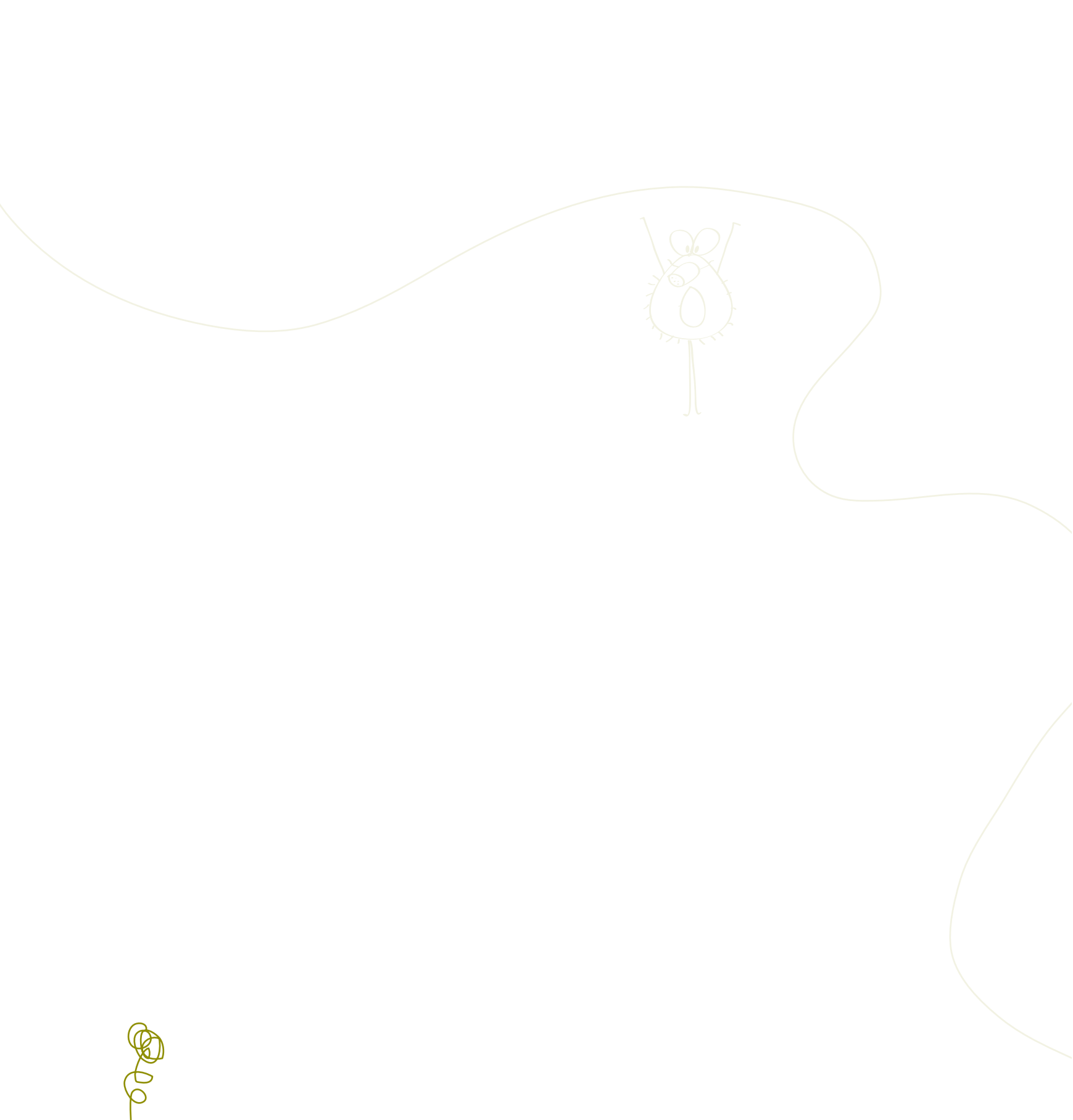
CHAPTER 3

MENTAL HEALTH

unlocking the asylum doors



3

MENTAL HEALTH

unlocking the asylum doors

Equipped with modern health-care methods and a better understanding of mental illness, the World Health Organization and its partners are working to open the asylum doors. Much has changed in the past 30 years.

Bouaké, Côte d'Ivoire, 1982: Grégoire Ahongbonon was in a street when he had his revelation. "I was walking along and I saw a man, a mentally ill person, completely naked digging through a trash can for something to eat," he says. It was something that he had seen many times before in the streets of Bouaké and normally he would have crossed over to the other side and kept on walking. He was, by his own admission, afraid of people with mental disorders, a perspective he shared with many.

Ahongbonon is not a psychiatrist. In fact, he started out repairing tyres. "I also owned a taxi company," he says. "I was doing well. I owned my own car at age 24, but then I lost everything. I became so depressed I even considered suicide." But then the rediscovery of his religious roots turned him towards others.

