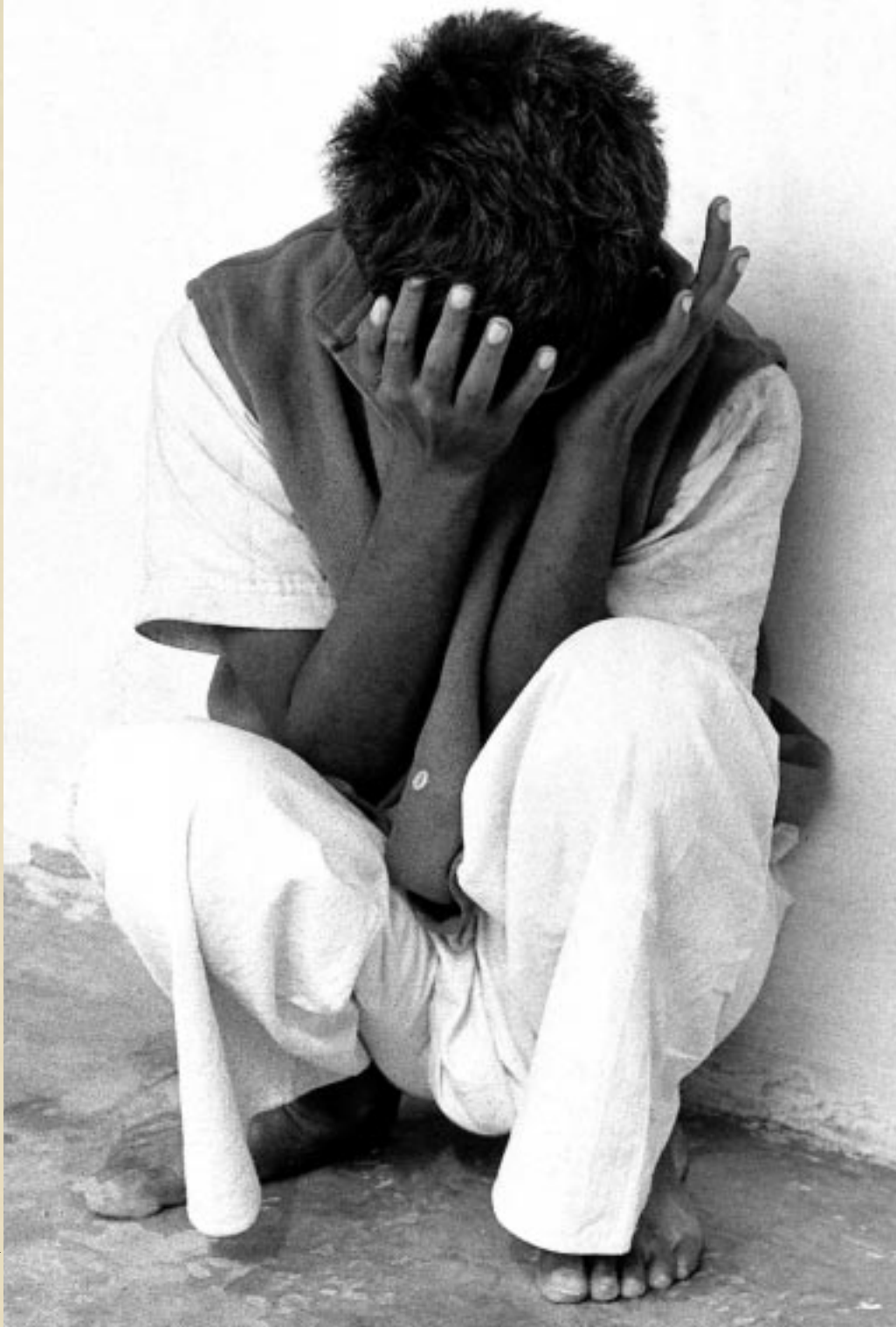


M E N T A L H E A L T H A R O U N D T H E W O R L D



**Stop exclusion
Dare to care**

WORLD HEALTH DAY 2001
World Health Organization



Address by Dr Gro Harlem Brundtland

Director-General of the World Health Organization



Photo: © WHO, Akerden



On 7 April 2001, all peoples and governments around the world will observe World Health Day. This year is devoted to mental health. We

focus on mental health in recognition of the burden that mental and brain disorders pose on people and families affected by them, and with the aim to highlight the important advances made by researchers and clinicians in reducing suffering and the accompanying disability. Our message is one of concern and hope.

The road ahead is long. It is littered with myths, secrecy and shame. Rare is the family that will be free from an encounter with mental disorders or will not need assistance and care over a difficult period. Yet, we feign ignorance or actively ignore this fact. This may be because we do not have sufficient data to begin addressing the problem. In other words, 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. And, because we lack this knowledge, we have not done well to address mental and brain disorders. As we fail to acknowledge this reality, we perpetuate a vicious cycle of ignorance, suffering, destitution and even death. We have the capacity

– within us – to tackle the next frontier. Within people, within societies, within governments. Together we have to work to make the change.

An estimated 400 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.

The simple truth is that we have the means to treat many disorders. We have the means and the scientific knowledge to help people with their suffering. Governments have been remiss in that they have not provided adequate means of treatment to their people. And people have continued to discriminate against those that suffer from these disorders. Human rights violations in mental hospitals, insufficient provision of community mental health services, unfair insurance schemes and discriminatory hiring practices are only some of the examples. By accident or by design, we are all responsible for this situation today.

The time for reckoning is now. Let us look at this day as an opportunity and

a challenge. A day to reflect upon what remains to be done and how we can do it. Let us use this day and the weeks ahead to take stock and advocate for policy changes on the one hand and attitude changes on the other. Together with our Member States, let us pledge to work towards a day when good health will also mean good mental health.

This past century has seen spectacular changes in the way we live and think. Human brilliance and technology have come together to propose solutions we dared not imagine fifty years ago. We have conquered diseases that once seemed insurmountable. We have saved millions of people from premature death and disability. And our search for better solutions to health is, as it should be, ceaseless. The solutions to mental health problems are not difficult to find; many of them are already with us. What we need is to focus on this as a basic necessity. We must include solutions and care for mental health in our search for a better life for all in a systematic way. Only then will our successes be more meaningful. On this day, we must commit to “Stop exclusion – dare to care.”

