WORLD HEALTH ORGANIZATION

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# Mental health: responding to the call for action

## Report by the Secretariat

1. This document provides the Health Assembly with updated information on mental health issues in the light of the considerable focus given to mental health over the past 18 months in the work of WHO and in Member States.

2. **The toll of mental disorders is high.** Currently 450 million people suffer from some form of mental or brain disorder, including alcohol and substance abuse disorders. One in four families has at least one member who is affected. Projections from 1990 to 2020 suggest that the portion of the global burden of disease attributable to mental and brain disorders will rise to 15%. Depression, schizophrenia, bipolar disorder, alcohol dependence, Alzheimer's and other dementias are all found among the 13 leading causes of years lived with disability.

3. **Depression is a leading cause of disability.** Currently 121 million people suffer from depression and the burden of depressive illness is rising. The world over, twice as many women suffer from depression as men. Depression is also increasingly afflicting young people. Closely linked to depression are the serious and growing troubles of dependence on alcohol and other substances and suicide, with 70 million people suffering from alcohol-use disorders globally. More than 800 000 die from suicide each year. Young people are most at risk accounting for well over half all suicides.

4. **The costs of mental disorders are staggering.** Sufferers and their families or carers often experience reduced productivity at home and in the workplace. High health care costs and lost productivity can seriously affect families, creating or worsening poverty. The price for countries is tremendous. In the United States of America the annual costs of mental illnesses consume about 2.5% of gross national product (or US$ 148 billion). In the United Kingdom of Great Britain and Northern Ireland, aggregate costs of mental illness have been estimated to be £32 billion. Reduced ability to work and associated productivity losses account for about 45% of these costs.

5. **Most mental and brain disorders can be treated.** Effective medications and psychosocial interventions are available for most disorders and these solutions are entirely within reach of all countries. Yet, even in established market economies with well developed health systems, it has been estimated that much less than 50% of persons suffering from depression receive treatment. In developing countries, treatment rates for depression may be as low as 5%.

6. **Stigmatization and discrimination are among the key obstacles to care.** Around the world people do not seek, obtain or follow treatment because of fear, deficient resources or lack of information. They are commonly victimized for their illness and become targets for human rights abuses and discrimination. Stigmatization and discrimination are key factors that impede people from obtaining the help they need.

7. **Mental health resources are dismally scarce.** Globally, the resources for mental health in countries present a picture of severe shortage and neglect. A WHO study of mental health resources, the ATLAS (abuse trends linkage alerting system) project, collected information from 185 countries. Highlighting the dismal aspect of the picture, the results indicate that 41% of countries do not have a mental health policy, 25% do not have mental health legislation, 37% do not have mental health community care facilities, more than 25% do not have some of the basic psychotropic drugs in primary care settings, and 40% do not have treatment facilities for severe mental disorders at primary care level. About half the countries of the world have less than one psychiatrist and psychiatric nurse per 100 000 population and in spite of deinstitutionalization more than 65% of psychiatric beds in the world are still located in mental hospitals. There is a huge gap between the burden of mental disorders and available resources. These figures are more alarming when one considers that 28% of countries do not have a specific budget for mental health and, of those countries reporting actual mental health expenditure, 36% spend less than 1% of their total health budget on mental health. Even the voluntary contributions for mental health received in WHO in 2000-2001 (US$ 7 194 823) reflect this discrepancy: this amount was a mere 0.63% of all voluntary contributions received for the same period.

8. **World Health Day 2001.** Over the past three years WHO has strived to move mental health from the periphery of health policies and practice to a more prominent position in international public health. In line with decisions of the Executive Board and the Health Assembly, 2001 became a landmark year for mental health. WHO set the stage for global mental health action through awareness raising, generation of political will, and ensuring that new scientific and biomedical information on mental disorders is disseminated. World Health Day 2001 mobilized countries to carry forth the message "Stop Exclusion, Dare to Care". The response of people around the world was overwhelming, and ranged from declarations and speeches from the Pope, prime ministers and presidents to sponsored events involving health professionals, health and human rights activists, people suffering from mental illness or neurological disorders, family members and carers in 144 countries. All gave the same resounding message of determination to end the stigmatization and discrimination that undermine efforts to prevent and treat mental illness, and to put an end to the isolation of people with mental illness within societies.

9. **Ministerial Round Tables.** Ministers of health and senior health officials from some 130 countries participated in the round table discussion at the Fifty-fourth World Health Assembly of the obstacles they face in meeting the mental health needs of their populations and the way forward. They recognized that their respective countries' mental health situation is, to a marked degree, determined by the socioeconomic and political context, and highlighted several determinants, such as rapid economic reforms and social change, including economic transitions, conducive to alarming rates of unemployment, family breakdown, personal insecurity and income inequality. Poverty, a powerful determinant of mental health status, remains a reality in many countries with women, children and the elderly most affected. Many countries experience political instability, social unrest and armed conflict. As a result, there are large populations of traumatized refugees and internally displaced persons who must be resettled, often in countries with limited resources. The epidemics of HIV/AIDS have had a major social and economic impact on many countries, leaving large numbers of people with serious mental problems. Women face demanding social pressures in a context of gender-based disadvantages; many experience physical and sexual violence, with consequent high rates of depression and anxiety disorders. Young people, particularly street children and those exposed to violence, are at high risk for misuse of substances including alcohol. Indigenous people and other minority groups are experiencing social upheaval that is accompanied by climbing suicide rates.