Photo 3.1. Benin, 2007. Grégoire Ahongbonon (right) with a mental health patient

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"I saw that it was Jesus Christ who suffered through this poor man," he says. "It forced me to question my fear." He walked up and asked if he could help. The man needed food and water. And he needed something else. After a series of similar encounters, Ahongbonon came to the realization that everyone needed the same thing. "I saw that people with mental disorders were seeking love like everyone else."

Love and respect, and clean water. Ahongbonon and his wife began to walk the streets of the city at night handing out food and drink. From there they opened a little chapel in a back room on the grounds of the general hospital in Bouaké, and began, says Ahongbonon, "to look after people". The results surprised everyone, including Côte d'Ivoire's minister of health, who agreed to expand the space and build a centre inside the hospital. This was a major breakthrough in Côte d'Ivoire where, as in many other countries, the mentally ill had for a long time been kept in institutions located at a distance from cities. "It was for me a miracle," Ahongbonon says.

From that point people came to Ahongbonon with word of sick relatives or friends and he began to see things he could barely believe. "People chained to trees and left in the forest," he says, shaking his head. "Men, women, children." And these were not acts of casual cruelty. They were attempts at a kind of treatment. "People believe that by making the person suffer, they will drive the demon from the body," Ahongbonon explains.

To banish such superstitions – that people with mental disorders are struck by witchcraft – and to integrate them back into society, Ahongbonon established the Saint Camille de Lellis Association the following year, 1983. He and his co-workers work hard to remove the stigma attached to mental illness and free those afflicted with mental disorders from chains or blocks of wood, where they have been placed by their families or village chiefs. By 2006, the association had established a network of 10 centres in Côte d'Ivoire and Benin and had treated thousands of people, 85% of whom have been reintegrated into society. "We have come to see work as essential to the recovery of people with mental disorders," says Ahongbonon, who encourages patients to engage in a range of vocational activities such as farming. "People who have been chained up for years feel enormous relief in working. We have people who have come through our programme to become lab technicians," Ahongbonon says proudly (Photo 3.1).

Such treatment of people with mental disorders is a universal phenomenon. Virtually every society has locked up their 'insane', and many continue to do so. In poor countries it may mean keeping patients in chains, while in wealthier countries patients are sedated and confined to institutions (see Box 3.1 Breaking the chains). This is one of the greatest challenges for WHO and its partners in their work to encourage a better understanding of mental illness, and promote effective and humane treatment.

Dr Itzhak Levav is also a passionate advocate of mental health care reform. In November 1990, as Regional Coordinator for Mental Health in WHO's Regional Office for the Americas, Levav organized a conference in Caracas, Venezuela, that was to become a milestone in public health.

Levav, a psychiatrist, had seen the abuses of people afflicted by mental disorders. He was determined to return their dignity and humanity. It did not mean he wanted to stop giving them treatment. It just meant that their treatment should be based on sound scientific evidence and human rights. He and his WHO colleagues proposed that conventional psychiatric care in Latin America should be decentralized. To help countries do this, WHO engaged volunteer consultants to provide technical support to the countries. The Organization maintained – and continues to do so today – that patients do better if they are not locked up

Box 3.1. Breaking the chains

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Côte d'Ivoire, 1990s. Man chained to a tree

Dr Mohammad Taghi Yasamy was visiting a mental hospital in Hargeisa in northern Somalia where, to his horror, he saw patients who were chained to posts. Yasamy, a mental health specialist at WHO, asked for an explanation. "They said it was because these people were out of control," he recalls. "But when I opened the chains, I found that most of the patients were quite calm." That day – after discussions with the patients, families and health providers – an idea was born. The Chain-Free Initiative is now a WHO programme to stop restraining people with mental health conditions.

The WHO initiative has three phases: chain-free hospitals, achieved by removing chains, and reforming hospitals into patient-friendly and humane places with no restraints; chain-free homes, which involves removing the chains in homes and providing training for family members on how to help a sick relative recover; and chain-free environment, which involves removing the invisible chains of stigma and restrictions on the human rights of people with mental illness.

Through this initiative, WHO wants hospital staff to become more aware of human rights issues and to adopt more humane and scientific methods of caring for these patients. The initiative encourages the creation of associations for service users and families, and the establishment of chain-free committees to lobby for humanitarian assistance to people with mental illness.

The Chain-Free Initiative was first piloted in the Somali capital, Mogadishu, and then in Kabul, Afghanistan, in early 2007, where it became a joint project between WHO, the Ministry of Public Health and the Kabul Mental Hospital. As a result, the hospital is now well maintained and all chains have been removed. The programme is catching on in other countries.

"In Kabul, family members showed a lot of support," says Yasamy. "They were keen to help out in providing a more decent living standard for the patients." Yasamy hopes that eventually patients can live and work independently and enjoy full reintegration into society.

