Round Table Discussion

Making mental health services work at the primary level

Michele Tansella[1]

WHO's agenda for mental health is encouraging (*1*), and the following points are made in order to supplement the information and proposals contained in it.

Prevention of mental disorders

The recommendations in *Setting the agenda for mental health* state clearly that the evidence for primary prevention of severe mental illnesses is relatively scarce and that, in general, the effectiveness of primary prevention strategies has been proved only in some areas. I believe that, while waiting for more substantial evidence concerning strategies to prevent *specific* mental disorders, the recommendations should include reference to the usefulness of some *non-specific* strategies, such as those aiming to combat poverty, domestic isolation, powerlessness (resulting, for example, from low levels of education and economic dependence), the oppression of women *(2, 3),* child abuse, the abandonment of elderly people, and the violence and trauma experienced by forced migrants and refugees.

Diagnosis and clinical practice

As the report mentions, WHO has produced a significant number of assessment tools which are now widely used, though many of them still need to be improved. However, most of these instruments are for use at the patient level, while we also need ways to measure input, process and outcome of treatment and care at the service level. Such instruments have to be designed, put into operation and adapted to different cultures. Some of them can be made by translating ethical principles into objective measures. The role of WHO in doing this work can be crucial. Nine principles directly relevant for mental health services and their evaluation at the local level have recently been proposed *(4)*: autonomy, continuity, effectiveness, accessibility, comprehensiveness, equity, accountability, coordination and efficiency. From their initials they can be referred to as the three ACEs. Few of them have been translated into quantitative, standardized measures. Such measures at the service level would greatly improve our ability to evaluate and compare mental health services in different settings and cultures, and in various parts of the world.

In community-based programmes, poor adherence to treatment is common, especially with regard to medication. In a meta-analysis of 24 studies it has been found that adherence in people with mental disorders ranges from 24% to 96%, with a combined average of 54% *(5).* In a longer time frame, non-adherence rates have climbed to 74%, with an accompanying rise in relapse rates *(6).* There is now evidence that certain approaches to improving adherence levels are effective *(7, 8),* but as Haynes et al. observe, "it is high time that additional efforts be directed toward developing and testing innovative approaches to assist patients to follow treatment prescriptions" *(9).* The need for protocols and guidelines for the optimal use of available effective treatments, in particular of psychotropic drugs, has been well recognized for some time. Emphasis should now be placed on the complementary need for programmes to implement these guidelines, and for techniques (with cognitive, behavioural and affective components) to improve adherence, especially in patients with chronic mental disorders.

On managing depression in primary care settings, there is no doubt that this is an appropriate and cost-effective approach, and can be best achieved where primary care physicians have access to referral facilities and to essential medication. However, a key point in these projects is for general practitioners (GPs) to be able to diagnose depression and identify patients who would benefit from treatment. Many studies have shown that in this area improvement is both necessary and possible *(10).* However, efforts are often devoted only to teaching GPs to recognize depressive symptoms and suggest treatment. The importance of what happens *before* recognition of psychiatric symptoms is often overlooked. A biopsychosocial approach to patients with mental disorders is indispensable, and it involves using patient-centred, problem-based interview skills. Ingredients for teaching this approach are video feedback by supervisors on consultation with real or simulated patients, and role-play in small groups with a supportive group atmosphere.

The doctors have to learn open-ended questioning, picking up verbal and non-verbal cues, handling emotional responses, clarifying and checking them, and finding out about the patient's health beliefs. They have to do this *before* they learn the list of symptoms and complaints presented by depressive patients. The teaching of such lists for use within the traditional physician-centred approach is useless. It is widely recognized that patient-centred and problem-based interview skills improve recognition of emotional distress, and that much harm is done by trying to use standardized screening and case-finding instruments instead *(11–13).* Only when they have acquired such general skills can GPs acquire the specific ones of recognizing, managing and treating

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[1] Director, Department of Medicine and Public Health, University of Verona, Ospedale Policlinico, 37134 Verona, Italy (tel: +39 045 508860; fax: +39 045 500873, e-mail: tansella@borgoroma.univr.it).

patients with depressive disorders. This two-step procedure is well known but easily forgotten, because quicker, less expensive and easier methods of training are often preferred. WHO should discourage such attempts at taking short cuts to improving the treatment of psychiatric disorders in primary care.

How WHO can contribute

Mental health research is rapidly advancing our knowledge of factors influencing the onset, course and outcome of mental disorders. This advance must be encouraged and promoted through financial support and promotion of research. A wide range of bodies and institutions is involved in this enterprise. My view is that the main contribution of WHO should be to ensure the use of evidence-based results of research for improving health promotion and systems of health care in all countries and in all subgroups of the population, especially the most disadvantaged. Both the translation of research into practice and the dissemination of good practices are extremely complex and difficult tasks. *Setting WHO's agenda for mental health* provides an excellent summary of how to carry them out. ■

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WHO and mental health — a view from developing countries

N.N. Wig[1]

Developing countries and WHO programmes

The World Health Organization has played a very important part in the development of mental health care in developing countries. The influence of WHO is visible in almost all the major developments in mental health care in these countries during the last 50 years, be it in the curriculum for undergraduate medical education, or in the introduction of a mental health component in primary care, or in setting up national programmes for mental health, or in the strengthening of training and research capabilities. It is a record of which WHO can be proud. It also adds to WHO's responsibility to be especially attentive to the needs of developing countries when planning its mental health programme for the 21st century (*1*).

The problems in developing countries of inadequate financial and human resources, together with the pressure of other health priorities, are known all too well. It is, however, not often appreciated that developing countries are also rich in the resources which are so important for the success of many mental health programmes and are as yet grossly underutilized. They include close family ties, extensive social networks, and rich cultural traditions. Resources of this kind, if properly used, can contribute greatly to the success of mental health programmes.

Advocacy for mental health

One of the major difficulties in developing countries is in giving some degree of priority to mental health programmes in the midst of competing health problems such as infections, malnutrition, unsafe drinking-water, and high maternal and child mortality. These are undeniably very pressing and urgent health problems, but so are mental disorders. The tragedy of developing countries now is that we have to fight simultaneously on the fronts both of communicable and of noncommunicable diseases. These problems make advocacy for mental health all the more indispensable, as there is tremendous apathy in this regard among the medical administrators and decision-makers. Initiative and support from WHO would be crucial for changing this attitude and achieving priority status for mental health in developing countries.

