Ministerial round tables

Mental health

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

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

3.   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.

4.   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.

5.   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 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.

6.   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 changes in social behaviour, interpersonal support, personal coping and adverse social conditions such as unemployment, limited education, discrimination on the basis of sex, human rights violations and poverty.

7.   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 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.

8.   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).

9.   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. Each of the four concurrent ministerial round tables to be held during the Fifty-fourth World Health Assembly may focus on some or all of these critical areas. The Annex contains additional information and discussion points to guide ministers in their preparations.

ANNEX

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, the United States of America

1.   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.

2.   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.

3.   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.

4.   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 those 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

5.   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 sigmatization and discrimination of the mentally ill, these failings have led to a wide range of human rights violations. Mental illness has often been seen as untreatable, and mentally ill individuals are labelled as violent and dangerous. People with alcohol and substance dependence are considered morally and psychologically weak. The media perpetuate these negative characterizations. Stigmatization often leaves persons suffering from mental illness rejected by friends, relatives, neighbours and employers, leading to aggravated feelings of rejection, loneliness and demoralization.

6.   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.

7.   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.

8.   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.

9.   Introducing legislative reforms that protect the civil, political, social, economic, and cultural entitlements and rights of the mentally ill is also crucial. However, alone this step will not bear the fruits expected by legislators without a concerted effort to erase stigmatization as one of the major obstacles to successful treatment and social reintegration of the mentally ill in communities. The

public needs to be engaged in a dialogue about the true nature of mental illnesses, their devastating individual, family and societal impacts, and the prospects of better treatment and rehabilitation alternatives. At the same time, stigmatizing attitudes need to be tackled frontally through campaigns and programmes aimed at professionals and the public at large. Public information campaigns using mass media in its various forms; involvement of the community in the design and monitoring of mental health services; provision of support to nongovernmental organizations and for self-help and mutual-aid ventures, families and consumer groups; and education of personnel in the health and judicial systems and employers – all are critical strategies to start dispelling the indelible mark, the stigma caused by mental illness.

Discussion points

•   What measures has your country put (or does it plan to put) in place to fight discrimination and stigmatization of mentally ill people and their families?

•   What is the level of responsibility and the role of the public health sector in tackling such stigmatization and discrimination?

•   How can other sectors contribute to stopping the denial, through discrimination, to mentally ill people of equitable access to services and consideration?

•   Given that mental health legislation requires a balance between the right to individual liberty, the right to treatment and the legitimate expectation of community safety, what are the critical issues in formulating, implementing and enforcing balanced legislation?

SOCIOECONOMIC FACTORS

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

10.   Socioeconomic factors influence mental health in powerful and complex ways, especially poverty. 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, and illustrate the broader concept of poverty, which includes not only economic deprivation but also the associated lack of opportunities for accessing information and services.

11.   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.

12.   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 (see paragraph 8) for most mental disorders is large but for the poor segments of populations in all countries it is seemingly unbridgeable.

13.   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

14.   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.

15.   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 diverse 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.

16.   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.

17.   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

18.   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.

19.   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.

20.   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

21.   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.

22.   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?

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