Photo 3.2. Trinidad and Tobago, 1977. Doctor prepares to sedate his patient

WHO/M. Beaubrun

in asylums or remote psychiatric hospitals, but integrated into the community. It is an approach based on breakthroughs in treatment made since the 1950s. That was the idea behind the Caracas conference, and it caused something of an uproar among psychiatrists.

Like a visit to the dentist

Psychiatrists in Europe and the USA came out of the 1940s armed with some very blunt instruments – crude versions of electroconvulsive therapy, where the brain is given an electrical shock for therapeutic effect, and even more brutal 'psychosurgical' procedures, such as prefrontal lobotomy. Dr Walter Freeman's refinement of this procedure involved driving a spike into the frontal lobe of the brain. Such was Freeman's enthusiasm for lobotomy and its 'calming' effects that he recommended it for patients, even those with mild symptoms, and predicted that it would become as commonplace as a visit to the dentist.

Fortunately, Freeman's 'vision' was swept aside by the first effective psychiatric medicines, which became available in the 1950s. Chlorpromazine, which became better known under the brand name Thorazine, was originally developed as an antiemetic – a drug that suppresses vomiting – but was found to have powerful antipsychotic properties. Thorazine didn't just calm people down, it also seemed to promote clarity in thinking, and revolutionized psychiatric care, making it much easier for severely ill people to return to society. Meanwhile, synthetic muscle relaxants, developed at the beginning of the 1950s, allowed for slightly safer use of electroconvulsive therapy, while antidepressants such as iproniazid offered hope to those diagnosed with mood disorders or depression. Ken Kesey's 1962 book *One Flew Over the Cuckoo's Nest*, a darkly humouristic exposé of asylum life that features a tyrannical nurse and ends in a lobotomy, was very much a book of its time.

The development of these drugs brought enormous change. In WHO's view, forcible restraint and psychosurgery had never been necessary. It had never been necessary for people with mental health disorders to be sedated and confined for many years in psychiatric hospitals (Photo 3.2). But now, with new mental care methods and new medicines, doctors finally had an alternative. Meanwhile, outside the asylum walls, society was changing. A broad social movement to shut down and reform mental hospitals was gaining momentum and Caracas was the trigger.

Major reforms started in Brazil, Chile, Italy, Spain, the United Kingdom and other countries.

But while the possibilities for treatment were improving, not everyone saw the benefits. Where money was scarce, the impetus for mental health reform was weaker. Poor countries, such as Kenya, Uganda and the United Republic of Tanzania, for example, had difficulty just maintaining the status quo, and struggled to prop up dilapidated, overcrowded asylums.

Many of the patients spent years in such places, heavily sedated, never visited by qualified psychiatrists or relatives. Institutions like the Mathari Hospital in Kenya had existed since 1910 and had served the British colonial armed forces during the two world wars as a place where they could send their 'mad' soldiers. It was run along strictly segregationist lines, the 'native lunatics' – who represented 95% of the inmates – being corralled in 'bomas', buildings traditionally used for livestock, while the wards were reserved for Europeans.

Photo 3.3. Benin, 2008. Patients participate in a training project of the Saint Camille Association

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In the United Republic of Tanzania, the mental health system had been established under German colonial rule in the 1890s and was run along the same centralized lines as found elsewhere in Africa, the most famous large hospital being Muhimbili. But the system began to change in the 1960s, with the government pushing to establish more regional psychiatric units in an effort to get services closer to the people who needed them. In the late 1970s, the health ministry, working closely with WHO and the Danish development agency, started to decentralize mental health care, which was to be provided as part of the general health-care system – an integrated approach that came to typify WHO-supported models. Rehabilitation villages were also established, providing patients with training in skills, such as farming and carpentry (Photo 3.3).

Box 3.2. Schizophrenia – nature or nurture?

One misconception about mental illness is the belief that people are 'born that way' and nothing can be done to prevent it. Studies with identical twins show, however, that environmental factors play an important role in the development of mental illness too, and not least in the development of schizophrenia.

That was borne out by the experience of Dr Carolyn Spiro and her sister, Pamela Spiro Wagner. While on call at the psychiatric unit in Boston in the USA where Carolyn worked, she was stunned to hear the news – her identical twin sister had been diagnosed with schizophrenia, a severe mental disorder characterized by profound disruptions in perception and thinking, including hearing voices or experiencing delusions.

Despite being genetically identical, the sisters had taken starkly divergent paths. One had become a psychiatrist, the other – a psychiatric patient. Cases like this have prompted the question: to what extent do genes (nature) and environment (nurture) play a role in mental illness? If genes were the only determinant factor, then Carolyn would also have developed the disease just like her twin sister, Pamela, because they were genetically identical, but she didn't. The Spiro twins' story is told in a book *Divided minds: twin sisters and their journey through schizophrenia.*

Schizophrenia affects about 26 million people worldwide, and around 60% of cases are thought to involve a genetic predisposition. Twin studies show that if one identical twin develops schizophrenia, the second has a 50% chance of developing the condition too. With fraternal twins, who are genetically similar but not identical, the second twin will have a 9% chance of developing schizophrenia, which is above the 1% expected in the general population.