The need for a simple measure for mental health problems

One of the major stumbling blocks to measuring health problems is the current style of collecting

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[1] Professor Emeritus of Psychiatry, Postgraduate Institute of Medical Education and Research, Chandigarh. Address: 279 Sector 6, Panchkula 134109, Haryana, India.

epidemiological data in which overriding importance is given to mortality and causes of death. Diseases which do not cause death are left out as relatively unimportant and unglamorous in health programmes. One major advance in recent years has been the concept of disability-adjusted life years (DALYs). It has forced the health planners to take note of mental health problems. While DALYs are a great improvement over the routine measures of general morbidity, they have their own limitations. For example a DALY information set does not take into account the individual's socioeconomic circumstances, and is a very important dimension of health in developing countries. There is an urgent need for some simplified but reliable measure which can routinely report mental ill-health and the circumstances in which it occurs in developing countries.

How broad should be the concept of mental health?

The next important question for developing countries is how broad the concept of mental health should be. Should it be extended to include various psychosocial problems? There is a danger in going to one extreme or the other. If we restrict mental health to mental disorders only, it will become a narrow medical specialty with heavy emphasis on drug treatment. On the other hand if we move it out to the psychosocial problems of living we may dilute the medical model to such an extent that the health workers will not consider it as a legitimate health activity, and not pay sufficient attention to it. In the ultimate analysis, it is the community at large which decides what should be the boundaries of mental health. From my experience in the countries of South Asia, the Middle East and North Africa, I feel that the public at large sees mental health in the larger health context. When public leaders talk of mental health their concern is with the rising stress in life, alcohol and drug abuse, suicides, street violence, broken families, and the like. It is we, the mental health professionals, who must respond to this challenge. The mental health services must be more comprehensive in the 21st century even if we have to enlarge the boundaries of our health programmes.

Outpatient management in mental health care

Modern psychiatry developed in the mental hospitals of Europe in the 19th century. As a result, for a long time, mental hospitals remained the focus of its attention. Unfortunately, the inpatient services of mental hospitals deal with only a small part of the wide spectrum of mental health problems that occur in the community. Moreover, even for the care of the seriously mentally ill, inpatient management in a mental hospital is a costly and inefficient method of care.

Evidence from developing countries strongly suggests that for the vast majority of the mentally ill, outpatient management is the simpler, more cost-effective and humane method of care. The main advantage in outpatient management is the better use it makes of important family and community resources. Family support, which is so easily available in the developing countries, is the sheet anchor for treatment and rehabilitation of the mentally ill in the outpatient management.

Evidence from developing countries further supports the idea that it is possible to organize mental health services as a part of primary health care programmes, provided there are adequate training, supervision and referral systems along with provision of essential neuropsychiatric drugs. Such experiments have been successfully carried out in many countries like India, the Islamic Republic of Iran, Pakistan, the United Republic of Tanzania and many others.

The rise of nongovernmental organizations (NGOs) is also a significant phenomenon in the developing countries. They are playing an important role particularly in the field of human rights, gender issues, alcohol and drug problems, care of the aged, and mental retardation — all of which are closely related to larger mental health issues. NGOs normally work independently of ministries of health and other governmental systems with which WHO interacts. Newer ways have to be found to link up WHO programmes with NGOs at the country level. ■

1. Setting the WHO agenda for mental health. *Bulletin of the World Health Organization*, 2000, **78**: 500.

Mental health — getting beyond stigma and categories

Paul E. Garfinkel[1] & David S. Goldbloom[2]

The recognition of mental health as a priority for WHO is both welcome and overdue. It reflects the extent of morbidity and mortality caused by mental disorders worldwide and the great need to mobilize resources, awareness and knowledge in this area. WHO recently brought together experts to outline their current understanding of mental health challenges and discuss strategies for meeting them (*1*). Our comments here are confined to their recommendations with regard to measuring the burden of disease and basing the diagnosis of mental disorders on the best evidence available.

Best evidence for disease burden

The development and evolving acceptance of disability-adjusted life years (DALYs) as a measure of the burden of disease and the cost-effectiveness of

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[1] President and Chief Executive Officer, Center for Addiction and Mental Health, 33 Russell Street, Toronto, Ontario M5S 2S1, Canada.

[2] Physician-in-Chief, Center for Addiction and Mental Health, 33 Russell Street, Toronto, Ontario M5S 2S1, Canada.

interventions in different settings is a significant advance. Nevertheless, the report shows appropriate awareness of the limitations of such an instrument — since it cannot reflect the mechanisms involved in these disorders, or the individual experience of illness. Also, this measure does not reflect the hidden burden, the stigma, borne by the mentally ill.

The stigma suffered by the mentally ill dates back to antiquity and has its origins in fear, lack of knowledge and ingrained moralistic views. Though erroneous, these associations remain pervasive due to the universal terror of losing one's mind, and the assault to dignity and core identity which mental illness often represents through its production of disturbed actions and behaviour which society may regard as shameful. The fact that the causes and experiences of mental illness have not, in the past, been well understood has added to these fears and misperceptions. At times, the unusual and even unfounded nature of psychiatric theories and the practitioners who uphold them has compounded the problem. Families have often hidden the mentally ill, out of concern for their own safety and reputation, while communities have shunned them. Terror of the unknown is embodied in mental illness and, as a result, society does not treat the mentally ill as it does those suffering from other kinds of pain.

But there is some hope that this is changing: with the new assertiveness of patients, assumptions about this stigma are having to be re-evaluated. This movement has been greatly facilitated by less moralistic views of pathogenesis. The fact that well-known public figures have been prepared to come forward with personal descriptions of mental illness, in much the same way as others have for conditions such as breast cancer and HIV, has had an immense impact.

Further understanding of the connections between social determinants of illness, such as poverty and violence, with complex symptom patterns, supported by extraordinary developments in brain function imaging, may advance broad awareness of conceptual frameworks linking mind, brain and body. Such advances in understanding will further erode the damaging myths and stereotypes surrounding mental disorders. Progressive destigmatization will eventually be reflected by public funding for care, research and education that is proportionate to the prevalence of mental illness and the morbidity it engenders. That is very far from being the case today, and will require a concerted partnership between the profession and the public to reduce fear and ignorance and promote hope, compassion and understanding.