10. **Need for a dual perspective**. In view of these realities, ministers considered mental health from the broader perspective of promotion and prevention as well as from the more focused approach

towards mental disorders. WHO support was solicited for national surveys and studies to document the local burden of mental disorders, the factors affecting onset, progression and outcome of various mental problems, and the effectiveness of different approaches and interventions for prevention, treatment and care. This information was defined as urgently needed to inform policy formulation, funding and programme decisions. There was consensus that stigmatization greatly constrains people with mental illness, their families and carers, preventing them from seeking help, living productive lives and becoming integrated within communities. Stigmatization has an insidious effect on the development of health policies and services for instance denying parity in health insurance schemes. Ministers called on WHO to maintain the international momentum on mental health and support the implementation of interventions addressing stigmatization.

11. **Mental health through primary health care.** Ministers of health concurred that the marginalization of mental health from mainstream health and welfare services has contributed to the exclusion of the persons with mental illness and to the low priority of mental health in budget allocation, policy planning and service development. Mental health services must be delivered through primary health care even in countries with highly specialized care. For this integration, budgets must be increased; mental health teams must be trained; the needs of especially vulnerable groups must be met; communities must have access to crisis centres for the management of acute conditions; and broad public support for community care must be secured. To facilitate such a major effort the public health system should collaborate with nongovernmental organizations, social services and other community agents, many of which are motivated to fill some of the service gaps.

12. **Poverty and mental health.** Given that poverty is a powerful determinant of mental disorders, there must be equitable treatment for the poor. Many families without proper support could fall into the vicious circle of poverty and mental disorder, from which it is hard or impossible to extricate themselves.

13. ***The world health report 2001: Mental health: new understanding, new hope.*** Launched in October 2001, this landmark collection of information on science, public health and ethics provides Member States with useful guidance on evidence-based actions that will lead to heightened awareness of mental health, decreased stigmatization attached to mental disorders and a substantial reduction in the gap existing between those who receive treatment and those who do not. Its 10 final recommendations offer a concise vision for the future. Their uniqueness lies in the fact that they have been translated into three different sets of actions for three distinct scenarios which derive from the data generated by the ATLAS project, namely, countries with a low, medium or high level of mental health resources. *The world health report 2001* thus allows every country the possibility of adopting and implementing appropriate actions according to its actual and projected level of mental health resources.

14. **Mental health Global Action Programme: WHO's response to the call for action.** Building on these events of 2001, WHO designed a five-year programme of support for Member States to enhance their capacity to reduce the risk, stigmatization and burden of mental disorders and to promote mental health. This programme will focus on forging strategic partnerships for sustainable capacity building for mental health action in countries. Through a dual focus on prevention, treatment and rehabilitation of six priority conditions and the protection of the mental health of the most vulnerable population groups, the programme aims to increase governments' awareness of and responsiveness to mental health issues; to enhance the quality and effectiveness of services; and to reduce the pervasive effects of stigmatization and discrimination. Depression, schizophrenia, alcohol and drug dependence, dementia, epilepsy and suicide are high priorities because of the burden they impose on communities and the possibility of reducing it through the provision of comprehensive services.

15. Four core, interrelated strategies will be used, relating to information, formulation and implementation of integrated policies and services, advocacy and research.

- **Information.** Project ATLAS showed over a quarter of all countries do not have any system for collecting and reporting mental health indicators. In others, information systems have extremely limited reliability and reach. As a result, the formulation and implementation of rational mental health policies and services are impeded. Worldwide, many health care workers do not have access to the most basic information on detection and treatment of mental disorders. To respond to this need for better information, the Programme will promote the establishment and maintenance of national mental health monitoring and information systems to underpin health reform, to produce and disseminate evidence-based information for health care workers generally and to set up an international observatory of mental health in the world.

- **Policy and service development.** Based on accurate and relevant information, the Programme will focus on supporting governments in formulating and implementing coherent and comprehensive mental health policies and services according to their specific needs. This strategy is being given a high priority because evidence suggests that a large majority of countries are unprepared to cope with the rise in incidence of mental disorders. The three components of this strategy are inextricably linked and, while its concerns both prevention and management of the target disorders as well as the protection of the mental health of vulnerable population groups, its benefits will be useful for many other national health programmes. The activities required to implement this strategy will depend on the relevant scenario for realizing the 10 recommendations of *The world health report 2001*.

- **Advocacy.** Objectives include the promotion of human rights of people with mental disorders and of their families and monitoring the activities that protect these rights. WHO will support efforts aimed at motivating and informing decision-makers about the impact of economic and social policies on mental health; empowering consumers, families and nongovernmental organizations; organizing antistigmatization programmes in all population groups; and collaborating with the media to disseminate objective information on problems and solutions. Most importantly, the aim of creating a cultural change to promote the inclusion of people with mental disorders in various forms of community life will be pursued.

- **Research.** Emphasis will be placed on applied research in all countries, according to their specific needs and level of development, to guide cost-effective action. Most research is being done in industrialized nations and specific issues of concern to developing nations are not included. The Programme will therefore work to create sustainable research capacity within developing countries through the provision of research training to promising individuals from developing countries, the creation of an international network of scientists and institutions to support this effort, and the sponsorship of related mental health research activities.

16. **Strengthening mental health.** In January 2002 at its 109th session the Executive Board approved resolution EB109.R8 on strengthening mental health. The resolution calls on Member States to adopt the recommendations of *The world health report 2001* and to invest more, both nationally and in cooperation, in mental health and urges the Director General and regional committees to implement those recommendations. It highlights the need for collaboration and technical support that contribute to greater understanding of mental health issues, to more effective policies and programmes for prevention and care including programmes for victims of armed conflict and disasters, and to stronger coalition building for advocacy campaigns on mental health.

## ACTION BY THE HEALTH ASSEMBLY

17. The Health Assembly is invited to note the report.

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