By the mid-1970s, the World Health Assembly had fully embraced the revolution in health care and WHO was taking steps to put mental health at the heart of its concerns. Not that it had ever been far away. Indeed, the WHO constitution defines health partly in terms of mental health, declaring health to be a state of "complete physical, mental and social well-being". The WHO Expert Committee on Mental Health of 1949, which encouraged the application of psychiatric knowledge to preventive work, and the groundbreaking International Pilot Study of Schizophrenia of 1973 (see Box 3.2 Schizophrenia – nature or nurture?) were clear evidence of the Organization's commitment.

WHO reaches out

In the mid-1970s, WHO created the Division of Mental Health, and appointed a regional adviser for mental health in each of its six regional offices, one of whom was Levav. The new division expanded its network of collaborating centres from fewer than 10 to more than 100, including some of the most prominent people working in psychiatry from 80 countries – WHO was reaching out.

And becoming frustrated. Because it seemed that no matter how much the Organization sought to make the global community aware of current thinking on psychiatry, little seemed to change. Ten years after the World Health Assembly first acknowledged the existence of effective treatments for mental illness, WHO's director-general at the time, Halfdan Mahler, expressed growing frustration with the lack of progress in a report in 1988 entitled *Prevention of mental, neurological and psychosocial disorders.*

The report concluded with a statement that verged on a rebuke, saying, "… countries were fully aware of the major public health problem that mental, neurological and psychosocial disorders represent. Countries are also aware of the existence of effective measures for their prevention, and that the wide application of these measures could diminish the devastating effects of these disorders for health and social productivity of individuals, communities and nations." The final conclusion of the report was that although some activities had been undertaken at a regional and global level, "there was a vast potential for an enhancement of WHO's role in national efforts". The director-general wanted individual nations to invite WHO in, so that together they could come to grips with the problem of mental health care and start making a tangible difference.

But beyond making statements, there was a limit to what WHO could do. Publishing the latest research showing that shutting down old asylums was a good thing and that medicines to treat psychiatric disorders should be prescribed by primary health care providers made no difference if countries didn't make mental health a priority (Photo 3.4). Brazil was a case in point. In the late 1980s and early 1990s, patients there were locked up for indefinite periods in institutions designed to keep people off the streets rather than help them get better. The situation was made worse by a health system that granted funds according to the number of beds filled, a policy that had led to Brazil maintaining 246 psychiatric hospitals, with 70 000 beds. This compared to the United Kingdom, for example, which, while it had only a third of Brazil's population, maintained only 50 such hospitals. Not only were there more mental institutions in Brazil, but the hospitals there had a financial incentive to prevent their 'inmates' from leaving.

Something needed to change. "We needed to broaden the debate," Levav says, recalling those turbulent times, and Caracas was the ideal forum. A broader debate required participants from different spheres, such as non-specialists like Ahongbonon. Levav made sure that such people were invited – as well as politicians. "The conference was very well attended at a ministerial and even senatorial level," Levav recalls. "These days we think nothing of having government people present, but back then it was not so usual."

Mental health was at the bottom of everyone's political agenda. There were no lobby groups, while the people affected – the mentally ill and their families – formed a narrow constituency that politicians had little interest in

Photo 3.4. Colombia, 1974.
Patient locked behind bars

WHO

cultivating. In so far as politicians were aware of their country's mental health arrangements at all, they were generally – and with good reason – ashamed. Levav thought this was wrong, and that politicians should be made to take responsibility for their policy, and, if they didn't like it, to change it.

The presence of human rights activists at the Caracas meeting was vital. "With the Inter-American Commission for Human Rights of the Organization of American States there, we knew the debate would be different. We all knew there was going to be finger-pointing," Levav says.

In the end, the fingers were pointed at Mexico. "There was a lot of tension at the conference with people speaking very openly," Levav recalls. "Mexico was far from being the only country to face challenges in its mental health system, but as it turned out there was also a good deal of criticism of Mexico, and the Mexican officials went on the defensive. In the end, that was a good thing because it polarized the debate and made it easier for people to get behind a declaration calling for fundamental reforms." Later, Mexico did endorse the Caracas Declaration, as it became known.

The Caracas Declaration called for reform of mental health legislation to protect the civil rights of people with mental illness and decentralize psychiatric care in the Americas. For the first time, media and advocacy groups had been invited to join the debate. It was a watershed moment, especially for Latin America. The English-speaking Caribbean followed suit. Prior to the Declaration, psychiatric care in Latin America generally meant custodial care – incarceration – in remote asylums characterized by understaffing, and poor hygiene, food and clothing. In other words, the familiar nightmare.

In some countries change was already in the air. In parts of Argentina, Brazil, Colombia, Ecuador, Panama and Paraguay, which all enacted new constitutions in the 1980s, there were provisions allowing for more civil rights, including those of mental health patients.

