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MINISTERIAL ROUND TABLE

This document explains why WHO is increasing the attention it pays to mental health and identifies a number of issues that the ministerial round table at the fifty-second session of the Regional Committee may choose to address in its discussions.

1. INTRODUCTION

Mental health has been neglected. The reasons for this include the historical separation of mental and physical health in the professional and public minds, a poor understanding of the concepts of mental health and mental illness, the stigma attached to mental illness, and a failure to recognize the extent of the individual and community burden of mental illness and poor mental health.

While physical health has improved over the last 50 years, mental health has declined. There are number of important issues associated with the decline in mental health (these are addressed in more detail in the regional strategy on mental health in document WPR/RC52/14):

- Social and economic factors have had a significant overall negative effect on the level of mental health in the Region.

- For this and other reasons, including improved survival rates in all age groups, the burden of mental and neurological disorders has grown in both developing and developed countries. Mental and neurological disorders include common disorders such as depression, anxiety, and substance abuse and dependence; less common but disabling conditions such as schizophrenia; epilepsy and dementia; and intellectual disability.

- These disorders account for 27% of the disease burden in the developed countries of the Region and 15% in the other countries of the Region.

- Because mental health training is often not part of the general health system, psychosocial aspects of health care (such as the psychological care and support of individuals and families living with chronic diseases such as HIV/AIDS) are often neglected.

- Suicide is an important problem closely linked to mental health. People living with mental disorders and those abusing alcohol and drugs are at increased risk of attempted or completed suicide. People suffering social and economic stresses, indigenous populations and prisoners are also at risk.

2. DISCUSSION POINTS

1. How are social and economic problems related to mental health and mental disorders?

Rapid social change is associated with rising stress levels for many people throughout the Region. In addition, social and economic instability is apparent in many countries, some of it associated with ‘globalization’ of the world economy, and continued or growing impoverishment of broad groups of rural and poorly educated people. Disasters, armed conflict and violence, displacement, urbanization, migration, unemployment, work stress, unwanted pregnancies, family disruption, and social isolation all affect people in the Region.

These factors are associated with increased rates of depression, anxiety, alcohol and substance abuse, and a decline in overall mental health. People become more likely to develop illness, and less able to cope with the effects individually or within the family. The impact of these factors also makes it harder to gain access to health services because of cost, distribution, or stigma.

Population growth and increased survival at all life stages also mean that more people in developing, as well as developed, countries are reaching the age groups at risk for mental disorders. This includes adolescents and young adults, the age groups at risk for schizophrenia, common mental disorders such as depression, and substance abuse. It also includes older people, at risk for dementia.

The association between mental disorders and conditions that impose high costs on society (such as unemployment, poor productivity, social exclusion, family disruption, suicide) is well known. Yet mental health can also be considered as a positive resource, a key contributor to the quality of life and to social connection. For these reasons, improving the population's mental health can play an important role in decreasing the social burden, reducing the costs associated with mental disorders, and contributing to the growth of social connection, tolerance and participation.

2. How are mental health and mental illness understood?

Health can be defined as a state of balance which individuals establish within themselves and with their environment. It is the product of a number of interrelated dimensions, including mental, physical, emotional, social, cultural and spiritual. Mental health is an indivisible part of health. As with all aspects of health, it is more than the mere absence of illness. It includes the ability of people to think and learn, to understand and live with their own emotions and the reactions of others.

Confusion about the concepts of mental illness and mental health has limited the development of programmes and the availability of resources for mental health. People with mental illness are often considered to be identifiable and different from the rest of the population. Yet the term mental illness means different things to different people. Confusion about the term has been a powerful reason for the low priority given to mental illness, and scepticism about the capacity to treat or prevent.

Two potent sources of confusion about the idea of mental illness exist in the public mind. First, mental illness has to be distinguished from other causes of social deviance also involving distress and abnormal behaviour. Mental illness, eccentricity, and badness are different in meaning. Some individuals may be labelled with more than one of these terms, but it is vital to keep the terms separate. If mentally ill people are seen as ill rather than as eccentric or bad, it is easier to seek ways of providing them with appropriate services, and to seek approaches to prevention and mental health promotion. A second source of confusion is the tendency to overlook the highly specific symptoms and distress of a mental illness because people in the community equate them with common misery and crises. The illnesses of depression and anxiety, for instance, often have a quality difficult or impossible for those suffering "common misery" to understand.

The treatment of mental illness has historically been separated from the rest of medicine and health care. In the isolated setting of the asylums, practitioners saw many seemingly incurable patients. The supposed incurability of insanity and melancholy made practitioners believe the causes were entirely biological. The idea has since persisted that prevention of mental illness is 'all or none'. The psychoanalytic and psychotherapeutic practice which flourished outside the asylums from the middle of the twentieth century also neglected to focus on illness as a product of a system influenced by biological, psychological and social factors.

The fundamental concept of disease as having more than one cause is the basis for preventive medicine. Mental illness has generally been excluded from this framework. However psychiatric treatment services have changed greatly over the last fifty years. Most treatment and care now take place outside large institutions. The expectation is that treatment and care in the community will foster approaches to the problems of mental illness that are similar to those of any other illness.

