by a mental disorder at some stage of life. The risk of some disorders, including Alzheimer's disease, increases with age. The conclusions are obvious for the world's ageing population. The social and economic burden of mental illness is enormous.

Today we know that most illnesses, mental and physical, are influenced by a combination of biological, psychological and social factors. Our understanding of the relationship between mental and physical health is rapidly increasing. We know that mental disorders are the outcome of many factors and have a physical basis in the brain. We know they can affect everyone, everywhere. And we know that more often than not, they can be treated effectively.

This report deals with depressive disorders, schizophrenia, mental retardation, disorders of childhood and adolescence, drug and alcohol dependence, Alzheimer's disease and epilepsy. All of these are common and usually cause severe disability. Epilepsy is not a mental problem, but we have included it because it faces the same kind of stigma, ignorance and fear associated with mental illnesses.

Our report is a comprehensive review of what we know about the current and future burden of all these disorders and their principal contributing factors. It deals with the effectiveness of prevention and the availability of, and barriers to, treatment. We deal in detail with service provision and service planning. And, finally, the report outlines policies needed to ensure that stigma and discrimination are broken down, and that effective prevention and treatment are put in place and adequately funded.

In more ways than one, we make this simple point: we have the means and the scientific knowledge to help people with mental and brain disorders. Governments have been remiss, as has been the public health community. By accident or by design, we are all responsible for this situation. As the world's leading public health agency, WHO has one, and only one option – to ensure that ours will be the last generation that allows shame and stigma to rule over science and reason.

Gro Harlem Brundtland
Geneva
October 2001
This landmark World Health Organization publication aims to raise public and professional awareness of the real burden of mental disorders and their costs in human, social and economic terms. At the same time it intends to help dismantle many of those barriers – particularly of stigma, discrimination and inadequate services – which prevent many millions of people worldwide from receiving the treatment they need and deserve.

In many ways, The World Health Report 2001 provides a new understanding of mental disorders that offers new hope to the mentally ill and their families in all countries and all societies. It is a comprehensive review of what is known about the current and future burden of disorders, and the principal contributing factors. It examines the scope of prevention and the availability of, and obstacles to, treatment. It deals in detail with service provision and planning; and it concludes with a set of far-reaching recommendations that can be adapted by every country according to its needs and its resources.

The ten recommendations for action are as follows.

1. **Provide treatment in primary care**

   The management and treatment of mental disorders in primary care is a fundamental step which enables the largest number of people to get easier and faster access to services – it needs to be recognized that many are already seeking help at this level. This not only gives better care; it cuts wastage resulting from unnecessary investigations and inappropriate and non-specific treatments. For this to happen, however, general health personnel need to be trained in the essential skills of mental health care. Such training ensures the best use of available knowledge for the largest number of people and makes possible the immediate application of interventions. Mental health should therefore be included in training curricula, with refresher courses to improve the effectiveness of the management of mental disorders in general health services.

2. **Make psychotropic drugs available**

   Essential psychotropic drugs should be provided and made constantly available at all levels of health care. These medicines should be included in every country’s essential drugs list, and the best drugs to treat conditions should be made available whenever possible. In some countries, this may require enabling legislation changes. These drugs can ameliorate symptoms, reduce disability, shorten the course of many disorders, and prevent relapse. They often provide the first-line treatment, especially in situations where psychosocial interventions and highly skilled professionals are unavailable.

3. **Give care in the community**

   Community care has a better effect than institutional treatment on the outcome and quality of life of individuals with chronic mental disorders. Shifting patients from mental hospitals to care in the community is also cost-effective and respects human rights. Mental
health services should therefore be provided in the community, with the use of all available resources. Community-based services can lead to early intervention and limit the stigma of taking treatment. Large custodial mental hospitals should be replaced by community care facilities, backed by general hospital psychiatric beds and home care support, which meet all the needs of the ill that were the responsibility of those hospitals. This shift towards community care requires health workers and rehabilitation services to be available at community level, along with the provision of crisis support, protected housing, and sheltered employment.