Best evidence for diagnosis and clinical practice

With the emergence of a broad array of psychosocial and pharmacological interventions, diagnostic classification has re-emerged from the late 19th century as a guide for the clinician to treatments of established efficacy, and for the researcher to future needs. Psychiatry has fully embraced the scientific agenda and approach as a means of dealing with issues raised by local conventions in diagnosis. However, the current focus on diagnosis, based on categorization and the setting of arbitrary thresholds and the numbering of necessary symptoms, may be a two-edged sword which detracts from our capacity and determination to develop a deeper understanding of individuals and the mechanisms which underlie their suffering. We need this systematic approach, but we need to know its limits.

Diagnosis is imperative for medical practice — it represents a form of communication that permits detailed examination, investigation of approaches to treatment, and delineation of prognosis. Used in a rigid or thoughtless manner, however, it may detract from, rather than enhance, medical practice, despite the fact that diagnosis has a significant bearing on the new generation of treatments.

The Diagnostic and Statistical Manual (DSM), for example, has contributed to a distortion in the way that psychiatry approaches people. In the extreme, it can be used as a means of avoiding an in-depth understanding of individuals. The DSM-IV has become widely accepted, in large part because of its reliability, and it can also describe the diverse aspects of rather complex variables. In this regard, its data-based, atheoretical orientation is a strength, but it may also be a limitation. DSM-IV has been developed in such a way as to minimize any underlying theory of psychopathology. One may make a DSM diagnosis while knowing little about the patient as a person, thereby reducing the person to a disorder based on a check-list of signs and symptoms. Ironically, this has occurred at a time when the rest of medicine has started to pay more heed to the psychosocial determinants of health and disease. This reductionism must be corrected if we are to remain a humanistic, humanitarian profession, for it is impossible to treat suffering individuals without an awareness of history, symbolic meaning, conflict, ambivalence, social context and the relevance of existential concerns. This is particularly so if our formulations are to encompass the radical shifts in society involving technology, changes in family and societal support, and the commercialization of existence. These shifts may account for the current epidemic of depression and other psychiatric disorders.

Just as diagnosis can play a critical role in care, so too can the conceptual frame that is used in order to understand mental disorder. As both practitioners and investigators, we need to order the potential chaos of observation and information into conceptual frameworks, which give meaning to the nature of the work and provide the models by which we care for our patients. Debates about the essence of our field have been waged throughout the history of humanity. With our current knowledge, we most usefully understand psychiatric disorders as multi-determined illnesses with complex etiologies and needing multiple approaches to treatment, which include encompassing the biological, psychological and social realms.

Earlier periods saw reductionistic views — whether about psychoanalytic, biological or social approaches — that did not serve patients well. The history of such trends gives particular cause for concern, as we have observed over the last 25 years a return of biological reductionism. This trend has been fuelled by the re-linking of psychiatry to medicine, which has been necessary and desirable, but not if it entails discarding important contributions from earlier times and other schools of thought. The current trend has also been catalysed by the exciting breakthroughs in biological treatment and the recent wave of understanding from neuroscience. Paradoxically, it is when psychiatry is most comfortably ensconced within medicine as medical psychiatry that we can speak out most effectively against the narrowness that inevitably will result from extreme biological reductionism.

Without the breadth of a conceptual model which incorporates the multidetermined nature of illness and thereby leads to individualized and compassionate care, coupled with advances in treatment, the essence of the care of the patient is diminished – just as it is with an exclusive over-reliance on descriptive diagnosis. ■

1. Setting the WHO agenda for mental health. *Bulletin of the World Health Organization*, 2000, **78**: 500.

Mental disorders and economic change — the example of Hungary

Istvan Bitter[1]

As the notes on WHO's agenda for mental health point out, disability-adjusted life years are a useful way of measuring some aspects of mental health, but other ways are needed too (*1*). Socioeconomic indicators also directly affect epidemiology. The political, economic and social changes since 1989 in Hungary have had a major impact on health care (*2*). Suicides and disability contribute significantly to the burden of mental disorders. In this paper we would like to highlight recent changes in suicide rates and disability rates in Hungary, which is a good example of a country making the transition from communism to a market economy. We will look first at the correlation between decreasing suicide rates and improved treatment of depression, then at social and occupational dysfunctions in relation to changing market forces.

Fig. 1. **Distribution of depressive symptoms, Hungary (*2*)**

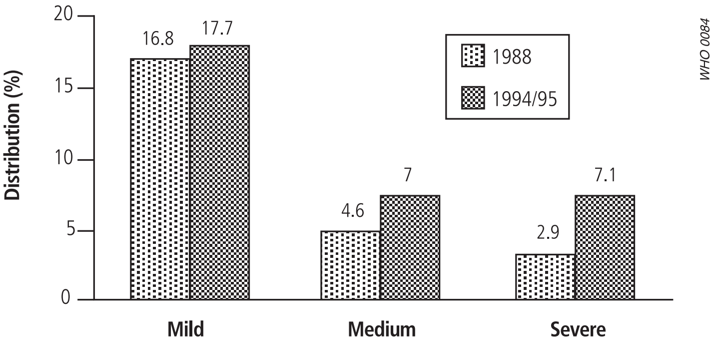
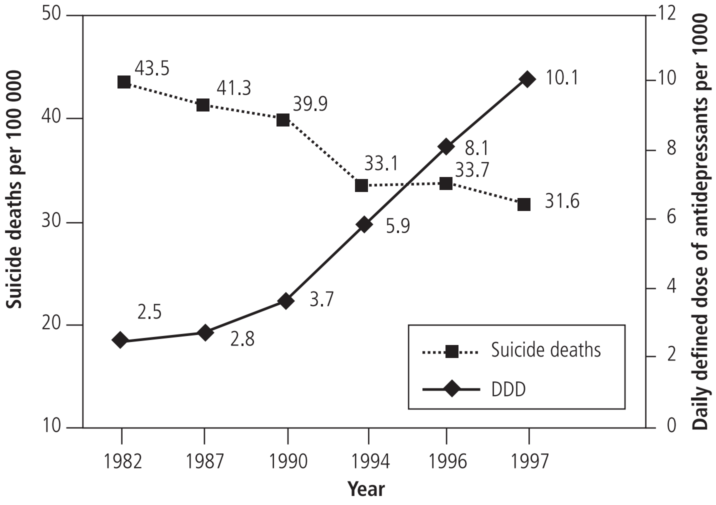