After Caracas, the pressure for reform grew, and led eventually to new legislation. In Brazil, for example, laws were introduced that guaranteed the rights of people with mental illness. Senator Paulo Delgado was the author of a bill designed to phase out psychiatric hospitals in his country, regulate compulsory commitment to mental units and encourage care in the community. People with mental health disorders were in Delgado's view "the world's most oppressed people, one of the last groups still not given basic human rights".

Dissenters branded 'insane'

After the 1990 Caracas Declaration, human rights became a touchstone in discussion of mental health care reform, and this remains the case today. "People with mental disabilities must be empowered everywhere. Human rights violations of people in psychiatric institutions occur every day in countries across the world," says Dr Benedetto Saraceno, former director of WHO's Department of Substance Abuse and Mental Health.

The push to reform the system in Brazil was given extra weight by the support of writer Paolo Coelho, who wrote a letter to the Senate that, as "a victim of the violence of being committed [to a psychiatric hospital] totally unjustifiably, I see this new law not only as opportune, but absolutely necessary." Coelho, who has written several best-selling books, revealed that his family had committed him to a mental institution claiming that he suffered "psychological upsets" and was hostile to his parents.

His father even cited Coelho's political views as symptomatic of mental illness. Brazil was not the only country where political dissenters were branded 'insane'. Some countries went further and actually used psychiatry as a weapon to suppress political dissent, for example, the former Soviet Union, where some government critics were treated with psychoactive drugs and confined to asylums for years.

A year after Caracas, in 1991, Modest Kabanov, director of the Bekhterev Psychoneurological Institute in the Russian city of St Petersburg, was one of the first to officially acknowledge past abuses in Soviet psychiatry. Kabanov led an investigation by psychiatrists into the case of a former Red Army general called Pyotr Grigorenko who was committed to psychiatric hospitals twice, in the 1960s and 1970s. They rehabilitated Grigorenko by officially declaring him 'sane'. It was the first step in a programme of rehabilitation for thousands who had suffered similar treatment.

In Brazil, the reform programme rested on two pillars: the creation of decentralized units to care for people with severe psychiatric disorders and a programme that gave money to families who welcomed home relatives who had spent years confined in mental hospitals.

Since 1995, the number of psychiatric beds in mental units in Brazil has fallen by around 41%, whereas community services have increased ninefold. Reform has also increased access to essential psychotropic drugs for all citizens.

For Saraceno, Brazil's achievements in this area are remarkable. "I attended meetings in Brasilia such as I have never seen in my life, organized and funded by the government and attended by hundreds of severely mentally ill patients discussing mental health reform – a remarkable example of empowerment, democracy and consultation," he says. Similarly impressive, in Saraceno's view, is the fact that reform has taken place without huge expenditure.

The next significant step forward came in Europe, where, in 1999, WHO and the European Commission agreed to collaborate on mental health reform. In Italy, for example, some of these reforms had already started as early as 1978 and led to a network of services that allowed people with mental disorders to live in the community. For example, in Trieste, the psychiatric hospital was closed down and replaced by community-based services providing sheltered accommodation, acute care when needed, social support and help finding work.

What was happening in Europe served to draw attention to what was not being done elsewhere. Addressing the European Conference on Promotion of Mental Health and Social Inclusion held in Tampere, Finland, in October 1999, WHO director-general Dr Gro Harlem Brundtland said that while the mental health issues and problems in Europe certainly needed attention, Europe also had to consider its responsibilities regarding the rest of the world.

Studies carried out in the previous 20 years had shown that mental disorders were twice as frequent among the poor as among the rich, and by extension in developing as opposed to developed countries. Nor was it just a question of poverty. If you added to the psychological pressures brought by hunger, overcrowded living and low levels of education, the horrors of war and the psychosocial impact of natural disasters and diseases, such as HIV/AIDS, you had the basis of a global mental health crisis that could only get worse.

A mental health snapshot

Brundtland's comments in Finland anticipated one of WHO's most significant initiatives in this area to date, the publication in 2001 of the Organization's annual flagship publication the world health report, entitled *Mental health: new understanding, new hope*, a milestone in consciousness-raising that sought to give a comprehensive global picture of mental health. Dr Shekhar Saxena, Director of WHO's Department of Mental Health and Substance Dependence, says: "For the first time we had a document that enabled us to talk about the facts rather than having to base our discussions on assumptions about global mental health."

A huge undertaking, the report was a snapshot of the entire planet's mental health.

The report showed that roughly one in 10 adults – an estimated 450 million people at the time – were affected by mental disorders. It also showed that psychiatric disorders accounted for about 12.3% of the global burden of disease for the year 2000, a figure that was forecast to rise to 15% by 2020. From the point of view of disability alone, without the effects of premature death, the impact of mental illness was starker still, accounting for 31% of all years lived with disability.