Gro H. Brundtland



Myths hurt – face them

Facts help – use them

Mental health today

A vision for the future

Where to learn more

Introduction

Mental health is an integral component of health through which a person realizes his or her own cognitive, affective and relational abilities. With a balanced mental disposition, one is more effective in coping with the stresses of life, can work productively and fruitfully, and is better able to make a positive contribution to his or her community. Mental and brain disorders, by affecting mental health, impede or diminish the possibility to reach all or part of the above. Preventing and treating them clears the road to achieving one's full potential.

As mental health is a fundamental building block for human development, we must face the facts that mental health problems are a part of life, that they can arise and that they can be addressed.

Stop Exclusion

There is no justification in ethics, science or society to exclude persons with a mental illness or a brain disorder from our communities. There is room for everyone.

The health care system can lead the way. No rationale exists for excluding mental health services from the general health care system. Parity between physical and mental health is vital.

Dare to Care

Don't fear those experiencing a mental illness. It can happen to anyone.

Don't ignore early warning signs.

Dare to challenge the myths and the misconceptions.

Provide better care; ensure access to care, insist on equity in care. All this must be done and all this is possible if we dare to believe that mental health care is a basic health concern for all.

Introduction



Do mental and brain disorders only affect adults in rich countries?

No. All are affected – children and adults, rich and poor.

Number of persons world-wide with epilepsy (yellow) and schizophrenia (blue) (in millions)

Source: The International League Against Epilepsy (ILAE) 1999

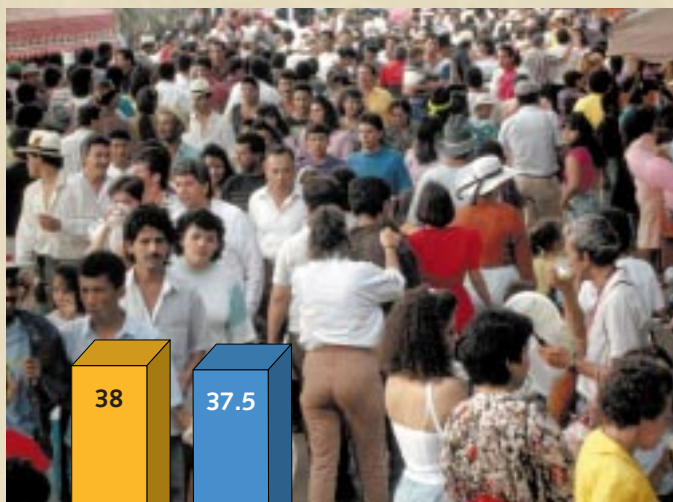
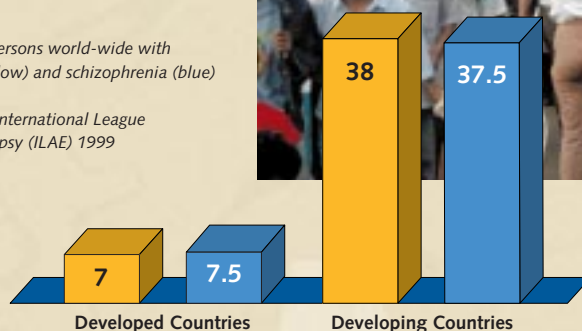


Photo: © WHO, C. Gaggero

No one is immune.

Mental and brain disorders affect adults, elderly, children and adolescents

Approximately one in five of the world's youth (15 years and younger) suffer from mild to severe disorders. A large number of these children remain untreated as services simply do not exist. The majority of treatments have been traditionally geared to adult patients, ignoring the need for early intervention in childhood.

- Some 17 million young persons in the 5-17 age group in Latin America and the Caribbean are affected by mental or brain disorders severe enough to require treatment.

- A study has shown that 10% of school children in Alexandria, Egypt suffer from depression. Anxiety among the secondary-level school children in their final year of school was found to reach 17% in this study.

Mental and brain disorders are a concern for both developed and developing countries

No nations and no peoples are spared:

- In a landmark WHO study in 27 developing and developed countries, no population has been found to be free of schizophrenia.

- Alcohol abuse is another common disorder that knows no boundaries. For example, in Russia, 35,000 people die every year from fatal alcohol poisoning.
- Epilepsy is universal and more frequent in developing countries
- A recent survey in a rural Pakistani village concluded that 44% of the adults were affected by depressive disorders.

Are mental and brain disorders just a figment of one's imagination ?

No. They are real illnesses that cause suffering and disability.

"Pull yourself up – it's all in your imagination." How often have we heard that? It's not just friends and family that fail to grasp the existence of a mental disorder. Even governments choose ignorance, as seen by the fact that mental health is often excluded from their health priorities and plans.

Mental disorders are real

Mental illnesses and brain disorders provoke suffering, cause disability and can even shorten life as we see from episodes of depression after a heart attack, numbers of liver disease resulting from alcohol dependence or cases of suicide. The existence of mental and brain disorders often remains hidden, voluntarily by the patient or simply unrecognized as a real illness by the person and their family. Yet the underlying abnormal substructure of many disorders has been identified by images of the brain. Thus to ignore their existence is akin to denying that cancer exists because we are unable to see the abnormal cells without a microscope. **Mental illnesses can be diagnosed and treated before it is too late.**

The symptoms are a sign of real illness

There are people who suffer from overwhelming fears that are accompanied by a host of recognizable symptoms. Others grapple with constant negative or unpleasant thoughts and turn to alcohol to escape. In some cases, the patient's pain can be so excruciating that suicide is seen as a relief. *In the year 2000, there will have been an estimated one suicide death every 40 seconds.*

It is easy to ignore or dismiss many symptoms, yet the fact is that five out of the ten most disabling disorders are psychiatric in nature. **Unipolar depression, alcohol use, bipolar affective disorder (manic-depression), schizophrenia and obsessive-compulsive disorder are among the 10 leading causes of disability world-wide in 1990.** The disability associated with mental or brain disorders stops people from working and engaging in other creative activities, e.g., a mother may cease caring for a baby, an adolescent may stop socializing with peers, and an elderly person may no longer take care of himself or herself.



Photo: © UNHCR, A. Hollmann

“If someone has a broken arm, you feel sorry for them. But when (the problem is) psychiatric, people don't know how to react because they can't see anything. But just because you can't see someone's pain, it doesn't mean they don't need your care and support.”

Samoan woman, manic depressive, 29 years old, Auckland, New Zealand



Is it impossible to help someone with a mental or brain disorder?

No. Treatments exist and caregivers can be assisted.