Fig. 2. **Suicide deaths and daily defined dose (DDD) of antidepressants, Hungary**



Source: data courtesy of Z. Rihmer

Table 1. **Selected data on unemployment and disability, Hungary**

Year	Population (x 10^6)	Number of registered unemployed	Number of new disabled	Number of approved disability claims per 10 000 entitled persons	Number of disability pensioners per 1000 persons
1989	10.5886	14 200	–	–	501.8
1990	10.3584	79 521	64 826	132.8	540.9
1991	10.3446	406 124	71 871	–	–
1992	10.3359	663 027	68 030	–	–
1993	10.2897	657 331	53 722	–	–
1994	10.2648	556 463	55 935	–	–
1995	10.2401	495 893	58 305	–	723.9
1996	10.2018	264 400	56 298	166.6	749.9
1997	10.1709	234 000	45 766	150.2	771.1
1998	10.0920	313 000	39 338	–	782.1

Depression and suicide rates in Hungary

Epidemiological data on depression and suicide before and after the major political changes in

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[1] Department of Psychiatry and Psychotherapy, Semmelweis University Budapest, Balassa str. 6, 1083 Budapest, Hungary (email: bitter@psych.sote.hu).

Hungary show an increase in depression (see Fig. 1), a decrease in suicide and an increase in the use of antidepressants (*3–5*).

The improvement in the treatment of depression has been a result of changes in the Hungarian health care system. General practitioners have been motivated by privatization and capitation to provide better services. Several antidepressants were marketed in Hungary, and until July 1999 they enjoyed 100% reimbursement. A nationwide educational campaign for the general public, general practitioners and psychiatrists began in 1990, and contributed to better recognition and treatment of depression.

The continuing decrease in suicide rates and increase in the use of antidepressants (Fig. 2) supports the hypothesis of Rihmer, that recognition and treatment of depression strongly influence suicide rates (*4*).

Employment and disability rates

Since the collapse of communism, the cost of making the transition to a market economy has been overwhelming: after 1989 the volume of gross domestic product decreased by one quarter and in 1998 still had not reached the level of 1989. Big state factories with accommodation for their workers were shut down, and this resulted in a wave of unemployed and homeless people. Psychiatric patients were among the first to be hit by unemployment and homelessness. There was increasing competition for employment, and government and health workers lost their control over employment and housing.

The communist governments left behind them a weak social support network and no self-help groups. Unemployment was zero from 1950 to the end of the 1980s, and stood at 8–12% in the 1990s. A 47-fold increase was registered in the unemployment rate in 1992 as compared to 1989, and there has been an 80–150% increase in the number of disability pension applications since 1989. The number of approved disability pension claims also had a transitory increase (Table 1). Of the newly disabled, 15–16% have mental disorders, which is the second largest group after patients suffering from cardiovascular disorders. Many data, such as those missing in Table 1 and approved disability claims in different diagnostic categories, could not be obtained, because the Hungarian insurance system was not computerized until recently.

To give a further example, let us suppose that the disability pension rate for patients suffering from schizophrenia is 60%, and the employment rate for this group is 40% when unemployment is at 0% for the general population. With a 10% unemployment rate in the general population, the employment rate for patients would decrease to 34%, and if unemployment was doubled or tripled for patients, their employment rate would decrease to 28% or 22%. With 100% unemployment there is no difference between patients and non-patients (as is the case in some small villages in Hungary).

We have no data on whether prejudices are increasing or decreasing in Hungary, but discrimination has increased as a result of it being easier to see or manifest prejudice. We conclude that such social and occupational functions as work or housing may have different diagnostic values in different cultures and societies. This value may change dramatically in times of political and economic change. Increasing competitiveness without compensatory measures (such as improved rehabilitation and an efficient social support network) may lead to increasing discrimination against patients stigmatized with different aspects of the disorder of schizophrenia. Years lost due to disability are an important measure but the socioeconomic context has to be taken into account as well. ■

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Removing the barriers to effective mental health care: a view from Turkey

M. Orhan Öztürk[1]

WHO's new agenda for mental health makes it abundantly clear that mental health problems have grown to be a major part of the global burden of disease and that mental health has to be considered a priority not only in health planning but also in the overall development plans of any country (*1*). Similar statements have been made in the past, however, though probably not with such authority or with burden of disease figures to support them, but for the most part they have fallen on deaf ears among policy-makers, and even among health professionals. The essential question is why this is so, and why problems of mental health

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[1] Turkish Academy of Sciences; Emeritus Professor of Psychiatry, Hacettepe University Faculty of Medicine. Professor Öztürk's address is Büklüm Sokak 89–3, Kavaklidere 06700 Ankara, Turkey.

persist while there have been so many and such unprecedented improvements in other areas of health.

Setting the WHO agenda summarizes the best evidence for the prevalence, prevention, diagnosis and treatment of mental disorders, and makes sound recommendations for WHO's mental health activities. Further recommendations are needed, however, on how to deal with the historical, social, cultural, professional and political barriers to designing and activating cost-effective mental health projects. We need to know more about these barriers if WHO is to overcome them in pursuing its agenda for mental health, and convincing the authorities of culturally diverse nations and communities that concerted action is possible.

Stigma is commonly blamed for the failure to recognize, accept and deal with mental health problems. Although much is now known about the history and causes of stigma and how it impedes cultural development, this knowledge can also be used to condone the deficiencies of health systems which maintain negative medical attitudes and detrimental institutions for the mentally ill in many parts of the world. An investigation on pathways to psychiatric care in Ankara has shown that mental patients and their families, many of whom are from rural areas, prefer to take their problems to mental health specialists rather than general practitioners (*2*). This finding and my experience of the last 45 years suggest that where adequate health services are delivered and where the patient is seen as a human being rather than a mentally deranged person, the stigma factor is diminished radically.

Another impediment is the idea of priorities, which dictate that mental health can be considered only after solving such problems as malnutrition and infectious disease. While this may be true in many cases, it is also true that many of these serious problems are often caused by parental schizophrenia, depression, alcoholism or other types of mental suffering. Conversely, devastating earthquakes, such as those that occurred recently in Turkey, and other such disasters, can cause mental health disorders or disabilities. Such events may lead to immense and persistent mental suffering which is easily overlooked in tragic physical conditions. It is understandable that visible external suffering receives more immediate attention than suffering which is invisible and internal, but this can lead to neglect which allows mental trauma to turn gradually into life-long tragedy.