For all the reasons we have seen so far, mental health disorders are often hidden from view. The report's findings were dynamite. It was the first time that the full magnitude of these disorders became evident on a global scale (see Box 3.3 How big is the problem?).

Box 3.3. How big is the problem?

One reason why mental illness tends to be neglected is the difficulty of measuring the problem. It is not difficult to count the work days lost to influenza, but much more difficult to make the same calculation for, say, depression.

That changed with the introduction of a measure known as disability-adjusted life-years (DALYs). First developed by the World Health Organization in the 1990s, DALYs measure what is known as the burden of disease – in other words the size of the health problem – by calculating the sum of years lived with disability (YLD) and the number of years lost (YLL).

In 2004, psychiatric and neurological conditions together accounted for 13% of the global burden of disease. Some of the main disorders included in this are:

- alcohol disorders 2%
- bipolar affective disorder 1%
- dementia 1%
- schizophrenia 1%
- unipolar depressive disorder 4%.

Unipolar depression ranked as the third largest contributor to the global burden of disease worldwide and the greatest contributor in middle- and high-income countries.

These metrics not only allow us to gain a better idea of the true effect of mental and psychiatric disorders, but knowing the scale of the problem also makes for more effective planning and management of public health programmes.

That year, WHO took up the cause in a big way. Director-general Brundtland not only devoted the *World health report* to the subject of mental health, she also made it the theme of World Health Day on 7 April that year and the subject of a roundtable discussion for health ministers from WHO's Member States at the annual World Health Assembly gathering in Geneva.

Perhaps the most striking finding of the 2001 report was that nearly half of all countries had no national mental health policy whatsoever. A quarter didn't even have legislation establishing the rights of people with mental disorders. Nearly a third of nations had no specified budget for mental health, while roughly one third of the global population lived in nations that invested less than 1% of their total health budget in mental health. As a general rule, the poorer the country, the less they invest in mental health.

Photo 3.5. Benin, 2006. To fight the fear and stigma of mental illness, former patients participate in vocational training to learn how to make fabrics for dresses and table cloths

Fondazione Saint Camille

But the picture was not entirely bleak. A 'Caracas effect' was taking place. Where mental health policies did exist, for example, half had been formulated during the previous 10 years – in other words after the Caracas Declaration. Significantly, nongovernmental organizations (NGOs) were active in the mental health sector in many developing countries, such as Grégoire Ahongbonon's Saint Camille Association in Côte d'Ivoire and Benin (Photo 3.5).

Four years after the *World health report*, another report, the *Mental health atlas 2005,* revealed that while there were nearly 10 psychiatrists per 100 000 people in Europe, there were only 0.04 psychiatrists for every 100 000 people in Africa. The reality then, and now, is that many people with mental illness were not receiving the treatment they needed.

As well as giving a clear picture of global mental health, the 2001 report called on countries to provide treatment at the primary care level – that is to say, where generalist doctors treat patients in the community. This would enable the largest number of people to get faster access to services and psychotropic medicines.

Today, WHO continues to recommend that people be cared for in the community, believing that this approach is more cost-effective than treating people en masse in mental hospitals and that it leads to better treatment outcomes, an improved quality of life while encouraging the respect of human rights.

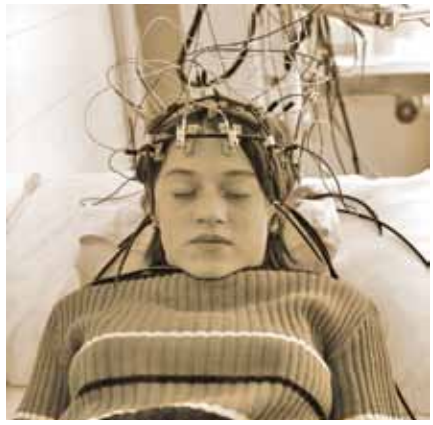
At a more macro level, WHO also continues to call for policies, programmes and legislation based on scientific evidence and human rights considerations. To achieve this, most countries would have to increase their budgets for mental health from the existing very low levels. There would also need to be improved training of the mental health professionals and also support for primary health care programmes providing mental health care. Finally, WHO recommends that countries monitor community mental health care services closely and support research that could help gain a better understanding of mental disorders and develop more effective methods of caring for and treating people with such disorders.

Little or no treatment

Recommendations and guidelines are, however, not enough and some countries need more assistance in adopting a modern approach to mental health. To help them take practical steps to achieving this, WHO launched the Mental Health Global Action Programme in 2008. More than 75% of people with mental disorders in developing countries receive no treatment or care.

The new programme aims to make politicians more aware of the problem, so that they take it more seriously and spend more money on it. In Africa alone, nine out of 10 people with epilepsy go untreated, unable to obtain simple and inexpensive anticonvulsant drugs (Photo 3.6). The extra cost to extend services for mental disorders to more people in need is not great. Provision of treatment also means training adequate numbers of specialized nurses and doctors, particularly in low- and middle-income countries, where staff shortages for mental health are often acute.

