Mental health in low- and middle-income countries

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Mental disorders in low- and middle-income countries (LAMIC) do not attract global health policy attention. This article is based on a selective review of research on mental disorders in adults in LAMIC since 2001 and recent analyses of disease burden in developing countries. Mental disorders account for 11.1% of the total burden of disease in LAMIC. Unipolar depressive disorder is the single leading neuropsychiatric cause of disease burden. Alcohol use disorders account for nearly 4% of the attributable disease burden in LAMIC. Mental disorders are closely associated with other public health concerns such as maternal and child health and HIV/AIDS. Poverty, low education, social exclusion, gender disadvantage, conflict and disasters are the major social determinants of mental disorders. Clinical trials demonstrate that locally available, affordable interventions in community and primary care settings are effective for the management of mental disorders. Mental health resources are very scarce and investment in mental health is <1% of the health budget in many countries. The majority of people with mental disorders do not receive evidence-based care, leading to chronicity, suffering and increased costs of care. Strengthening care and services for people with mental disorders is a priority; this will need additional investment in human resources and piggy backing on existing public health programmes. Campaigns to increase mental health literacy are needed at all levels of the health system.

Keywords: mental health/developing countries/mental illness

Introduction

Low- and middle-income countries (LAMIC) are distributed in all parts of the world: all of Africa, much of Asia and South and Central America, east Europe and the island states of the Pacific. Although >80% of the global population lives in LAMIC, just 6% of the research on mental health have been published in indexed journals from these countries. Notwithstanding this inequity, the past decade has witnessed a phenomenal growth in the evidence based on mental
health in LAMIC. Three international reports have been instrumental in documenting and reviewing this evidence, and for advocating for greater investment in global mental health. Perhaps, the most important report that initiated the recognition of mental health as a public health priority was the landmark Global Burden of Disease that expanded the scope for assessing the burden of disease to include disability—suddenly, mental disorders that were well off the radar of global health concerns on account of their low contribution to mortality found themselves squarely at the centre. Another landmark document published around the same time was the World Mental Health Report—this report broadened the scope and context of mental health beyond its traditional biomedical boundaries, defined by clinical mental health professionals, to include the larger social determinants and consequences of mental illness. Mental health was shown to be central to addressing issues of global health concern such as violence, dislocation and women’s health. The third document was the World Health Report of 2001, which focused on mental health—global mental health became, at least for that year, the major theme of the WHO’s programme of activities and, as a consequence, many LAMIC gave greater attention to mental health. The World Health Report (2001) remains the most valuable document advocating for global mental health today. These three documents were based on a wealth of research evidence from LAMIC, which had largely been unnoticed by the global health community. Since then, much more research has been published documenting mental health in developing countries from different perspectives. This research will be comprehensively reviewed in the forthcoming Lancet series on global mental health.

The review in this journal is based mainly on a selective analysis of research published since 2001. The focus of this review is on frank mental disorders; however, the author acknowledges that these are often arbitrarily defined on the basis of a person experiencing symptoms of mental illness that exceed a pre-determined threshold; this threshold does vary in time and place. Thus, persons who are just below this threshold may not suffer from a frank disorder, but may nonetheless suffer from distress that impairs their quality of life. This review is organized in five parts: the burden of mental disorders; the social determinants of mental disorders; the effective interventions for mental disorders; current care and resources for people with mental disorders and implications for policy and practice in LAMIC. This review focuses only on adult mental health—this is not to deny the importance of child mental health in LAMIC. Children comprise a quarter to half the population in LAMIC, and their mental health needs are important, and largely unaddressed. The reason for not including children within the scope of this article is because the types
of disorders, their risk factors, interventions and health system responses for child mental health are fairly distinct from those of adult mental health, and combining the two was simply not feasible, or pragmatic, within the scope of this review.

The burden of mental disorders

The recent report *Global Burden of Disease and Risk Factors* has become the latest benchmark to assess, and compare, the burden posed by various health conditions, in each region of the world. The major findings from this report, relevant to this review, are:

- neuropsychiatric disorders (which include unipolar depressive disorder, bipolar disorder, schizophrenia, epilepsy, alcohol and drug use disorders, dementias, anxiety disorders, mental retardation and selected neurological disorders) account for 9.8% of the total burden of disease in LAMIC; addition of self-inflicted injuries increases this proportion to 11.1%.
- Unipolar depressive disorder accounts for 3.1% of the total burden of disease attributable to non-communicable conditions in LAMIC; this disorder is the leading neuropsychiatric cause of burden of disease.
- Self-inflicted injuries account for 1.5% of all deaths in LAMIC; there are considerable regional variations in this proportion. Thus, self-inflicted injuries account for >2% of total deaths in Europe and Central Asia, making them the fifth leading cause of mortality in these LAMIC.
- Unipolar depressive disorders is the single leading cause of Years Lived with Disability (a measure of disease burden which estimates the years of health life lost through time spent in states of less than full health); two other mental disorders appear in the leading 10 causes—schizophrenia and alcohol use disorders.