Another critical and highly paradoxical impediment is, in my opinion, related to the quality and quantity of education and training given to the mental health workers in various disciplines. This, I believe, deserves more consideration in the future work of WHO and of all countries. As an example I shall take the situation in Turkey, as I believe this is more or less true in many other countries. In Turkey the schools and therapeutic institutions where mental health personnel (physicians, nurses, social workers, clinical psychologists and others) receive education and training are highly influenced by those of Western European and North American countries. These training centres have not yet reached the level at which their students can develop a sound understanding of mental health and ill-health. The hospital-oriented and dehumanized medical model of training, mostly borrowed from North American and European practice, is not only dominant but is also alluring for politicians and investors. This seems to be one of the major barriers against promoting an active, effective and nationwide primary health care system in which continuous training and consultation for promoting mental health are conceivable. In both industrialized and developing countries, psychiatry and mental health are still often relegated to an inferior position in the health system. There is strong evidence that the majority of physicians and other health personel working in primary care centres do not recognize or know what to do about serious mental disorders such as schizophrenia or major depression (*3*).

WHO's endeavours to promote mental health activities in all parts of the world have been of great importance for many years. WHO's current emphasis and new agenda for mental health are convincing initiatives that are much needed. There can be no doubt that WHO's support and collaboration around the world have contributed greatly to the training of personel in the areas of public health and epidemiology. It is my impression, however, that WHO's major emphasis on primary health care has not been heard enough by the policy-makers and decision-makers of many countries. WHO could acquire a more effective and productive leading function by extending its traditional bureaucratic boundaries beyond the ministries toward educational and training centres to develop research for the assessment and improvement of the quality and quantity of training in mental health. ■

1. Setting the WHO agenda for mental health. *Bulletin of the World Health Organization*, 2000, **78**: 500.
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WHO can help to combat mental health illiteracy

Malik H. Mubbashar[1] & Khalid Saeed[1]

"Unity in diversity" may be a political slogan but it is also a fact. Over the last three decades, studies carried out in culturally diverse areas have consistently shown that mental health problems are present in all regions in more or less similar proportions, despite wide diversity of causes, symptoms, pathways to care and management strategies.

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[1] Professor Mubbashar is Director and Dr Saeed is Associate Professor at the Institute of Psychiatry, Rawalpindi Medical College and Rawalpindi General Hospital, Pakistan. Correspondence should be addressed to Dr Mubbashar (email: malik@isb.packnet.com.uk).

These problems have a significant burden associated with them, which may not be measurable with the tools currently available. The disability-adjusted life year (DALY) calculations have helped to show the importance of mental illnesses as a public health problem, but they miss many aspects of the real burden. These include the stigma, discrimination and abuse to which the mentally ill are subjected, and the fear, shame, guilt and loss of morale they suffer. A uniform system of measurement which includes these dimensions and can be used globally would help a great deal to facilitate comparisons across cultures, and WHO should support such an initiative. The following notes represent further points to be taken into consideration in setting WHO's agenda for mental health (*1*).

- WHO has met with considerable success in building systems to classify mental disorders and disabilities, show their prevalence, and assess their effect on the quality of life. This work can provide the building blocks for policies which lead to effective and just mental health services. Experience has shown that a clearly enunciated policy framework which is supported by governments and stakeholders is a prerequisite for improving the mental health indicators of a given population. While there is no universally applicable template for formulating and implementing a mental health policy, some of the necessary elements are widely known. WHO is in a unique position to make this knowledge available to individual Member States, together with mechanisms to evaluate their performance. WHO can also help by working with other United Nations agencies and donor agencies to make mental health an essential item in their policy dialogue with governments.
- The prevalence of neuropsychiatric disorders is expected to rise steeply in developing countries in the coming years because of the rising numbers of people reaching the age of risk of onset of these disorders. Stigma is probably the single largest hidden contributor to the burden that neuropsychiatric disorders impose on a population. It affects individuals, families, communities, professions and institutions alike. The way to combat this hidden burden is to bring it out into the open by exposing it to the light of "mental health literacy" at all levels, from local to international. WHO can help to do this by declaring "Mental Health Literacy Year", during which well-orchestrated campaigns can be initiated in all the regions and Member States, aimed at reducing the burdens of stigma, stereotyping, discrimination and the abuse of rights.
- Prevention of mental disorders and the promotion of mental health call for multidisciplinary action involving collaboration within and between sectors. For this kind of integrated and cohesive approach, a catalytic leader is needed. WHO can help to find and prepare leaders for this task, particularly from developing countries. This should be a priority, since even the best strategies fail without good leaders.
- Resource mobilization and maximization is another concept which needs to be among the priorities in the field of mental health. One of the strategies for doing this would be to adopt a 'needs assessment approach' at all levels.
- Another complementary strategy would be the integration of mental health not only in the general health sector but in the broader development objectives of countries.
- These activities underscore the need for carrying out systems research, to ascertain the inputs and processes they call for, and the expected outcomes and impact.
- Another priority for action is to encourage the use of information technology (IT) in its widest applications. The only realistic chance developing countries would have of overcoming the lack of resources, trained staff, infrastructure and administrative capacity is to use IT to enhance their human and social well-being. WHO must take the lead in actively encouraging and empowering developing countries to use IT, which could be used in particular for the standardization of management protocols for mental disorders.
- WHO is increasingly called on to fulfil its obligations by providing a sense of direction for the development of cost-effective, equitable and sustainable mental health programmes. ■

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Using all opportunities for improving mental health — examples from South Africa

Melvyn Freeman[1]

Neglect of mental health within health systems and health policies is not new. The commitment of WHO, therefore, to devote considerable attention to the challenges of mental health is most welcome. Moreover, the eminent team assembled to set the WHO agenda for mental health have put together clear and reasonable recommendations which will undoubtedly promote improved mental health globally (*1*). The point in this short commentary, though, is that the team have possibly overemphasized the relative position that research, knowledge and scientific argument play in policy and programme implementation.

While evidence-based intervention is a major goal of WHO and of most public health professionals (and I include myself), as Walt and others remind us

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[1] Director, Mental Health and Substance Abuse, Department of Health, Private Bag X828, Pretoria 0001, South Africa.