Photo: © PAHO, A. Waak

Counselor meets with a mother and her mentally impaired child during a counseling session in a community health center

Something can be done for all mental and neurological disorders

Some people recover completely. Others have a more difficult time. But in all cases, there can be an alleviation of suffering through different methods. For example,

- Schizophrenia, a severe disorder, is treatable. People suffering from schizophrenia can be helped with medication to reduce the symptoms. A relapse can be prevented with psychosocial interventions aimed at the family, for the benefit of all.
- Most recently diagnosed children and adults with epilepsy could have a complete control of seizures for many years, provided they receive appropriate medicines.
- Rehabilitation measures, aimed at enhancing social and personal skills, assist persons with depression to regain a normal life. Anti-depressant medication can also help in many cases.

Help can be found from the medical profession on two levels.

The general health workers, such as physicians and nurses, are the first professionals whom one could consult. Most communities have access to them but in some parts of the world, they are not prepared to address the emotional needs of their patients. With proper training and supervision these professionals could be better equipped to identify and provide effective treatment for mental and brain disorders. A major stumbling block is to lift the shame so that people will talk freely of their emotional problems with their family doctor.

The specialized health workers, including psychologists, psychiatrists (for mental disorders) and neurologists (for brain disorders), psychiatric and neurological nurses, social workers and occupational therapists provide expert care where available.

It is not enough to assist only the suffering person

The family, which constitutes the main support system, needs support as well to preserve its functioning and well-being. Such help is seldom received; more services for families need to be developed in all countries.

Are mental or brain disorders brought on by a weakness in character?

No. They are caused by biological, psychological and social factors.

Research is being conducted to determine the genetic origins or biological factors of various disorders

Genes have been shown to be associated with the origin of schizophrenia and Alzheimer's Disease. Depression is known to be associated with changes

in brain chemicals. Alcohol dependence, often branded as a vice resulting from poor moral character, is now linked to both the social environment and to genes. Mental retardation provides another example. One biological cause of this disorder is the lack of iodine, vital for brain development, in the diet of a growing child.

Social influences can significantly contribute to the development of various disorders

For example, individuals react differently to stressful situations. Loss of a loved one can potentially lead to a depression. Loss of work is associated with heavy alcohol use, suicide and depression. Poor nurturing environments, whether they are the result of broken families or violence in the home or community, can result in an increased risk of mental illness.

In some places of the world, mental illnesses are thought to be caused by evil spirits. This is a difficult issue. It pits faith against fact, faith healers against doctors, cultural beliefs against scientific knowledge. Perhaps to prevent a situation from taking a turn for the worse, mental health professionals can work with healers so that those who cannot be helped by traditional medicine can receive conventional treatments. **Mental health professionals serve the community better by understanding the cultural and social context within which their work is to be carried out.**

"You could get over it if you really tried." How often is this said? Yet, it is not a question of willpower or effort alone. In some cultures, people may also consider that "immoral" behaviour or bad fate are responsible for mental health problems. Let us not simply blame the person or poor luck but try to understand the complexities of a mental or brain disorder.

Extreme poverty, war and displacement can influence the onset, severity and duration of mental disorders.



Photo: © WHO/WPRO, M. Murray-Lee



Photo: © UNHCR, C. Sattlinger

“Mental illness is one of the major afflictions of mankind that has had little support in the past. During the last half century there has been quite a revolution in the understanding and treatment of major mental illness such as depression, schizophrenia, manic depression and anxiety. Rather than a flaw in character or a consequence of a dysfunctional family, recent research has shown that mental illness has biological roots.”

Julius Axelrod, 1970 Nobel Prize for Medicine in a letter to WHO Director-General on 30 June 2000



Should we just lock up persons with mental illness ?

NO. People with mental illness can function and should not be isolated or restricted.



Is this what we want ?

Photo: © CICR, C. Chiacchiarri

We have seen there are many possible treatments available; there are also better and more appropriate conditions in which we can provide these treatments.

Today, the picture in the world is far from perfect, but **care is now available in a variety of environments.** People's own homes, clinics, emergency rooms, psychiatric wards in general hospitals and day care centers are all viable options. Rehabilitation is carried out in hostels, cooperatives, sheltered workshops and through social support groups.

Like physical disorders, mental and brain disorders vary in severity. There are those that are:

- transient (like an acute stress disorder);
- periodic (like bipolar disorder, characterized by periods of exaggerated elation followed by periods of depression);
- long lasting and progressive (like Alzheimer's Disease).

Treatment must be appropriate to the disorder, and take into account the individual's situation: is the person alone at home? Does he/she have family who could provide care together with the doctor or a nurse? **The best alternative will depend on each individual, and in any situation, the human rights of people must be preserved.**

The treatment of mental illness is most often associated with mental hospitals. Institutions that violate basic human rights, stripping one's dignity through inhumane care still exist today. Too often abandonment, confinement, or isolation can be seen as the only solution when confronted with an ill person. **Yet, the facts show us that persons suffering from a mental illness or a brain disorder can improve and contribute to society.**

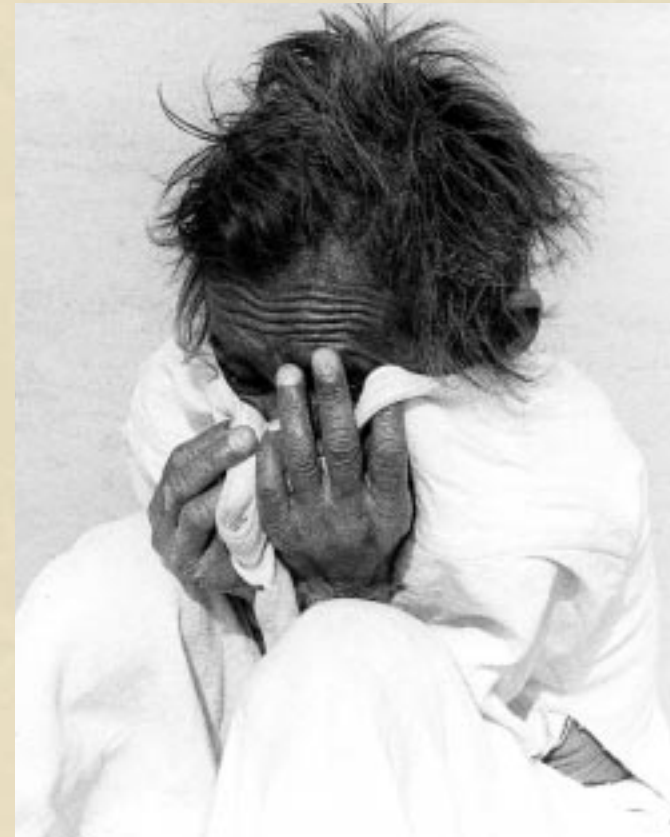


Photo: © WHO, A.S. Kochhar

There are many other misconceptions about mental illness and brain disorders. To address them all here would be well beyond the scope of this brochure. Take the time to explore your own personal prejudices and unfounded beliefs.