4. EDUCATE THE PUBLIC

Public education and awareness campaigns on mental health should be launched in all countries. The main goal is to reduce barriers to treatment and care by increasing awareness of the frequency of mental disorders, their treatability, the recovery process and the human rights of people with mental disorders. The care choices available and their benefits should be widely disseminated so that responses from the general population, professionals, media, policy-makers and politicians reflect the best available knowledge. This is already a priority for a number of countries, and national and international organizations. Well-planned public awareness and education campaigns can reduce stigma and discrimination, increase the use of mental health services, and bring mental and physical health care closer to each other.

5. INVOLVE COMMUNITIES, FAMILIES AND CONSUMERS

Communities, families and consumers should be included in the development and decision-making of policies, programmes and services. This should lead to services being better tailored to people’s needs and better used. In addition, interventions should take account of age, sex, culture and social conditions, so as to meet the needs of people with mental disorders and their families.

6. ESTABLISH NATIONAL POLICIES, PROGRAMMES AND LEGISLATION

Mental health policy, programmes and legislation are necessary steps for significant and sustained action. These should be based on current knowledge and human rights considerations. Most countries need to increase their budgets for mental health programmes from existing low levels. Some countries that have recently developed or revised their policy and legislation have made progress in implementing their mental health care programmes. Mental health reforms should be part of the larger health system reforms. Health insurance schemes should not discriminate against persons with mental disorders, in order to give wider access to treatment and to reduce burdens of care.

7. DEVELOP HUMAN RESOURCES

Most developing countries need to increase and improve training of mental health professionals, who will provide specialized care as well as support the primary health care programmes. Most developing countries lack an adequate number of such specialists to staff mental health services. Once trained, these professionals should be encouraged to remain in their country in positions that make the best use of their skills. This human resource development is especially necessary for countries with few resources at present. Though primary care provides the most useful setting for initial care, specialists are needed to provide a wider range of services. Specialist mental health care teams ideally should
include medical and non-medical professionals, such as psychiatrists, clinical psychologists, psychiatric nurses, psychiatric social workers and occupational therapists, who can work together towards the total care and integration of patients in the community.

8. **LINK WITH OTHER SECTORS**

Sectors other than health, such as education, labour, welfare, and law, and nongovernmental organizations should be involved in improving the mental health of communities. Nongovernmental organizations should be much more proactive, with better-defined roles, and should be encouraged to give greater support to local initiatives.

9. **MONITOR COMMUNITY MENTAL HEALTH**

The mental health of communities should be monitored by including mental health indicators in health information and reporting systems. The indices should include both the numbers of individuals with mental disorders and the quality of their care, as well as some more general measures of the mental health of communities. Such monitoring helps to determine trends and to detect mental health changes resulting from external events, such as disasters. Monitoring is necessary to assess the effectiveness of mental health prevention and treatment programmes, and it also strengthens arguments for the provision of more resources. New indicators for the mental health of communities are necessary.

10. **SUPPORT MORE RESEARCH**

More research into biological and psychosocial aspects of mental health is needed in order to increase the understanding of mental disorders and to develop more effective interventions. Such research should be carried out on a wide international basis to understand variations across communities and to learn more about factors that influence the cause, course and outcome of mental disorders. Building research capacity in developing countries is an urgent need.

**THREE SCENARIOS FOR ACTION**

International action is critical if these recommendations are to be implemented effectively, because many countries lack the necessary resources. United Nations technical and developmental agencies and others can assist countries with mental health infrastructure development, manpower training, and research capacity building.

To help guide countries, the report in its concluding section provides three “scenarios for action” according to the varying levels of national mental health resources around the world. Scenario A, for example, applies to economically poorer countries where such resources are completely absent or very limited. Even in such cases, specific actions such as training of all personnel, making essential drugs available at all health facilities, and moving the mentally ill out of prisons, can be applied. For countries with modest levels of resources, Scenario B suggests, among other actions, the closure of custodial mental hospitals and steps towards integrating mental health care into general health care. Scenario C, for those countries with most resources, proposes improvements in the management of mental disorders in primary health care, easier access to newer drugs, and community care facilities offering 100% coverage.