(*2, 3*), "evidence" is but one factor of a myriad of "power and process" issues which determine policy and its implementation. I will not dwell on this point but make the argument that, in developing countries especially, to achieve improved mental health status, strategies have to be inclusive, and "spaces" created by priorities outside of mental health need to be more effectively utilized.

I have recently had a number of opportunities to present the case to politicians and senior health planners in South Africa for giving high priority to mental health. Largely thanks to research results, including DALYs and data on the effectiveness of interventions, most of the people in these positions now take mental health very seriously. Nonetheless, their empathic responses have generally been mixed with frustration and defensiveness. It appears that though past skepticism about the importance and role of mental health has been largely dissipated, the situation for mental health has not necessarily improved.

Though the "evidence" is compelling, and there is much compassion for mental suffering, health choices are complex. In South Africa, with its extreme past neglect for even basic health services in previously black townships and in rural areas, there are concerns such as overcrowded and dilapidated hospitals, low immunization levels, poor nutrition status, and neglect for preventive and promotive programmes, all competing for limited resources. Then there are also competing facts and figures. For example South Africa is rated as one of the countries in the world with the highest HIV/AIDS infection rates, with an estimated 1500 new infections per day (in a population of 40 million). The HIV prevalence rate among women attending public antenatal clinics is over 20%, while 65% of new infections occur among those between 15 and 25 years of age. South Africa also has one of the highest tuberculosis rates in the world, with nearly 90 000 cases notified in 1998 alone (*4*). And so the list of competing priorities continues. In other developing countries where resources are even smaller and health problems greater, the onerousness of the choices is even more pronounced.

In the light of the resource demand, it is at times necessary and strategic to select national priorities (often Presidential priorities) and link mental health programmes to these, rather than attempting to attract resources to mental health itself. I will use two examples to illustrate how we, in South Africa, are attempting to do this.

Violence and crime are endemic in South Africa. The consequences for the country economically and socially are enormous. Not surprisingly, President Mbeki has committed the government to dealing with this as a top priority. Inter alia, a National Crime Prevention Strategy (NCPS) has been set up consisting of various government departments and involving business and nongovernmental organizations. While the human and financial resources allocated to this are fairly modest, earmarked funds have made it possible to begin certain programmes which would otherwise not have been possible. The Health Department (Mental Health Directorate) has taken responsibility for:

- training general health workers in "victim empowerment";
- setting up "violence referral centres" in certain disadvantaged areas;
- setting up violence prevention programmes in schools;
- developing mother–infant bonding programmes for violence prevention in poor communities.

In different circumstances, and with perhaps minor differences in the programmes themselves, we may have initiated projects and termed them:

- counselling training for health practitioners;
- crisis centres for emotional problems;
- mental health promotion in schools;
- simply, mother–infant bonding.

However, the truth is that without the NCPS, it is unlikely that any of these programmes would have been approved. "Piggy-backing" on the NCPS has thus allowed for the development of a number of important mental health projects.

There have been other secondary positive results of our linked approach. For example, good relations have developed with departments such as Education, and Safety and Security, which have had benefits not only related to these specific issues, but more generally for health and mental health. Rather amusingly, but nonetheless still important for mental health in macho South Africa, we now also have broad-shouldered senior police officials talking about the critical importance of early infant relations as a crime prevention strategy.

The second example of linking to a national government priority is taken from within health itself. HIV/AIDS is regarded as a national crisis which is receiving the highest presidential and intersectoral attention. Two areas in which mental health has linked programmes are life-skills and counselling.

In order to prevent the spread of HIV amongst schoolchildren, a massive national initiative has been launched to provide HIV/AIDS-related life-skills at both primary and secondary school levels. Teachers in every school are being trained to run this programme. It had been an aim within mental health to develop and introduce mental health and substance abuse life-skills in schools for some time, but the scale and resources needed for such a project were seen as unmanagable — in the short term at least. However, when we recognized that the core life-skills needed for substance abuse prevention and mental health promotion were not different from those required for HIV/AIDS prevention, doors were opened for us. The opportunity was taken to simply add on relevant components. Through this we not only avoided reinventing the wheel but will soon have programmes introduced which would not have been possible within mental health alone.

Similarly, the need for pre-test and post-test counselling on HIV/AIDS has been prioritized both as an approach to prevention and as a matter of ethics and human rights. The goal is to have counsellors in every clinic within five years. Such trained personnel need not be available for HIV/AIDS activities only, but could also be used for other mental health problems. The linked programmes thus offer real possibilities which a mental health department alone would not have.

For mental health and mental health services to grow in developing countries every opportunity must be taken. More research is needed, specifically more local research which assists country and local planners. More emphasis must be placed on using indigenous healing methods (a factor which the WHO agenda team also seems to have underemphasized) and more care should be taken to maximize process possibilities. Strategies such as the examples of "linking" referred to, should be further examined so that countries may be assisted to make the best use of limited opportunities. We now look forward to the implementation of the Task team's recommendations and the worldwide improvement of mental health. ■

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From evidence to practice: mental health in Australia

Helen Herrman[1]

The four themes used to shape the report on WHO's agenda for mental health allow us to consider mental health and the role of WHO in a comprehensive way (*1*). *Best evidence* is a unifying idea. It requires consideration of which kinds of evidence, and how to act on available knowledge and opinion.

Evidence, equity and services research

The focus worldwide is now shifting to demonstrate how much of the burden of disease can be relieved by service provision or other initiatives. Health care resources are limited and demand will continue to grow. Introducing evidence-based treatment strategies for schizophrenia and other psychoses and for depression, in the context of the global burden of disease studies, is important. The next step is to compare the effectiveness of service provision for people living with depression, anxiety, psychosis, and other illnesses.

Information about effectiveness, however, can easily be misleading. More work is needed before this comparison between disorders can be used meaningfully to allocate resources. Assessing the burden averted by service provision requires attention to study design. Longitudinal studies of cohorts of individual patients are required, with assessment of outcomes in several dimensions (*2*). Policy-makers need evidence which is relevant and well interpreted, and to be made aware of the remaining gaps in evidence. The evidence may be weakest for the most disadvantaged groups. More work has been done on the cost-effectiveness of treatment for depression than for other mental disorders. Concern for human rights and equity can be spurs to gather appropriate evidence as much as to assist disadvantaged people directly.

