

None the less, ethical conflicts often relate to social suffering arising purely as a consequence of severely limited resources.

Ethical issues necessarily relate to what is acceptable in our own societies, and to our responsibilities to those societies. The issues are not really different in principle in Africa but the emphasis is different. The culture of the

individual and multiple groupings must be respected in the planning and provision of psychiatric services. A continual process of seeking the highest ethical standards of care for everybody in mental health care must be the aim, without any differences regionally or within health care provision – that is, no discrimination for psychiatric patients, wherever they may be.

ASSOCIATIONS AND COLLABORATIONS

The World Health Organization's Mental Health and Substance Abuse Programme

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There has been a rapid rise in the number of people with mental disorders. These disorders represent a major challenge to global development. The burden will be higher in developing countries, which have the least resources to respond. World-wide, 450 million people are affected at any given time. No group is immune to mental disorders but the risk is higher among: the poor; children and adolescents; abused women; the unemployed; persons with little education; neglected elderly people; victims of violence; migrants and refugees; and indigenous populations.

Mental disorders can result in substantial disability, as well as social and occupational disadvantage, in both developed and developing countries. They impair psychological and social functioning, and individuals with mental disorders and disability end up in more socially disadvantaged circumstances.

We can say that mental ill health is a significant contributor to poverty. In addition, the poor have been shown to be more likely to have a mental disorder than those with higher incomes. People in socially disadvantaged situations are exposed to more adverse life events than those in more advantaged environments. We can say that poverty is also a significant contributor to mental ill health.

Finally, poor provision of mental health care results in poor outcomes, avoidable relapses and insufficient rehabilitation. We can say that poor mental health service provision is a significant contributor to the perpetuation of mental ill health and poverty.

However, effective (in some cases cost-effective) interventions are available for almost all mental disorders. These interventions often do not cure the disorders but substantially improve symptoms or decrease relapses, or lead to social (not clinical) recovery, or improve quality of

life. Programmes of mental health promotion and mental ill health prevention can reduce a population's overall vulnerability to disorders and improve its general mental health, through improved individual skills and resources, the empowerment of communities, and improvements in the socio-economic environment. Nevertheless, cost-effective interventions are not always implemented and there is a huge gap between treated and untreated (World Health Organization, 2003).

Closing this gap is therefore a clear obligation: otherwise no discourse around new classifications, concern about more sophisticated diagnosis, or the development of innovative psychopharmacological research can be credible, at least not from the global and moral perspective of the World Health Organization (WHO).

2001 was the Year of Mental Health. The WHO World Health Day in 2001 was a resounding success. Over 150 countries organised activities, including the delivery of major addresses by political leaders and the adoption of new mental health legislation. At the 2001 World Health Assembly, over 130 ministers responded positively, with a clear and unequivocal message: mental health, neglected for too long, is crucial to the overall well-being of individuals, societies and countries. The theme of the *World Health Report 2001* was mental health, and its 10 recommendations have been positively received by all member states (World Health Organization, 2001).

As a result of these activities in 2001, a Mental Health Global Action Programme (mhGAP) was created (World Health Organization, 2002a) to put strategic directions in place for addressing the findings presented in the *World Health Report*.

GAP logic is based on four strategies:

- *Increasing and improving information for decision-making and technology transfer.* We should know

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The areas of promotion of mental health and prevention of mental disorders are being investigated systematically for evidence-based programmes; a comprehensive report is being developed.

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more about the magnitude and the burden of mental disorders around the world, and know more about the resources (human, financial, sociocultural) that are available in countries to respond to the burden generated by mental disorders. We should increase and improve the transfer of technologies related to mental health.

- *Raising awareness about mental disorders through education and advocacy for more respect of human rights and less stigma.* We should address not only the general public but policy makers, politicians and other sectors.
- *Assisting countries in designing policies and developing comprehensive and effective mental health services.*
- *Building local capacity for public mental health research in poor countries.*

At the WHO Executive Board meeting in January 2002 a resolution on mental health was adopted. It strongly supports the mhGAP and urges action by member states. The resolution was endorsed unanimously by the World Health Assembly in May 2002 (World Health Organization, 2002b).