All of the above recommendations and actions stem from the main body of the report itself.
Outline of the Report

Chapter 1 introduces the reader to a new understanding of mental health and explains why it is as important as physical health to the overall well-being of individuals, families, societies and communities.

Mental and physical health are two vital strands of life that are closely interwoven and deeply interdependent. Advances in neuroscience and behavioural medicine have shown that, like many physical illnesses, mental and behavioural disorders are the result of a complex interaction between biological, psychological and social factors.

As the molecular revolution proceeds, researchers are becoming able to see the living, feeling, thinking human brain at work and to see and understand why, sometimes, it works less well than it could. Future advances will provide a more complete understanding of how the brain is related to complex mental and behavioural functioning. Innovations in brain imaging and other investigative techniques will permit “real time cinema” of the nervous system in action.

Meanwhile, scientific evidence from the field of behavioural medicine has demonstrated a fundamental connection between mental and physical health – for instance, that depression predicts the occurrence of heart disease. Research shows that there are two main pathways through which mental and physical health mutually influence each other.

Physiological systems, such as neuroendocrine and immune functioning, are one such pathway. Anxious and depressed moods, for example, initiate a cascade of adverse changes in endocrine and immune functioning, and create increased susceptibility to a range of physical illnesses.

Health behaviour is another pathway and concerns activities such as diet, exercise, sexual practices, smoking and adhering to medical therapies. The health behaviour of an individual is highly dependent on that person’s mental health. For example, recent evidence has shown that young people with psychiatric disorders such as depression and substance dependence are more likely to engage in smoking and high-risk sexual behaviour.

Individual psychological factors are also related to the development of mental disorders. The relationships between children and their parents or other caregivers during childhood are crucial. Regardless of the specific cause, children deprived of nurture are more likely to develop mental and behavioural disorders either in childhood or later in life. Social factors such as uncontrolled urbanization, poverty and rapid technological change are also important. The relationship between mental health and poverty is particularly important: the poor and the deprived have a higher prevalence of disorders, including substance abuse. The treatment gap for most mental disorders is high, but for the poor population it is indeed massive.

Chapter 2 begins to address the treatment gap as one of the most important issues in mental health today. It does so first of all by describing the magnitude and burden of mental and behavioural disorders. It shows they are common, affecting 20–25% of all people at some time during their life. They are also universal – affecting all countries and societies, and individuals at all ages. The disorders have a large direct and indirect economic impact on societies, including service costs. The negative impact on the quality of life of individuals and families is massive. It is estimated that, in 2000, mental and neurological disorders accounted for 12% of the total disability-adjusted life years (DALYs) lost due to all diseases and injuries. By 2020, it is projected that the burden of these disorders will have increased 15%. Yet only a small minority of all those presently affected receive any treatment.
The chapter introduces a group of common disorders that usually cause severe disability, and describes how they are identified and diagnosed, and their impact on quality of life. The group includes depressive disorders, schizophrenia, substance use disorders, epilepsy, mental retardation, disorders of childhood and adolescence, and Alzheimer’s disease. Although epilepsy is clearly a neurological disorder, it is included because it has been seen historically as a mental disorder and is still considered this way in many societies. Like those with mental disorders, people with epilepsy suffer stigma and also severe disability if left untreated.

Factors determining the prevalence, onset and course of all these disorders include poverty, sex, age, conflict and disasters, major physical diseases, and family and social environment. Often, two or more mental disorders occur together in an individual, anxiety and depressive disorders being a common combination.

The chapter discusses the possibility of suicide associated with such disorders. Three aspects of suicide are of public health importance. First, it is one of the main causes of death of young people in most developed countries and in many developing ones as well. Second, there are wide variations in suicide rates across countries, between the sexes and across age groups, an indication of the complex interaction of biological, psychological and sociocultural factors. Third, suicides of younger people and of women are a recent and growing problem in many countries. Suicide prevention is among the issues discussed in the next chapter.