We should all recognize that persons with mental illness suffer not only on account of their illness. They are often socially stigmatised, if not condemned. In everyday life, this impedes that people:

- reintegrate fully into society, obtain decent housing, a paying job or a reasonable social life. For a person who has been discharged from a psychiatric hospital, such exclusion may lead him back to the hospital;
- go for treatment when necessary, for fear that the search for help be known to others causing a loss of social status to both the person or the family. This is a serious problem since suffering is not relieved and functioning or quality of life may be affected as the disorder continues.

The myths surrounding mental health problems are responsible for terrible shame and contribute to the low levels of treatment.

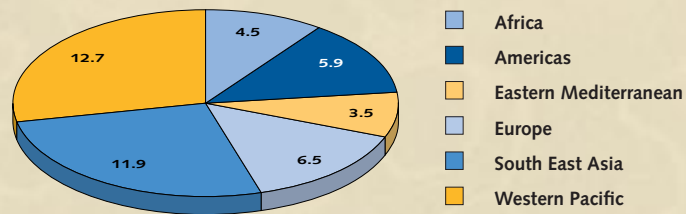
“ I experienced homelessness at one stage coming out of the hospital. I had nowhere to go. I had no other choice. My family at that point was struggling with their own view of my condition and there was no place in the family for me. If my family had been educated, taught how to help me, supported and helped, then my story would be very different. Families need to be involved – they are after all the ones we rely on the most.”

Woman with a schizophrenic disorder, 43 years old, New Zealand

“ I am the main care-giver for my husband's brother, who is schizophrenic. The families of the mentally ill ... need to know that they are not to blame for the illness that has torn their family apart. Shame and fear build walls of silence. Now is the time to speak out so that families can know that they are not alone, that they have nothing to be ashamed of. The public must be educated to recognize symptoms, to know that mental illness can strike anywhere and to understand that help is available.”

Mrs. Kathy Esquivel, wife of former Prime Minister of Belize, Central America

Schizophrenia



Number of people with schizophrenia world-wide (in millions)

What is it?

Schizophrenia is characterized by profound disruption in thinking and feelings, affecting language, thought, perception, and sense of self. It often includes psychotic experiences such as hearing voices or holding fixed abnormal beliefs, known as delusions.

How many suffer?

Around 45 million persons world-wide above the age of 18 suffer from schizophrenia at some point in their lives. The disorder has been found in all nations where studies have been conducted. It begins at a young age and can impair functioning causing the loss of an acquired ability (i.e., not being able to gain one's own livelihood or disruption of studies).

What can be done?

Research has advanced the understanding of the disorder and made major contributions to the treatment. Treatments are both of a biological nature (e.g. medication) as well as psychosocial (e.g. psycho education of the family and rehabilitation). The helplessness of the past has been replaced by considerable hope since conditions that once were treated in

closed institutions have been giving room to interventions at home, in community services, general hospitals and hostels. Psychosocial rehabilitation has made considerable strides and has enabled patients to find a place in the workforce, in their families and communities. Early treatment is essential for better recovery.

“My first-born son, today aged 39, was first hospitalized at age 17 for about four months, some four years after his mother died of cancer. The official diagnosis of schizophrenia was disclosed to me only five years after its onset.

“For about ten years while at home, my son refused to take medication due to adverse side effects, refused to see doctors leading to extreme confrontations. For the last five years he is being treated with medication and his condition has stabilized. He now lives in a very decent hostel [half way home] and works in supervised employment for few hours every working day. His social life and personal relations are much improved.

“Beyond the personal saga, I gained extensive experience in the last years. I am involved as member – and recently as chairman – of a family organization. I strongly believe that today most schizophrenia patients and their families can avoid the *via dolorosa* we went through, if using adequate combinations of medication and psycho-social rehabilitation – with strong emphasis on the latter. This, however, requires drastic reform – beyond lip service – by the medical establishment and the public authorities – in the allocation and proper use of the public health funds and manpower. Our families’ organization is committed to struggle to achieve this reform, but it is still a steep uphill struggle.”

Father of a person with schizophrenia from Israel



Photo: © UNHCR, A. Hollman

“I am about fifty-seven years of age. I had never experienced any odd or abnormal state of mind. Neither had I ever known any such thing about any of my family members. By nature I am a very contented person, generally very helpful and cooperative, even to my casual acquaintances. Holding a very senior position in a leading educational institution, I have no problem with my job, status and family.

“In the month of April 2000 all of a sudden I observed certain changes in my mental make-up. Though there was no personal provocation I developed a kind of phobic anxiety, started attaching motives to happenings and persons around. There was a feeling of undue sadness, lack of vigour and inability to concentrate on work and personal matters. I started losing interest in all normal activities; loss in weight, appetite and sleep was also experienced, thus causing so many simultaneously occurring complications, both physical and mental.

“I was diagnosed with depression and assured that it was curable. I religiously followed my doctor's instructions. I have visited him four times and have the satisfaction that with the grace of the Almighty and with the able handling by the esteemed Doctor, I have regained my confidence and have restarted taking interest in all normal activities around.”

Male patient from India

What are they?

Depressed mood and loss of interest and pleasure characterize these disorders. If they alternate with exaggerated elation or irritability they are known as bipolar disorders (one pole, depressed; another pole, elation or mania). Their severity, the symptoms that often accompany the depressed mood and the duration of the disorder differentiate them from normal mood changes that are part of life.

The causes of these disorders vary, there are psychosocial risk factors that influence the onset and persistence of the depressive episodes as well as biological factors of different kinds.

How many suffer?

Studies demonstrate that one out of seven adult persons in the USA have a mood disorder during a single year, 7% in Brazil, almost 10% in Germany and 4.2% in Turkey. In the USA, 5% of children aged 9-17 were found to have depression, a disorder thought to spare youth and adolescents. Ignoring this reality can result in suicide. Depressive disorders and schizophrenia are responsible for 60% of all suicides.