The need for adequate and continuing treatments in a stable, safe and stimulating environment for people with persisting psychotic disorders, and the efficacy of these, has been known from experience and demonstrated by cohort studies for some time. However there is much concern that the knowledge about efficacious treatments is not disseminated and applied (*3*). This requires the demonstration that treatments are effective in improving the quality of life and alleviating disability and symptoms in patients in regular service environments. Otherwise, to quote Abrahamson, "there is pressure to repeat old mistakes in new settings, and to neglect long-term patients living in hospital and community settings in the face of opportunities for providing services to people with apparently more to gain" (*4*).

There is pressure to complete this work quickly because of competition between areas for resources. Disadvantage may be compounded, however, if conclusions about cost-effectiveness are reached prematurely. Misleading conclusions about treatment outcomes may be drawn from cross-sectional studies of patient populations, in which patients who recover are lost from view; or from using measures of health gain which are not comprehensive. The measurement of treatment outcomes needs to include disability and self-reported quality of life as well as symptoms and death rates. Other service outcomes are also relevant. The DALY provides a summation of morbidity and mortality measurement at the population level. For individual treatment studies, the use of appropriate measures is important for highlighting needs and gains in all of the areas that are significant to individuals and their families, as well as to clinicians and service providers. Such measures include those being developed by WHO to assess disability, quality of life and diagnosis. These views will not all be congruent, but each has value and is part of the evidence base. People with mental disorders have more often than not in the past been denied a

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[1] Professor and Director of Psychiatry, St. Vincent's Mental Health Service (Melbourne), and University of Melbourne, 41 Victoria Parade, Fitzroy 3065 Victoria, Australia (tel: +613 9288 4751 fax: +613 9288 4802; e-mail: herrmahe@svhm.org.au).

voice (*5*). Few people other than those directly involved can describe how life is affected by a psychotic disorder or by depression, and the effects of the illness and the consequent disability are often hidden.

Service partnerships for psychosis and depression

In Australia and other countries with relatively well-resourced health systems, the challenge is to make better use of the primary health services and community support for people with psychosis, and provide appropriate assessment and consultation from the specialized mental health services for those with depression and anxiety. In most such countries, specialist services are absorbed with treating psychosis, and primary health services struggle to deal alone with the burden of depression and anxiety. The components include multidisciplinary mental health teams, primary health services with their government and nongovernmental partners in housing, welfare and vocational services, and the people with mental disorders themselves, together with their families. All these resources exist but their efforts are hindered by their historical legacies of separation from one another.

In Australia, universal health insurance allows access to primary health care and comparatively good access to private medical specialists including psychiatrists. Initiatives to improve partnerships between private psychiatrists and state-funded mental health services, and between these sectors and primary health services, may help to avert the introduction of US-style managed care which is seen as a threat to the standards of mental health care in private practice. Another fundamental need in state-funded and private services is to examine the roles and relationships of psychiatrists and other mental health professionals in treatment teams. This includes the definition of roles and clinical authority, responsibility for decisions, and dealing with conflict about leadership.

Mental health promotion

The role of WHO in providing information, advice and advocacy to governments, in collaboration with other organizations, is vital in these areas. It is also important for WHO to lead the way on mental health promotion. While there is evidence for the effectiveness of a number of specific interventions to prevent mental disorders, there is also a strong and growing evidence base for many other aspects of mental health. These include its social determinants, the links between mental and physical health, and the links between mental health and risky behaviour such as substance use, violence and unsafe sex. Likewise there is evidence for the effectiveness of action to improve social connectedness, reduce discrimination and violence, and increase economic participation. These are some of the data that demonstrate the need for intersectoral action to improve mental health. That action also builds up social capital, improves the quality of life, increases life expectancy, and reduces levels of stress, anxiety and depression.

Though caution is needed with regard to premature closure on the evidence for treatment and prevention, evidence for the need for mental health promotion is strong and can be used boldly. Mental health promotion is different from the prevention and treatment of mental disorders but complementary to them, and all three are needed *(6)*. Mental health promotion does not use health care resources, but it needs specialized advocates. It also needs to be 'mainstreamed' with health promotion in general, as mental health services are mainstreamed with general health services. ■

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Getting down to cases — making mental health interventions effective

Leon Eisenberg[1]

The reports of consultative meetings and expert committees assembled by international organizations necessarily sacrifice bite and specificity for comprehensiveness and diplomatic niceties. The report in question (*1*) resembles its predecessors and, undoubtedly, its successors in this respect. The points reached by consensus are unexceptionable. But so many points are made, and made so blandly, that they are unlikely to lead to action. What must be added is detailed specification of what needs to be done, what the barriers are to doing it, how those barriers can be overcome, and how progress towards a specified goal can be measured. Let me reflect on the proposal for depression, a disorder that causes an enormous disease burden, one for which cost-effective interventions are available, and one which must be applied in primary care sites, as the Report notes.

The extent of the burden from depression has been thoroughly documented by WHO. It is equally

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[1] Maud and Lillian Presley Professor of Social Medicine and Psychiatry Emeritus, Harvard Medical School, 641 Huntington Avenue, Boston, MA 02215–601, USA.

clear that there are simply not enough specialized mental health personnel, even in the most affluent countries, to manage all patients suffering from depression. Therefore, public health policy must promote depression management in general health care. However, before expending resources on apparently efficacious treatments, we will need to be certain that they are effective. What is the state of the evidence?

This question rests on the distinction between "efficacy" and "effectiveness." "Efficacy" refers to a statistically significant treatment benefit demonstrated in a rigorously designed and executed randomized, controlled trial. "Effectiveness" refers to positive clinical outcomes observed when that treatment is applied in the community under ordinary conditions of practice. Whereas there is substantial evidence for the efficacy of a number of drugs and carefully designed psychotherapies in treating depression, data on effectiveness are at best equivocal when those measures are applied in primary care settings (*2, 3*). This must give us pause.

What can account for the difference between efficacy and effectiveness? First, the characteristics of psychiatric research samples differ from those encountered in primary care. In research studies, enrolled patients must meet specified diagnostic criteria; comorbidity usually leads to exclusion. In contrast, in primary health care, patients with chronicity, comorbidity, and sub-threshold diagnoses make up a substantial fraction of general practice.