Chapter 3 is concerned with solving mental health problems. It highlights one key issue in the whole report, and one that features strongly in the overall recommendations. This is the positive shift, recommended for all countries and already occurring in some, from institutionalized care, in which the mentally disordered are held in asylums, custodial-type hospitals or prisons, to care in the community backed by the availability of beds in general hospitals for acute cases.

In 19th-century Europe, mental illness was seen on one hand as a legitimate topic for scientific enquiry: psychiatry burgeoned as a medical discipline, and people suffering from mental disorders were considered medical patients. On the other hand, people with these disorders, like those with many other diseases and undesirable social behaviour, were isolated from society in large custodial institutions, the state lunatic asylums, later known as mental hospitals. The trends were later exported to Africa, the Americas and Asia.

During the second half of the 20th century, a shift in the mental health care paradigm took place, largely owing to three independent factors. First, psychopharmacology made significant progress, with the discovery of new classes of drugs, particularly neuroleptics and antidepressants, as well as the development of new forms of psychosocial interventions. Second, the human rights movement became a truly international phenomenon under the sponsorship of the newly created United Nations, and democracy advanced on a global basis. Third, a mental component was firmly incorporated into the concept of health as defined by the newly established WHO. Together these events have prompted the move away from care in large custodial institutions to more open and flexible care in the community.

The failures of asylums are evidenced by repeated cases of ill-treatment to patients, geographical and professional isolation of the institutions and their staff, weak reporting and accounting procedures, bad management and ineffective administration, poorly targeted financial resources, lack of staff training, and inadequate inspection and quality assurance procedures.
In contrast, community care is about providing good care and the empowerment of people with mental and behavioural disorders. In practice, community care implies the development of a wide range of services within local settings. This process, which has not yet begun in many regions and countries, aims to ensure that some of the protective functions of the asylum are fully provided and that the negative aspects of the institutions are not perpetuated.

The following are characteristics of providing care in the community:
- services which are close to home, 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;
- a wide range of services which address the needs of people with mental and behavioural disorders;
- services which are coordinated between mental health professionals and community agencies;
- ambulatory 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.

However, this chapter warns against closing mental hospitals without community alternatives and, conversely, creating community alternatives without closing mental hospitals. Both have to occur at the same time, in a well-coordinated, incremental way. A sound de-institutionalization process has three essential components:
- prevention of inappropriate mental hospital admissions through the provision of community facilities;
- discharge to the community of long-term institutional patients who have received adequate preparation;
- establishment and maintenance of community support systems for non-institutionalized patients.

In many developing countries, mental health care programmes have a low priority. Provision is limited to a small number of institutions that are usually overcrowded, understaffed and inefficient. Services reflect little understanding of the needs of the ill or the range of approaches available for treatment and care. There is no psychiatric care for the majority of the population. The only services are in large mental hospitals that operate under legislation which is often more penal than therapeutic. They are not easily accessible and become communities of their own, isolated from society at large.

Despite the major differences between mental health care in developing and developed countries, they share a common problem: many people who could benefit do not take advantage of available psychiatric services. Even in countries with well-established services, fewer than half of those individuals needing care make use of such services. This is related both to the stigma attached to individuals with mental and behavioural disorders, and to the inappropriateness of the services provided.

The chapter identifies important principles of care in mental health. These include diagnosis, early intervention, rational use of treatment techniques, continuity of care, and a wide range of services. Additional principles are consumer involvement, partnerships with families, involvement of the local community, and integration into primary health care. The
chapter also describes three fundamental ingredients of care – medication, psychotherapy and psychosocial rehabilitation – and says a balanced combination of them is always required. It discusses prevention, treatment, and rehabilitation in the context of the disorders highlighted in the report.

Chapter 4 deals with mental health policy and service provision. To protect and improve the mental health of the population is a complex task involving multiple decisions. It requires priorities to be set among mental health needs, conditions, services, treatments, and prevention and promotion strategies, and choices to be made about their funding. Mental health services and strategies must be well coordinated among themselves and with other services, such as social security, education, and public interventions in employment and housing. Mental health outcomes must be monitored and analysed so that decisions can be continually adjusted to meet emerging challenges.