3. What is mental health promotion, what evidence do we have about its effectiveness, and what can be done now?

WHO defines health promotion as action and advocacy to address the full range of potentially modifiable determinants of health. The personal, social and environmental factors promoting mental health on the one hand and protecting against ill health on the other, can be gathered together under three main headings:

- *Building and maintaining healthy communities*. Healthy communities provide a safe and secure environment, the basic needs of food, warmth and shelter, positive educational experiences, employment and good working conditions. They also provide a supportive political infrastructure and minimize conflict and violence. Healthy communities allow individuals to take control of their lives and provide community validation, social support, positive role models.

- *Enabling each person to deal with the social world through participation, tolerating diversity and accepting mutual responsibility.* These skills are often associated with positive experiences of early bonding, attachment, relationships, communication and feelings of acceptance.

- *Enhancing each person's ability to deal with thoughts and feelings, the management of life and emotional resilience.* These skills are often associated with physical health, self esteem, ability to manage conflict and the ability to learn.

Fostering these environmental, social and individual qualities is the objective of mental health promotion (concerned with the determinants of health) and prevention (focused on the causes of illness). Mental health promotion requires action in the socio-political sphere: for example, reducing unemployment, improving schooling and housing, working to reduce stigma and discrimination of various types, and reducing the risks of brain damage from malnutrition, infection and trauma. The key agents in this respect are politicians and educators, and members of nongovernmental organizations.

Prevention of illness is sometimes categorized by stages of intervention in an assumed causal chain: as primary (to prevent onset of illness), secondary (to reduce the duration and associated disability by early treatment) or tertiary (to reduce sequelae). When causal pathways can be identified, as in some cases of depression, this concept can be useful in prevention of mental illness.

Another approach to health promotion and prevention categorizes interventions according to the levels of risk of illness or scope for health promotion, in various population groups, and makes it clearer what type of collective action is required: universal (directed at the whole population, e.g. good prenatal care), selected (targeted at subgroups of the population with risks significantly above average, e.g. family support for the young, the poor, mothers experiencing their first pregnancy) or indicated (targeted at high-risk individuals with minimal but detectable symptoms, e.g. screening and early treatment for symptoms of depression and dementia).

The activities of mental health promotion may be 'mainstreamed' with health promotion, although the advocacy for mental health needs to continue with specific messages. Many of the activities mentioned above will also promote physical health, and physical and mental health are closely associated.

4. Why does mental illness fare so badly in resource allocation?

There are two main reasons for the limited resources allocated to mental health. The first relates to the stigma and poor understanding of mental health and illness. These have stood in the way of government and society recognizing the extent of the problem of mental illness and the opportunities to improve mental health, by providing services for people with mental disorders, and by collective action to promote mental health. The second reason relates to health statistics. Death rates greatly underestimate the disease burden resulting from mental illnesses. In recent years the World Bank, in cooperation with WHO, developed a new index to measure total burden of disease, disability-adjusted life years (DALYs). DALYs summarize the ill health, disability and loss of life from identifiable diseases in a single numerical measure. While still imperfect, DALYs give a much more realistic measure of the relative level of the disease burden attributed to mental illness. According to these measures, the burden of mental illnesses constitutes 15% of the total burden of disease in the developing countries of the Western Pacific Region. Depression will be one of the largest health problems worldwide by the year 2020.

Problems of mental health are a major and increasing threat to the quality of life, to the economy, and to public health throughout the world.

5. Why should developing countries consider improving services to people with mental disorders and their families?

In all countries, the rates of mental disorders are higher in people who experience relative social disadvantage. For example, depression is more common in women in most countries. Depression in women is in part related to their social position, poor childbirth spacing, domestic and social violence, and an excessive burden of work.

People living with severe mental illnesses are among the most disadvantaged people in any community. The physical and emotional consequences of illness affect their ability to function in family, social and vocational realms, and they experience discrimination in many aspects of life. The complications include family disruption, substance abuse, suicide, illness and premature death from other causes, unemployment, poverty, social isolation and homelessness. Many of these critical outcomes can be avoided with early recognition and treatment; or with appropriate and sustained support for people and families living with long-term illness.

The economic costs of mental disorders are high. Direct costs include costs of health and social services, but there are also other costs, including lost employment and productivity, impact on the productivity and social function of families, and premature death.

However, in all countries most people with potentially remediable disorders are not treated. There is a continuing failure to recognise and treat mental illness, particularly anxiety and depression, in people attending primary or general health care. Approximately 20% of these patients suffer from a well-defined mental illness, often associated with a physical illness; and in a high proportion this is chronic with substantial disability and increased use of health care. Poor access to effective treatments for depression, epilepsy and psychosis is common across the Region, contributing to avoidable disability, much of it in young people and persisting into later life.

While developing countries have many competing health priorities, it is essential that they should not neglect mental health, as in the past. Mental disorders account for 15% of the disease burden in developing countries and mental health is inextricably tied to physical health. The need for effective policies on mental health is particularly acute in countries that have undergone war, famine or other natural or man-made disasters.

5. CONDUCT OF THE MINISTERIAL ROUND TABLE

The ministerial round table has the following objectives:

- to raise awareness among health policy-makers and decision-makers in the Region about mental health and to stimulate thinking about policy changes needed to reduce the burden of mental illness in the Region;

- to encourage sharing of experiences and opinions on these issues, based on the current situation in countries throughout the Region;

- to identify, in general terms, WHO's role in this area.

Ministers attending the session, or their representatives, may participate in the round table discussions and each Member State is invited to nominate one participant. The round table will be preceded by a panel discussion on mental health.