What can be done?

Despite the existence of solutions, the majority of people with depression do not receive adequate treatment. This implies that there are millions of people in the world currently affected by the disorder whose suffering and disability is prolonged because their condition goes undetected or, often, is not well treated. A reluctance to speak

about one's feelings or poorly trained medical personnel can be at the root of this. Fortunately, there are now clear guidelines for the treatment of mood disorders which include both antidepressant medications and psychological interventions, such as cognitive psychotherapy and social support.



Photo: © UNHCR, E. Dagnino

What is it?

Alzheimer's Disease is a form of dementia which destroys brain cells, disrupting the transmitters which carry messages in the brain, particularly those responsible for storing memories. It is one of the most common types of dementia world-wide and accounts for 50% to 60% of all cases. Dementia is a progressive degenerative brain syndrome which affects memory, thinking, behaviour and emotion. Symptoms may include a loss of memory, difficulty in finding the right words or understanding what people are saying, difficulty in performing previously routine tasks, personality and mood changes.

How many suffer?

There are currently estimated to be about 11 million people world-wide with Alzheimer's Disease. This figure is projected to nearly double by the year 2025.

The late stage of Alzheimer's Disease is one of total dependence and inactivity. At this stage individuals are no longer able to care for themselves and do not recognize relatives, friends and familiar objects. This represents an enormous burden on families and the health care system.

A study by the American Alzheimer's Association in 1998 has shown that this disease costs US businesses US\$33 billion a year; US\$26 billion related to

the absenteeism of caregivers – employees who take care of people with the disease, with businesses contributing another US\$7 billion toward the total cost of care. There are no global figures as yet for the financial impact of Alzheimer's Disease.

What can be done?

There is currently no cure for Alzheimer's Disease. Over the last five years there has been a growth in the number of drugs being developed or considered for use in people with dementia, particularly Alzheimer's Disease, which seem to provide symptomatic relief for some patients. Interventions given by family caregivers can reduce the family's distress and that of the person with Alzheimer's Disease, as well as delaying nursing home placement where this is available. Support for persons with Alzheimer's Disease and their family can come from different sources but is often of limited availability. Voluntary organizations such as Alzheimer's Disease associations give practical and emotional help as well as training for caregivers and professionals.

Alzheimer's Disease

“ I now deeply regret that I was irritated by my husband's behaviour instead of being considerate of him in such a situation, as I did not understand what was wrong. Eventually at the age of 55, (my husband was) diagnosed (with) Alzheimer's Disease. I attended the caregiving study class at the public health centre with my husband. On a public health nurse's recommendation, my neighbours kindly attended the centre to increase their knowledge of the disease. I was helped by them enormously after his wandering started. Although I feel I will never be able to accept my husband's disease, I would like to thank him for giving me the opportunity for mental development.”

A woman's story from Japan

Epilepsy

What is it?

Epilepsy is a brain disease characterized by repeated seizures (“fits”) which may take many forms, ranging from the shortest lapse of attention to severe and frequent convulsions. The causes are multiple, e.g., trauma to the brain, infections such as encephalitis, parasites, alcohol or other toxic substances. However, in half of the cases, the causes remain unknown. Epilepsy is treated by neurologists when available or by psychiatrists in many other places.

How many suffer?

It is estimated that about 45 million people of all ages around the world are affected by epilepsy, while 1% of the total burden of disease in the world results from it. This calculation of the burden of disease takes into account premature deaths resulting from the disease as well as the loss of healthy life years due to disability. The number of people with epilepsy is over five times higher in developing countries than in developed countries.

A vast majority of those suffering remain untreated. Take the case in Africa, for example, where up to 80% of people suffering from epilepsy do not receive any treatment at all.



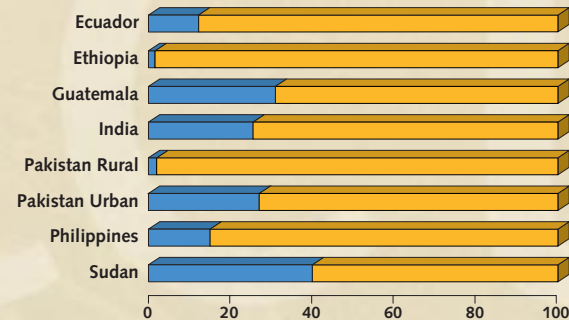
Photo: © WCC, P. Williams

Bet-El School for children with epilepsy run by the NGSK Church in Cape Town, South Africa

What can be done?

The solutions exist so that up to 70% of newly diagnosed cases can be successfully treated with anti-epileptic medication that is taken without interruption. After 2-5 seizure free years, the anti-epileptic medication may be gradually withdrawn in 60-70% of the cases, provided the physician indicates such a course of action. Yet the health care system in many places has

failed to recognize or find those with epilepsy and in some cases, has failed to provide the right treatment to those it has recognized. The important thing to note for a disorder so frequent is that there are medications which are both effective and cost efficient. Given their low price, they are an affordable remedy in all countries.



Treatment gap in developing countries 1988-1996

% of ill persons not receiving treatment in yellow.

Source: The International League against Epilepsy 1999.



Mental retardation

What is it?

The World Health Organization defines mental retardation as a condition of incomplete or halted development of the mind, which is characterized by the impairment of skills as manifested during the developmental period that contributes to the overall level of intelligence, e.g., cognitive, language, motor and social abilities.



Photo © UN/DPI, L. Solimssen



Photo: © Produced by S. Pic

"The Lonely Flower" painting by a severely mentally retarded adult.

How many suffer?

It is estimated that the number of individuals with mental retardation differs in relation to the level of country development. The percentage of young persons, aged 18 and below, suffering from severe mental retardation reaches 4.6% in the developing nations and are estimated to be between 0.5%-2.5% for the established economies. The difference between both figures indicates that, potentially, preventative efforts made to reduce mental retardation, such as better maternal and child health care as well as specific social interventions, could result in an overall decrease of mental retardation worldwide.

What can be done?

The mental potential of all persons, including of those who are limited by retardation, can either be developed or wasted. A positive attitude coupled by appropriate educational and vocational programs can help those with mental retardation to adjust and succeed by performing at their highest level. To achieve such goals, services need to be provided and self help groups, of both families and individuals, need to be fostered. The empowerment of parents could accelerate the formulation of healthy policies, programs and services.

Alcohol dependence

What is it?