Second, patients who are willing to accept referral to a psychiatric facility (and to agree to enroll in a research trial) may differ in important ways from those who deny depression and refuse referral, a common pattern in primary care. Motivation to comply with treatment will be much higher. Depression presenting as chronic pain or chronic fatigue involves different clinical challenges from depression presenting with feelings of hopelessness or guilt.

Third, part of the gap is attributable to sub-optimal practice. In research, substantial time is invested in explaining the protocol, obtaining informed consent and asking subjects to commit themselves to staying the course. These procedures activate the patient as a participant. Investigators are eager to maintain sample size, so they make themselves unusually available to patients (convenient appointments and schedules, easy phone access, educational material, mailed reminders, etc.). In a busy practice, the press of time often leads to omitting explanation and education. Drug prescribing may be homoeopathic; poor patient adherence further reduces blood levels. Prescriptions go unrenewed because there is no follow-up. Recent US studies have documented poor medication compliance across the board in primary care (*4–6*).

If this is true in the industrialized world, the problems are greater in developing countries. Time available to assess and counsel patients is so short as to preclude optimal care. Adding another set of chores to already overworked clinicians defies practicality. What is called for is ways to increase the capacity of providers by a system of care; for instance, by adding workers with sufficient mental health training to sensitize physicians to patient problems, by maintaining the drug supply, by monitoring patient compliance, and by alerting the clinician when treatment is not working.

Sermons will not suffice. They have been directed at generalists for more than 50 years. Ill-thought-through schemes introduced to enhance the care delivered have repeatedly fallen foul of clinical routine and time constraints. Dispensing pills is simply not enough. Consulting and other non-medication strategies are essential. Doing more takes time. How can that be accomplished?

No single clinical protocol will fit the needs of all developing countries. Designing an effective plan begins with identifying *local* needs, *consulting* primary health care workers for advice on feasible interventions, and making outcome measures an integral feature of study design so that effectiveness or lack of it can be recognized.

Conclusion

WHO is ideally positioned to promote research on the effectiveness of interventions to treat depression in primary care settings in order to deploy resources effectively. It should:

- convene workshops on study design for carefully chosen investigators from developing countries to enhance indigenous research capacity;
- identify 3 or 4 countries capable of generating and carrying out studies with appropriate sample size;
- provide support during the design phase by a working group in each country assisted by WHO personnel and consultants;
- sponsor those specific research proposals for support from World Bank as the lead international agency financing health research;
- follow through with long-term evaluative research on outcomes after programmes have been in place in the community for several years. ■

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Expanding and strengthening the mental health care system

David Goldberg[1]

The recognition of mental health as a priority for WHO is welcome, and should now be followed by action to improve health outcomes, especially in the developing world. The recommendation to use DALYs is welcome too (*1*), though not unexpected, but the suggestion that WHO needs "additional tools" to probe relationships between mental disorder and variables such as gender and social status is misconceived. Many others throughout the world have documented and will continue to document such relationships: it is important that WHO should be seen to be taking public health action which will improve health outcomes throughout the world. Such actions include setting standards for the general availability of proven psychotropic drugs, continuing to put pressure on governments to modernize their mental health policies, and above all supporting training activities which are designed to improve the skills of both doctors and their helpers in primary care clinics, so as to raise the standard of mental health care in each country.

In many parts of the developing world the specialized mental health services are either not accessible at all or they require a long and arduous journey. Improving the standards of mental health care in general medical clinics seems to offer the best hope for the population. The recommendation to target depression in primary care is especially welcome, as this is a high-prevalence disorder which responds to treatment. The evidence from an earlier WHO study (*2*) shows that prevalence rates vary widely between centres, and that rates for treatment with an appropriate psychotropic drug are low. Even when the correct treatment is prescribed, it is taken for on average less than a month, and relapse rates one year later are very high (*3*).

In most countries, primary care clinics are demand-led, and this will often mean that relapses of depressive illness will not be known to the primary care clinic. The task is to ensure that patients persevere with their treatment, and that they are followed up by primary care staff so that patients who relapse can be offered treatment.

Excellent contributions to the treatment of depression can be made by non-medical staff such as psychologists (*4*) and nurses (*5*), and the newer antidepressants are better tolerated by patients, and so more likely to be prescribed in therapeutic doses by doctors (A. Tylee, personal communication, 1999). It is important that other members of the primary care team are also involved in the care offered to these patients, so that treatment skills are learnt by others such as practice nurses or multipurpose health workers.

The recommendation that WHO should advise Member States to make better use of "intrinsic community resources" in improving mental health care is especially welcome, and is likely to lead to substantial health benefits in many parts of the world. In Pakistan a new cadre of health worker — called "lady health workers" — has been inaugurated with mainly preventive functions; but such workers may also play an important part in supplementing the help that depressed patients receive from the general medical clinic. The task for the future is to expand the workforce available to provide help to distressed patients: these may sometimes be funded by statutory authorities, but can also be provided by voluntary organizations.

Well-intentioned efforts to educate doctors about depression may not be effective, however, in places where the general practitioners have had reasonable exposure to psychiatric teaching and treatments for depression are freely available. If outcomes are to be improved in general medical settings, what doctors need to do is acquire new skills through guided practice, rather than new knowledge through didactic teaching.

Doctors need help in managing the medically unexplained somatic symptoms which commonly accompany depressive symptoms. A simple intervention has been shown to be cost-effective, since it is associated with lower medical costs and lesser disability (*6–8*).

In parts of the world where specialist mental health services are well developed, it is important to improve the coordination between such services and those in primary care. If this is not done, care is often duplicated or poorly coordinated, and delays occur when the primary care physician tries to get help with a patient in crisis. With severe psychotic illnesses, well-coordinated care, together with plans that are agreed with the patient and his carers between episodes, can often prevent episodes of illness altogether; this is an important aspect of secondary prevention. Newer treatments — such as a cognitive behavioural approach to the prevention of episodes of bipolar illness, have proved useful in preliminary trials, and may also need to be made more generally available.

Numerous trials have shown that assertive outreach is the most effective form of treatment for patients with severe mental disorders treated in the community; this needs to be combined with the provision of sheltered housing and home-based rehabilitation schemes for such patients. The statement that WHO should play a part in the rehabilitation of patients with schizophrenia is therefore welcome, as these form a relatively disadvantaged group in most countries. ■

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[1] Professor Emeritus, Institute of Psychiatry, King's College, London SE5 8AF, England.

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