Editorials

Mental health in the 21st century

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We know from mortality statistics that over the last century human life expectancy has increased as never before – though not always for the poor of the planet, who are still easy prey to the usual killers. Using instruments such as the DALY (disability-adjusted life year) we can shift the focus from how people are dying to how they are living. What the DALY does is to quantify not only the number of deaths but also the impact of premature death and disability on a population, combining them into a single unit of measurement of the overall burden of disease.

With this shift in perspective, some of the major killers – such as malaria and tuberculosis – remain prominent. Mental illness, however, suddenly bulks very large indeed. It may not in itself be fatal, but it causes extensive disability in rich and poor countries alike, and is increasing.

Why? There are many reasons. The first is that, with the increase in life expectancy, the body often outruns the mind; this is manifest in the DALYs lost to Alzheimer disease and other forms of dementia. Next, many societies and communities that customarily offered support to their needier members through family and social bonds now find it much harder to do so. Then there are the obvious cases of civil war and chaos, as well as more subtle threats that one contribution to this issue of the *Bulletin* finds in "the radical shifts in society towards technology, changes in family and societal supports and networks and the commercialization of existence which may account for the current epidemic of depression and other psychiatric disorders" (*1*). Factors that, taken individually, may be neutral or beneficial, can add up to an environment that is hostile to mental health.

Make no mistake about the extent of the problem: worldwide, mental disorders accounted for approximately 12% of all disability-adjusted life years lost in 1998. Their contribution was higher in high-income countries (23%) than in those with low and middle incomes (11%). Major depression was ranked fifth in the 10 leading causes of global disease burden and this condition is as relevant in developing countries. After major depression, the most important causes of neuropsychiatric burden are alcohol dependence, bipolar affective disorders and schizophrenia. In high-income countries, dementias are the third leading cause of neuropsychiatric burden.

Five of the 10 leading causes of disability worldwide (major depression, schizophrenia, bipolar disorders, alcohol use and obsessive compulsive disorders) are mental problems. They are as relevant in poor countries as they are in rich ones, and all predictions are that there will be a dramatic increase in mental problems in the coming years. This brings me to my second question: what can be done?

There are some surprisingly simple and relatively cheap interventions. Mental retardation is perhaps the most frequent form of mental disorder in developing countries, and its prevalence can be reduced simply by adding iodine to salt, at very low cost. Improved obstetric care will reduce the problem further.

A demonstration project in China has shown that simple family interventions in combination with psychotropic drugs can substantially reduce the cost of treatment for schizophrenia. Psychosocial rehabilitation programmes can help persons with severe mental disorders such as schizophrenia to become productive members of society.

While there is no cure for dementia, there are inexpensive and culture-sensitive interventions that can help families and communities to provide better care for those affected with this disorder.

A large number of other such solutions exist, and this brings up a final question: why is care that is known to be affordable and effective not provided? Once again, there are several reasons, the main ones being: the low priority generally given to mental health; the traditional centralization of mental health services in large psychiatric institutions; and poor application of proven strategies – whether for lack of awareness among health workers and policy-makers, or because of poor organization and financing of services, lack of quality assurance or lack of essential psychotropic drugs. There is also the stigma of mental illness, which often inhibits sufferers from seeking treatment, and may even limit the willingness of mental health care providers to intervene.

In short, mental health depends on some measure of social justice; and mental illness, given its scale, must be treated at primary level where possible. Much of the preventive work will be in the area of poverty reduction and conflict resolution, while the approaches discussed in this issue of the *Bulletin* should help to stem the rise of this health hazard in the 21st century. ■

1. **Garfinkel PE, Goldbloom DS.** Mental health — getting beyond stigma and categories. *Bulletin of the World Health Organization*, 2000, **78:** 503–505.

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