Alcohol dependence is a mental disorder recognizable by symptoms which can include a strong and persistent desire to drink despite harmful consequences, inability to control drinking, a higher priority given to alcohol consumption than to other activities and obligations, tolerance to alcohol, and a physical withdrawal reaction when alcohol use is abruptly discontinued.

Alcohol can trigger health problems in a large number of problem drinkers (alcohol dependent or not), including accidents and injuries, heart disease, cancer, liver disease and alcohol psychosis. Alcohol is also related to social problems including crime, violence, marital breakdown, poor school performance, high rates of work absenteeism, suicide and financial debt.

How many suffer?

While there are an estimated 140 million alcohol dependents in the world, there are over 400 million people who drink excessively and can cause accidents, injuries, suffering and death. There is no reason to blame only "alcoholics". Excessive alcohol use is a leading cause of PREVENTABLE death, illness and injury. In 1992 the economic cost to society from alcohol in the United States was an estimated US\$ 148 billion, while studies in other countries have estimated that the cost of alcohol related problems range between 0.5% and 2.7% of the gross domestic product.

- 140 million alcohol dependents
- 78% are not treated
- Alcohol is responsible for 1.5% of all deaths in the world

What can be done?

It is very hard to determine exactly when a person has become dependent on alcohol and by that time a range of problems may have already occurred to the individual and others. As a result, assessing levels of alcohol consumption is the most effective way to identify problem drinkers early. For those at risk, brief interventions of only five minutes can lead to a 25% reduction in alcohol consumption, preventing progress to more severe problems, including alcohol dependence.

Treatment of alcohol dependence and withdrawal can be effectively carried out in community settings for most cases. Voluntary mutual help organizations can also play a large role in supporting recovery from alcohol dependence. However, measures aimed only at treating those who are dependent are not enough. Effective alcohol control policies are also needed.

“ I went to a party, Mom.

I went to a party,
and remembered what you said.
You told me not to drink, Mom
so I had a Sprite instead.
I felt proud of myself,
the way you said I would,
that I didn't drink and drive,
though some friends said I should.
I made a healthy choice,
and your advice to me was right
as the party finally ended,
and the kids drove out of sight.
I got into my car,
sure to get home in one piece,
I never knew what was coming, Mom
something I expected least.
Now I'm lying on the pavement,
And I hear the policeman say,
"The kid that caused this wreck was drunk,"
Mom, His voice seems far away.
My own blood's all around me,
as I try hard not to cry.
I can hear the paramedic say,
"This girl is going to die."
I'm sure the guy had no idea,
while he was flying high,
because he chose to drink and drive,
now I would have to die.
So why do people do it, Mom
Knowing that it ruins lives?
And now the pain is cutting me,
like a hundred stabbing knives.
Tell sister not to be afraid, Mom
tell daddy to be brave,
and when I go to heaven,
put "Daddy's Girl" on my grave.
Someone should have taught him,
that it's wrong to drink and drive.
Maybe if his parents had,
I'd still be alive.
My breath is getting shorter, Mom
I'm getting really scared.
These are my final moments,
and I'm so unprepared.
I wish that you could hold me Mom,
as I lie here and die.
I wish that I could say I love you, Mom
So I love you and good-bye.”

Author unknown, circulating on Internet

Taking stock

“Great numbers of mentally ill still live, shut away behind hopeless walls by the prejudices and incomprehension of society. The efforts of the most advanced psychiatrists to have the mentally ill treated as other sick people, who can be cured, are likely to remain fruitless as long as irrational fear of ‘madness’ is not conquered, as long as all the influential members of the social hierarchy do not understand that mental health is not only the business of specialists but must concern the whole community.”

This statement was written forty years ago, in a special issue of World Health commemorating World Health Day in 1959. What is remarkable is that this statement is still reflected in the public image of mental health today. As we realize that the global perception and practice in mental health remains much as before, we can bring to light the incredible accomplishments in many corners of the world. Today we have the opportunity to take one giant step forward collectively— out of the darkness – into the glimmering rays of knowledge that many have endeavored to bring forth. We know many things: mental and brain disorders are real illnesses, they are diagnosable, treatable and in some cases we know how they occur and how to prevent them. Anyone can be afflicted but we pretend not to be concerned.

A change now needs to happen in our hearts to accept the knowledge which has been gained and to adopt a new attitude about mental health. We are the missing link – the minds of some billion souls – that should come to realize that one’s mind and brain can become sick but can also be healed, just as the body.

We are on the path around the world to improve the care of persons with mental or brain disorders.



Group health session in Venezuela

Photo: © PAHO, A. Waaik

Reorienting Mental Health services

The United Nations Commission of Human Rights stated not only that **medical treatment should be considered as a basic right for people suffering from mental illness**, but also that those people have to be **protected from potential dangers**. This was far from the case for centuries of mentally ill patients. While some countries have been moved to change this situation, still others have not. Violations of human rights can be perpetrated both by neglecting the patient through carelessness and by forcing him/her into restraining or even violent care systems. Even under optimum circumstances, persons with mental illness in most countries are often powerless. Yet, family members and patients themselves can try to influence mental health policy and service organizations.

Latin America – an example of the “consumer” movement

In the early 1990’s, throughout Latin America care for persons with severe mental disorders was mostly provided in outmoded mental institutions that often violated human rights. Outraged by this situation, a group of parliamentarians, mental health workers, media, consumers and advocates, representing eleven countries gathered in Venezuela to analyse mental health care and suggest ways to upgrade it. The Caracas Declaration which resulted from this historical meeting has given further impetus to a movement of reform in mental health care that was on the making in several countries of Latin America.

Brazil is one example where considerable strides have been made. **Active participation of patients themselves in the formulation of policies to overcome past inequities provides a strong voice and vitality to a process of change that is moving the care from closed institutions into the community.** Change is resisted by some quarters, often as a result of ill-conceived notions and traditions, yet observers of the Brazil case note that the patients keep the agenda moving forward and force the pace of this reform among both professionals and society at large. The struggle has been taken to the streets and into the chambers of the parliaments. Brazil has developed innovative programmes, such as the one in the city of Santos, State of São Paulo, where mental hospitals of yesteryear have given room to alternative settings of care and where consumers are gainfully employed by co-operatives.