Governments, as the ultimate stewards of mental health, need to assume the responsibility for ensuring that these complex activities are carried out. One critical role in stewardship is to develop and implement policy. This means identifying the major issues and objectives, defining the respective roles of the public and private sectors in financing and provision, and identifying policy instruments and organizational arrangements required in the public and possibly in the private sectors to meet mental health objectives. It also means prompting action for capacity building and organizational development, and providing guidance for prioritizing expenditure, thus linking analysis of problems to decisions about resource allocation.

The chapter looks in detail at these issues, beginning with options for financing arrangements for the delivery of mental health services, while noting that the characteristics of these should be no different from those for health services in general. People should be protected from catastrophic financial risk, which means minimizing out-of-pocket payments in favour of prepayment methods, whether via general taxation, mandatory social insurance or voluntary private insurance. The healthy should subsidize the sick through prepayment mechanisms, and a good financing system will also mean that the well-off subsidize the poor, at least to some extent.

The chapter goes on to discuss the formulation of mental health policy, which it notes is often developed separately from alcohol and drug policies. It says mental health, alcohol and drug policies must be formulated within the context of a complex body of government health, welfare and general social policies. Social, political and economic realities must be recognized at local, regional and national levels.

Policy formulation must be based upon up-to-date and reliable information concerning the community, mental health indicators, effective treatments, prevention and promotion strategies, and mental health resources. The policy will need to be reviewed periodically.

Policies should highlight vulnerable groups with special mental health needs, such as children, the elderly, and abused women, as well as refugees and displaced persons in countries experiencing civil wars or internal conflicts.

Policies should also include suicide prevention. This means, for example, reducing access to poisons and firearms, and detoxifying domestic gas and car exhausts. Such policies need to ensure not only care for individuals particularly at risk, such as those with depression, schizophrenia or alcohol dependence, but also the control of alcohol and illicit drugs.

The public mental health budget in many countries is mainly spent on maintaining institutional care, with few or no resources being made available for more effective services in the community. In most countries, mental health services need to be assessed, reevaluated and reformed to provide the best available treatment and care. The chapter discusses three
ways of improving how services are organized, even with limited resources, so that those who need them can make full use of them. These are: shifting care away from mental hospitals, developing community mental health services, and integrating mental health services into general health care.

Other matters discussed in this chapter include ensuring the availability of psychotropic drugs, creating intersectoral links, choosing mental health interventions, public and private roles in provision of services, developing human resources, defining roles and functions of health workers, and promoting not just mental health but also the human rights of people with mental disorders. In this latter instance, legislation is essential to guarantee that their fundamental human rights are protected.

Intersectoral collaboration between government departments is essential in order for mental health policies to benefit from mainstream government programmes. In addition, mental health input is required to ensure that all government activities and policies contribute to and not detract from mental health. This involves labour and employment, commerce and economics, education, housing, other social welfare services and the criminal justice system.

The chapter says that the most important barriers to overcome in the community are stigma and discrimination, and that a multilevel approach is required, including the role of the mass media and the use of community resources to stimulate change.

Chapter 5 contains the recommendations and three scenarios for action listed at the beginning of this overview. It brings the report to an optimistic end, by emphasizing that solutions for mental disorders do exist and are available. The scientific advances made in the treatment of mental disorders mean that most individuals and families can be helped. In addition to effective treatment and rehabilitation, strategies for the prevention of some disorders are available. Suitable and progressive mental health policy and legislation can go a long way towards delivering services to those in need. There is new understanding, and there is new hope.
Mental health is as important as physical health to the overall well-being of individuals, societies and countries. Yet only a small minority of the 450 million people suffering from a mental or behavioural disorder are receiving treatment. Advances in neuroscience and behavioural medicine have shown that, like many physical illnesses, mental and behavioural disorders are the result of a complex interaction between biological, psychological and social factors. While there is still much to be learned, we already have the knowledge and power to reduce the burden of mental and behavioural disorders worldwide.