However, the WHO is aware that mhGAP risks remaining a merely theoretical exercise, with limited impact at country level unless further action is initiated. Therefore, the WHO Department of Mental Health has strengthened the normative work on information and policy, by developing the *Atlas* project and the WHO Mental Health Policy and Service Guidance Packages. The *Atlas* provides basic information on the mental health resources of all countries, while the Health Policy and Service Guidance Packages are a series of comprehensive, interrelated, user-friendly modules, designed to address the wide variety of needs and priorities in policy development and service planning.

Good information is a prerequisite for better decisions, for both the WHO and member states. The WHO will bridge the information gap by developing a set of indicators to monitor mental health systems and services at country level. The indicators are drawn from the 10 recommendations included in the *World Health Report 2001*: they suggest actions addressed to all parts of the mental health system, from treatment to prevention and promotion, and to research. The indicator scheme focuses on countries with low- and medium-level resources and goes far beyond the basic information available in the *Atlas*. Through these indicators, countries will be able to monitor their progress in the implementation of their reform policies, provision of community services and activities, and involvement of communities, consumers' and families' associations, and that of other governmental sectors in mental health promotion, prevention, care and rehabilitation. Countries will thus receive a clearer and more comprehensive picture of the main mental health issues and be able to assess improvement over time.

To make the implementation of the 10 recommendations feasible, the WHO has adapted the nature of the implementation to the general level of resources of the

country. In the particular case of developing countries, where the mental health gap is greater, the WHO will offer differentiated packages of 'achievable targets' for implementation (gap-reduction achievable national targets, or GRANTs).

The achievement of the targets will influence both health and social outcomes, namely mortality due to suicide or to alcohol/illicit drugs, morbidity and disability due to the key mental disorders, quality of life, and, finally, human rights. With progress, the standards will be upgraded until countries move up in continuous pursuit of excellence. Relying on sentinel communities in each group of countries and using one or more sentinel disorders (suicide risk, depression, schizophrenia, epilepsy, alcohol misuse, illicit drug use), the WHO will evaluate the impact of the package according to suitable parameters of change.

Of course, the assistance to countries through the GRANTs approach has not stopped WHO core normative and knowledge transfer functions in many key areas. These are discussed under separate headings below.

(1) Mental health prevention and promotion

The areas of promotion of mental health and prevention of mental disorders are being investigated systematically for evidence-based programmes; a comprehensive report is being developed. The WHO Programme is also implementing a large project on the prevention of substance use among young individuals in eight countries spread across four WHO regions.

(2) Mental health policy and service development

A Mental Health Policy and Service Guidance Package is being designed to address the wide variety of needs and priorities in policy development and service planning. The guidance package consists of a series of interrelated, user-friendly modules. These modules include: Mental Health Policy, Plans and Programmes; Legislation and Human Rights; Financing; Advocacy; Quality Improvement; Organisation of Services; and Planning and Budgeting for Service Delivery.

(3) Suicide prevention

The department has launched a global suicide prevention programme called SUPREMIS. The aim is to contribute to a reduction in suicidal behaviour, particularly in countries whose suicide rates are above the regional average. Its main activities are:

- monitoring and surveillance of mortality rates due to suicide
- production and dissemination of information
- technical assistance to member states
- a multi-site intervention study on the prevention of suicidal behaviours (for Brazil, China, India, Estonia, South Africa, Sri Lanka and Vietnam).

(4) Depression

As part of the activities related to the management of mental disorders of public health importance, the department regularly disseminates information and guidelines on the management of depression. It is currently conducting a project on the comorbidity of depression with alcohol use, cardiovascular diseases, cancer, HIV/AIDS and tuberculosis, in order to identify those factors dependent on depression that result in reduced compliance and adherence to the treatment of the comorbid condition. Appropriate management of depression improves both adherence rates and the outcome of those diseases.