Chile is another example of a country resolutely moving forward to transform its services. Today, community clinics are mushrooming all over its territory although, admittedly, some areas are yet to be covered. Moving north, in Central America, Panama and Belize, among other countries, are innovating the type of services offered. Belize, for instance, with just a single psychiatrist working in the country, has multiplied its resources by training family nurses known as psychiatric nurse practitioners, entrusted with the provision of mental health care. A recently conducted evaluation has shown that the public is satisfied with their services, now offered all over the country. Despite these improvements, there is still a long way to go to reach the aims that the authors of the Caracas Declaration had in mind. In Latin America, some populations do not have mental health coverage, many services remain substandard and human rights violations have not been banished.

De-institutionalization and human rights – the case in Europe

De-institutionalization (providing care to the mentally ill in community settings and not in harmful institutions) is very closely related to human rights concerns and represents a basic precondition of any serious mental health care reform. De-institutionalization is not the mere administrative discharge of inmates’ populations leading to dramatic patient neglect. On the contrary, de-institutionalization is a complex process, where **de-hospitalization must lead to the implementation of a network of alternatives, outside of the walls of the mental hospital.** A more positive notion of “non-institutionalization”, with emphasis on community alternatives should be the norm in all countries.

In Italy, the 1978 Mental Health Reform began a process of “humanization” of the psychiatric hospitals and led to the creation of community based services capable of enabling patients to live in normal environments. The Italian city of Trieste has created an impressive network of community based services, protected apartments and co-operatives employing mentally ill persons. The psychiatric hospital in Trieste was closed down and replaced by community mental health services operating 24 hours a day. These centres provide medical care, psychosocial rehabilitation, social assistance and when nec-

essary treatment of acute episodes. A number of protected apartments providing a “non-medical” and friendly environment for the most severely and chronically ill were created. Finally, work opportunities have allowed many patients to secure a substantial integration into the community life. Many other European cities have witnessed a marked shift from hospital-based to community-based systems leading to an important decrease of mental hospital beds and, in some cases, the closing of the whole institution. The Siauliai mental hospital in Lithuania, for example, is on the road to providing rehabilitation services and reintegration of psychiatric patients into the society. With the purchase of a residential building this year, increased attention is given to psychosocial interventions aiming to ensure that after treatment the patients can independently function at home and in society. Similar scenarios of community mental health care are being built in other regions of the world, yet still not in the generalized fashion that we hope for.



The Siauliai mental hospital in 1980

Photo: © L. Serpetuskas



The Siauliai mental hospital in 2000

Photo: © O. Bieliuskienė

Mental health as part of general health care services

Mental health care is a basic and essential building block for ensuring life-long good health. **The family doctor and general practitioner need to become increasingly better able to recognize any potential mental impairment or brain disorder in order to provide quality care.** In many parts of the world, different methods are being utilized to address this concern.

One example from the Middle East

An innovative approach for ensuring that basic mental health services are available to all people, even the most vulnerable and deprived groups, was conceived in Iran in 1985 as the "National Mental Health Programme".

A unique feature of the Iranian health system is the integration of health delivery and medical education in one ministry. At the base of a pyramid

approach are the Health Houses in rural areas (and more recently Health Units in urban areas); each one is responsible for the basic health needs of around 2000 people. These small units rely on human resources that are recruited from the community and trained. There is one community volunteer for every fifty families to assist them in getting any necessary medical attention. Health Centers group together four or five health houses or units and provide the services of a General Practitioner. Such a center is in turn supervised by the District Health Center and has access to specialist centers that are usually part of a University of Medical Sciences and Health Services. In each province of the country (population of sixty million), there is at least one such university which is in charge of health affairs of the province as well.

The integration of mental health care within this existing nationwide struc-

ture started as a test case in central Iran in 1987. Mental health responsibilities of each level were clearly defined and appropriate training, follow-up and supervision provided. The mental health system is supported by a third specialized level composed of 650 psychiatrists and about 10,000 psychiatric beds, although most of them are still in large psychiatric hospitals. To gradually decrease the reliance on mental institutions, there is a standing decree from the Minister of Health and Medical Education that 10% of the beds in all new general hospitals should be used for psychiatric care.

At present, the programme is active throughout the country: almost 60% of the rural Health Houses and 25% of the Urban or Mixed Health Centers comprising 5,500 general practitioners are active in providing mental health services.

This approach has been adapted by other countries in the region, such as Bahrain, Cyprus, Egypt, Jordan, Tunisia, Saudi Arabia and Yemen. There is more than one recipe for success but this approach to integrating mental health care within a primary health care system is a good testimony to what may be accomplished in other parts of the world.



Training of mental health professionals in Iran.

Photo: © A. Mohit



Woman with schizophrenia (holding child) in care at home with her family in India.

Photo: © R. S. Murthy

The empowerment of families

Family involvement in the care and rehabilitation of persons with mental or brain illness is being recognized world-wide as a key factor in successful treatment.

The case in South Asia

The family has been an essential part of mental health care programmes in South Asia for fifty years.

The first formal recognition of the importance of the family as part of organised mental health care can be traced to the mid 1950's in Amritsar Mental Hospital, India. Patients were brought for hospital admission as a form of abandonment once their mental illness was long-standing and their relatives had no more hope. As an experiment, the relatives were encouraged to stay with the patient during the treatment period by pitching tents on the hospital grounds. The success of this involvement led to other similar experiments and the system of including a family member has become an essential part of psychiatric in-patient care in all countries of the Region.

The focus of family interventions, to date, has been to build a relationship with caregivers based on understanding and empathy, and helping them to:

- identify ways to promote medication compliance;
- recognize early signs of relapse;
- ensure swift resolution of crisis;
- reduce social and personal disability;
- moderate the effect in the home environment;
- improve vocational functioning of the patient;
- develop self-help groups for mutual support and networking among families.

More than 500 persons who were long-stay patients in the mental hospital have been rehabilitated in Sri Lanka, by community education and family involvement. In a number of cities such as Jodhpur and Chennai in India, a camp approach to drug detoxification has included the families as "partners in care". The home

care programmes for elderly persons with dementia initiated in Kerala, India, is now spreading to other parts of the country. Another initiative is training for home care and support to family members of mentally retarded individuals. This has resulted in a movement that has generated vocational rehabilitation for the adult mentally retarded individuals. Families of a person with schizophrenic illness in many cities (such as Bangalore, Chennai, and Gauhati in India, Katmandu in Nepal and Colombo in Sri Lanka) have come together to form self-help groups and start day care centres, half-way homes, hostels and to put pressure on the policy makers to improve services for the mentally ill persons.