Photo 3.6. Socialist Federal Republic of Yugoslavia, 1982. Young woman receiving an electroencephalogram at the Psychiatric Institute in Belgrade. This is a method of diagnosing patients for epilepsy, by measuring the electrical activity produced by their brains



WHO/P. Almasy

Box 3.4. Alcohol and mental health

People have consumed alcohol – wine, beer and spirits – in diverse cultures around the world for thousands of years, but many of the health consequences of excessive alcohol consumption have only become clear recently.

Alcohol consumption has increased during the last few decades globally, with all or most of that increase in developing countries – many of which have little tradition of drinking alcohol or experience in prevention, control or treatment of alcohol-related health problems.

Alcohol can cause several diseases, including cancer of the oesophagus (or gullet through which food passes to the stomach) and of the liver, as well as cirrhosis of the liver. It is a risk factor for mental conditions, such as depression, bipolar disorder and anxiety as well as for domestic violence and road accidents.

Globally, alcohol causes an estimated 2.3 million deaths (3.8% of total) and 69 million (4.5% of total) of DALYs (see Box 3.3 How big is the problem).

WHO/B. Stephenson

United Kingdom, 1995. Alcohol consumption is a risk factor for depression, bipolar disorder and anxiety

A WHO study, known as the "mhGAP report, showed that, in low-income countries, extending an essential package of services to people with schizophrenia, bipolar disorder and depression and with one risk factor for mental illness – hazardous alcohol use – requires an additional investment as low as US$ 0.20 per member of the population/per person receiving treatment (see Box 3.4 Alcohol and mental health).

The new programme aims to make treatment available in developing countries for depression, schizophrenia, alcohol and drug dependence, dementia, epilepsy and suicide. A core part of this programme is to reduce the stigma attached to mental illness. The stigmatization of people with mental disorders is one of the biggest obstacles preventing people from seeking the treatment. But WHO's efforts alone cannot change attitudes to mental illness – its success will depend on the willingness of countries to change the way they deal with mental illness.

Twenty years after Caracas the signs are encouraging, as the number of governments, NGOs and individuals striving to improve mental health care has grown. As already stated, Brazil, Chile, Italy, Spain and the United Kingdom were among the first to reform their mental health care. Since Caracas, several developing countries have followed suit, including Ghana, Lesotho, Namibia and Sri Lanka. Meanwhile, reforms are under way elsewhere including in the Gambia and India.

Chile, for instance, is improving conditions for people with mental disabilities. For example, the national primary care programme in Chile includes treatment of depression for all who need it, bringing much needed care to thousands of its people.

A project in China, which integrated epilepsy control into local health systems, has achieved good results. This project showed that epilepsy could be treated there with an inexpensive anti-convulsant medicine by health professionals who had undergone basic training. That project, which started in six provinces, has now been extended to 15 provinces and tens of thousands of people have been treated.

Following a critical judgement by the African Commission on Human and People's Rights on human rights violations at the Campama psychiatric unit in 2003, the Gambia, asked WHO for assistance in drawing up a new mental health policy. In 2009, a new institution, the Tanka Tanka Psychiatric Hospital, opened to replace the Campama unit, which was closed down, while other new units were established at the country's six main general hospitals, thus integrating most mental health services into the country's primary health care system in which patients are treated on an outpatient basis.

Ghana is another African country to have called on WHO for help in drafting new legislation and starting to treat mental health disorders in the community. In 2007, an estimated 650 000 of the 21.6 million people living in Ghana were having severe mental disorders, while a further two million or so were living with moderate-to-mild forms of the disease. Treatment is available at most levels of care, but the majority is still provided through specialized psychiatric hospitals located close to the capital and therefore serving a fraction of the population. Government funding tends to go into these institutions, leaving community-based services to rely on private funding.

Through training, consultation and review of different drafts of new law using WHO materials and tools, Ghana has also developed new health legislation that shifts from institutional care to outpatient treatment in primary health care centres.

The Organization's work over the past 60 years has often influenced the debate in countries embracing reform. For example in India, where media discussion of a tragic fire which occurred at an asylum in Erwady, Tamil Nadu, in 2001 constantly referred to WHO's *World health report 2001* on mental health.

The fire prompted calls for mental health reform in India, with the Supreme Court recommending that a new policy be drawn up and that adequate and humane mental hospitals be established (Photo 3.7).

Photo 3.7. India, 2002. Women locked behind metal cage at the Institute of Human Behavior and Allied Sciences, New Delhi. India has been introducing reforms to its mental health system

WHO/P. Virot

Box 3.5. A suicide every 40 seconds

Suicide is arguably the most extreme expression of mental illness. Almost one million people die committing suicide every year, representing about 13 per 100 000, or around one death every 40 seconds.

Suicide rates have been higher among older men in the past, but today young people are most at risk in rich and poor countries alike, in particular women. For women aged between 20 and 59 years, suicide is the seventh leading cause of death worldwide.