(5) Schizophrenia

The department promotes a balanced approach to the management of schizophrenia, one that includes biological treatment, psychosocial rehabilitation, empowerment of consumers and support for families. A multi-site intervention study based on this approach is being conducted in India.

(6) Global campaign against epilepsy (GCAE)

The GCAE is a joint initiative of the WHO and leading non-governmental organisations (NGOs) in this area – the International League Against Epilepsy and the International Bureau for Epilepsy. There is a two-track strategy for the GCAE:

- providing a platform for general awareness
- assisting government departments of health in the development of national programmes on epilepsy.

More than 90 countries are currently involved in the various GCAE activities via the NGOs' chapters and WHO collaborating centres. Large demonstration projects are being carried out in Argentina, Brazil, China, India, Zimbabwe and Senegal.

(7) Substance dependence

The WHO Programme has prepared a report on the neuroscience of psychoactive substance use and dependence, with the aim of overcoming misconceptions and stigma associated with substance dependence, thereby improving access to treatment for those in need.

The Programme promotes strategies for the early identification and management of substance use disorders in primary health care, which have proved to be cost-effective with regard to alcohol problems. To improve our knowledge about the feasibility and effectiveness of screening and brief intervention for illicit drug use, we have developed and validated a screening instrument for drug use and have recently initiated a multi-site randomised controlled study on the effectiveness of brief interventions for illicit substance use in general medical settings.

In the area of the epidemiology of substance use, a global alcohol database (GAD) is being maintained. It is a

single source of global information on alcohol consumption and associated morbidity, mortality and country responses. Several research projects are being conducted in developing countries on alcohol involvement in injuries (12 countries), alcohol and gender (7 countries) and unrecorded alcohol consumption (4 countries).

(8) Comorbidity and adherence issues in infectious and non-infectious disease

It is well documented now that persons suffering from mental disorders have poorer physical health. Mental disorders affect the course and outcome of comorbid chronic conditions, such as cancer, heart disease, diabetes and HIV/AIDS, disorders that are associated with a heightened risk for diminished immune functioning, poor health behaviour, non-compliance with prescribed medical regimens, and unfavourable disease outcomes. For example, it has been shown that depressed patients are three times more likely not to comply with medical regimens than non-depressed patients, and that depression predicts the incidence of heart disease. The reverse relationship also holds true: people suffering from chronic physical conditions have a heightened probability of developing mental disorders such as depression. The Programme has developed a number of projects to address comorbidity and adherence issues.

The effects of drug dependence treatment, including substitution maintenance therapy of opioid dependence with a community-based directly observed therapy (DOT) approach, are being assessed to see whether it improves access and compliance to treatment for HIV/AIDS and for opportunistic infections among drug-dependent people with HIV/AIDS. Substance use, and injecting drug use in particular, is a driving force of HIV/AIDS epidemics in many parts of the world. Dependent drug users are at particular risk of HIV and hepatitis C transmission, as they have impaired control over their lifestyles and behaviours.

To address these problems the Programme has implemented the WHO Drug Injection Study Phase II – the largest epidemiological study of injecting drug use, involving 14 developing and transitional countries in all six WHO regions. Finally, we are carrying out a multi-site project on drug dependence treatment and HIV/AIDS in five countries in South East Asia and Eastern Europe. It aims to evaluate substitution maintenance treatment, and the capacity of services to prevent HIV among service clients, and to assist in the management of HIV-positive clients.

References

- World Health Organization (2001) *World Health Report 2001*. Geneva: WHO.
- World Health Organization (2002a) *mhGAP*. Geneva: WHO.
- World Health Organization (2002b) *Strengthening Mental Health. Resolution of the Executive Board of the WHO*, EB109.R8. Geneva: WHO.
- World Health Organization (2003) *Investing in Mental Health*. Geneva: WHO.

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