The successes of family care programmes have still not received the full support of professionals and planners to the extent that it becomes a routine part of psychiatric care. As we enter the 21st century, this must become commonplace for everyone around the world.



Photo: © Douleurs Sans Frontières, S. Laurent

Mental health counselling after floods in Mozambique.

Mental health care in countries in conflict

Many countries in Africa are engulfed in conflict and civil strife resulting in an adverse impact on the mental health and well-being of the affected populations. It is estimated that there are between 40 to 50 million refugees and displaced persons worldwide. Of these, only 22.4 million receive humanitarian protection and assistance and around 30% of these displaced persons are in Africa. Increasing poverty and lack of international legal consensus are some of the major factors preventing most of the refugees from receiving support.

Wars, other forms of violence and disasters contribute to the growth of psychological and socio-economic burden. Family disruption with an increase of abandoned children and women headed families; increase of street children; juvenile delinquency; prostitution; and alcohol and drug related problems are a common scenario in a number of countries of Africa. All these stressful events contribute to anxiety, depression, different psychosomatic disorders, phobias and post traumatic stress disorders.

Community Based Psychosocial Interventions – the story in Africa

Community based approaches to tackle mental health problems and other consequences of war and social disruption were recently the subject of two important inter-country meetings involving Angola, Burundi, Chad, Congo, Democratic Republic of Congo, Eritrea, Ethiopia, Lesotho, Liberia, Mozambique, Namibia, Rwanda, Sierra Leone, South Africa, Uganda and Zimbabwe. These countries have embarked on different types of community based interventions despite the difficult conditions which include:

- **prevention and promotion activities** such as peace education, conflict resolution skills, prevention of alcohol and drug abuse;
- **early detection and treatment of physical, psychological and social problems** involving nutritional rehabilitation, first aid for victims of land mines and other forms of injuries, psychological support using school teachers and self-help groups;
- **rehabilitation** through social reintegration, family reunification and the promotion of human rights.

The involvement of community and religious leaders, traditional medicine practitioners, women and youth organizations and self-help groups is very effective to ensure culturally sensitive initiatives.

Mental health care in transition economies

Innovating mental health – one example from Central Asia

Mongolia is a country which is changing from socialism to one with a market economy following a democratic political reform in 1990. This change has been affecting all aspects of Mongolian life: political, economic and social life, especially impacting on the family. In 1997, the National Health Policy has articulated the shift from a specialist to a generalist health care delivery system. As a consequence, general health services are being strengthened, and hospital based care has shifted to bring a greater emphasis on community based health care.

Policy makers and government authorities have recognized the importance of mental health by specifically including mental health services in the new national health policy. As a consequence, appropriate training in mental health and psychosocial skills is provided to all general health personnel. In addition, health promotion among youth to prevent the adverse effects of social changes (such as increased alcoholism, suicide, violence and criminality) has been undertaken. In the last two years at least 50% of general physicians in Ulaanbaatar City as well as the provinces in the eastern, western and central parts of the country have not only undergone mental health training, but have started to manage patients with mental health problems in their clinics. These general physicians have also included mental health topics in their health education activities in the schools and during their

home visits. Since 1999, the mental health training has been expanded to include the community health workers; many of whom attend to the nomadic groups representing 40% of the Mongolian population.

Since 1998, a decrease in admission and in the length of hospital stay at the State Mental Hospital has been noted. An increase in the number of patients treated in the general health clinics as well as those referred to the outpatient clinic and the Center for Mental Health are also recorded. A Mental Health Law, passed in 1999, provides for the continuation of these reoriented programs in the country.



We can do better Stop exclusion Dare to care



Photo: © WHO/WPRO, S. Suomela

Families

- In a crisis, involve all family members to solve the issue and support each other emotionally.
- Recognize early symptoms and encourage family members to seek help if needed.
- Support those suffering and do not dismiss their symptoms. Integrate them in the life of the family and the community.
- Join with other families to support each other and change common misconceptions.

Mental health care is a collective and continuous undertaking. It implies acting to preserve and recover that which makes people human, alongside with the spiritual life. It also requires a healthy environment, one that is peaceful, in which all people may prosper, where tolerance is generalized, and where violence is diminished. Without this, we are all at a greater risk for ill mental health.

Everyone can help

Individuals

- Encourage wholesome early attachments and the acquiring of age appropriate abilities in children.
- Seek help if you have a mental health problem or think you have symptoms.
- Join in efforts to dispel the myths about mental illness and brain disorders.



Photo: © WHO, A. Vaak



Photo: © UNHCR, C. Black

A vision for the future

- Every individual will recognize the importance of mental health.
- Patients, families and communities will be more empowered for taking care of their mental health needs.
- Health professionals will become more skilled in prevention and treatment of mental illnesses as well as the promotion of mental health.
- Policy makers will be better equipped to plan services more rationally and ethically.



Photo: © WCC, P. Williams



Photo: © WCC, P. Williams

Medical professionals

- Consider your patients' emotional state as well as their physical state.
- Seek out training to recognize symptoms and acquire skills to care for those with a disorder.
- Involve the families in caring for the patient.

Policy makers (governments and insurers)

- Mental health is influenced by social factors; ensure that policies extend beyond the mental health care system to include education, labor, criminal justice and general health care systems.
- Provide coverage to assume the costs of mental health care as a basic guarantee.
- Allot funds for mental health research.

Science

- Study, in a comprehensive manner, all factors, including genes, environment and behaviour that contribute to the cause and duration of mental and brain disorders.



Photo: © WCC, P. Williams

Mental Health professional associations

- Advocate for care to be provided equitably and in the most optimal conditions.

Media

- Contribute to empowering communities by reporting pertinent information and avoiding stereotypes and sensationalism.
- Focus on human rights of mentally ill persons.



Photo: © WHO/WPRO, S. Suomela

NGOs

- Educate the public about mental health and disorders.
- Organize support groups for families of the ill individuals.
- Mobilize public opinion about policies, programmes and welfare benefits for the mentally ill.

For more information

The WHO World Health Report which is focusing on mental illness and some brain disorders will be available in June 2001. The Report will provide more substance to the issues which have been highlighted in this brochure.

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Many non-governmental organizations are making a difference in improving mental health care and reducing exclusion. They are too numerous to list in this brochure. Visit the website www.who.int/world-health-day for links to many of these organizations.

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Bridge the gap

Health, as defined in the
WHO Constitution, is a state of
complete physical, mental and
social well-being and not merely
the absence of disease or infirmity.



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