While mental disorders, notably depression and problems associated with drug abuse, are risk factors for suicide, social and cultural factors can also play a role.

In China, suicide is the leading cause of death among adult women in rural areas and the rates of suicide among women are higher than among men.

Among the factors cited are family disputes, domestic violence, social isolation and the availability of lethal pesticides. In China and other parts of Asia, a high proportion of suicides in rural areas are by women who poison themselves with pesticides.

However, there is evidence that adequate prevention and treatment for depression, which tends to affect more women than men, as well as for other mental disorders, excessive alcohol use and substance abuse can reduce suicide rates considerably. Also, strategies to ensure that pesticides are stored properly and kept out of harm's way have been effective interventions in reducing the number of suicides in rural areas in Asia.

Bondevik's gamble

Levav, who strove so hard to get human rights onto the agenda at the Caracas conference of 1990, believes that the care of the mentally ill has come a long way. "I remember seeing naked people in a cage," he says. "A terrible thing, it is an image that has stayed with me. There were nameless people suffering terribly." He is convinced that in cases where there are such abuses, the patients would not remain nameless for long. "The pressure from the media now, coupled with the actions of advocacy groups and NGOs makes it less likely for that kind of thing to happen without it coming to the world's attention," he says.

In many countries, the asylum doors are no longer locked. But many people with mental health disorders still remain reluctant to come forward and seek help because they fear being branded a lunatic, or they fear the stigma attached to mental illness. One of the greatest challenges for all societies and for WHO is to fight that stigma.

In August 1998, Norway's prime minister Kjell Magne Bondevik, during his first term in office, announced that he was suffering from depression and was taking a break from his duties to seek treatment and recover. A few prominent Norwegians said the depression proved Bondevik was unfit to govern. But when he returned to work after three and a half weeks of rest, which included sleeping late, walking in the country and meditating, he found that his honesty and willingness to speak openly about his depression was rewarded. An opinion poll revealed that 85% of Norwegians thought their prime minister had done the right thing. The episode led to an outpouring of support from across the country that helped to break down the stigma surrounding mental illness.

Bondevik's gamble paid off, but it might just as easily have failed. As Saraceno, formerly of WHO, points out, while we consider it normal for someone to take time off work because of a physical ailment, we are less tolerant of illness that affects the mind. "If I break my leg skiing, people will say 'a physically active man, broke his leg. Of course he needs time off'. But if I say 'I cannot get out of bed in the morning because I am feeling depressed', they will say that I should pull myself together".

In South Africa, a recent public survey backed that view. It showed that most people thought mental illnesses were related to either stress or a lack of willpower rather than to medical disorders. Contrary to expectations, levels of stigma there were higher in urban areas and among people with higher levels of education.

The simple fact is that depression, schizophrenia and bipolar disorder are illnesses just as diabetes is an illness. Mental illness taken as a whole, estimated to affect 450 million people worldwide, is as much a public health issue as HIV/AIDS or any other infectious disease. The World Health Organization has long worked for a change in attitudes based on the assumption that mental illness and mental well-being are points on a sliding scale, rather than the poles of a notional 'heaven' where everyone is sane and a 'hell' where everyone is crazy.

Mental disorders are common all over the world and contribute substantially to overall disability and premature death, including by suicide (see Box 3.5 A suicide every 40 seconds). Despite this, many people with such problems receive little or no treatment or care. A WHO global review of scientific literature found that 32% of people in need of treatment for schizophrenia were not receiving it, while the number for depression was 56%, and for alcohol-related disorders was 78%.

At the launch of the Mental Health Global Action Programme in 2008, WHO Director-General Dr Margaret Chan called for more action to address "the abysmal lack of care, especially in low- and middle-income countries, for people suffering from mental, neurological, and substance use disorders". She described these as being "among the most neglected problems in public health" (see Box 3.6 Fact file: mental health).

Echoing so many before her, including her predecessor Brundtland, Chan said that the solution was not to "virtually imprison affected people in costly and largely ineffective psychiatric hospitals, where human rights abuses are often rampant".

She added: "People suffering from mental disorders face considerable stigma and discrimination. Their human rights are often violated in communities as well as in mental hospitals. This is another duty: to give these people a voice as active partners in calling for adequate and appropriate care." ■

Box 3.6. Fact file: mental health

Mental health is a state of well-being in which an individual can cope with the normal stresses of life, work productively and make a contribution to society.

- More than 450 million people suffer from mental disorders around the world, about half of which begin before the age of 14.
- Depression is ranked as the leading cause of disability worldwide.
- War and other major disasters have a big impact on mental health.
- Low-income countries have 0.05 psychiatrists and 0.42 nurses per 100 000 people. The rate of psychiatrists in high-income countries is 170 times greater and for nurses is 70 times greater.
- Few countries have laws that adequately protect the rights of people with mental disorders. Stigma attached to mental disorders and discrimination against patients and families prevent people from seeking mental health care.