It is notable, though, that the wider social costs of mental disorders, for example to families, social welfare or criminal justice systems, which are likely to be enormous, are not quantifiable. In addition, given that most mental disorders begin in childhood or young adulthood, the attributable burden of disease for adults in the age group of 15–44 is much higher, as shown in the estimates from 2000 (Table 1); one of the leading causes of disease burden in this age group is mental disorders. Furthermore, stigma associated with mental disorders is likely to lead to considerable under-reporting, particularly of events such as suicide; accurate counting of suicides in India and China have shown that rates are much higher than those reported in routine statistics and that self-inflicted injuries account for a quarter to half of all deaths in young women. Furthermore, mental disorders are also risk factors for other health problems, for example through the
contribution of alcohol use to road traffic accidents or liver disease—alcohol use accounts for nearly 4% of the attributable disease burden in LAMIC.  

Apart from demonstrating the high prevalence and associated disability of mental disorders, some of the most important evidence of the burden of mental disorders to emerge in recent years has been demonstrating how they contribute to the risk for, or are the consequences of, other health concerns of great importance in developing countries. This review will consider one such example: the relationship between the mental health of mothers, and birth-weight and child nutrition and health. Child survival and growth are a major public health priority in LAMIC, and one of the focal concerns of the Millenium Development Goals (MDG). A series of studies from south Asia, a region which houses about half the world’s malnourished children, have demonstrated that maternal depression after childbirth is common, and that it is a strong, independent, risk factor for child growth failure in the first year of life; maternal depression is associated with an increased risk of child physical health problems and incomplete immunization. Two of these studies have also shown that depression during pregnancy is associated with low birth-weight. Birth-weight and child under-nutrition are major risk factors for child mortality and thus, it is plausible that maternal depression also contributes to this burden. This

<table>
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<tr>
<th>Table 1 Burden of mental disorders in young adults</th>
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<tr>
<td>Both sexes, 15–44 year old</td>
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<tr>
<td>-----------------------------------------------</td>
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<tr>
<td>Unipolar depressive disorders</td>
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<td>Road traffic accidents</td>
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<td>Tuberculosis</td>
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<td>Alcohol use disorders</td>
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<td>Self-inflicted injuries</td>
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<td>Iron deficiency anaemia</td>
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<td>Schizophrenia</td>
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<td>Bipolar affective disorder</td>
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<td>Violence</td>
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Leading causes of disability—adjusted life years in 15–44 year old, by sex, estimates for 2000. Disorders in italics are mental disorders.
evidence has been replicated in studies from Africa and Latin America (Ferri et al; Adewuya et al; Stewart et al, unpublished). Indeed, mental health is central to a number of the other MDGs, notably those related to poverty reduction (see below), universal primary education and improving the lives of people living with HIV/AIDS. Although evidence on the role of mental health and care for HIV/AIDS is still patchy in LAMIC, there are many factors which demonstrate that mental health is integral to HIV/AIDS care programmes—thus, mental disorders such as substance abuse are risk factors for HIV/AIDS, and mental disorders such as dementias and depression are consequences of HIV/AIDS. Mental illness may be a major impediment to adherence with anti-retroviral drugs, a key requirement for successful management of HIV/AIDS.

Social determinants of mental disorders

The World Mental Health Surveys are generating a wealth of new data, using standardized interviews, on the prevalence of mental disorders and help-seeking behaviour in LAMIC; evidence from these surveys shows that while mental disorders are common in all countries, there is a considerable variation in the prevalence of these disorders. Apart from methodological factors, the most plausible explanation for this wide variation is likely to be the fact that social factors are major determinants of mental disorders, and that these do vary considerably across societies. Three key social determinants are recognized as risk factors for mental disorders.

Poverty and social exclusion have been well established as risk factors for mental disorders in high-income countries; many studies have replicated this association in LAMIC. People who live in the poor income groups, those who are less educated, those who are faced with acute economic difficulties (for example, consequent to unemployment), those who face debt, and those who face hardships in acquiring basic necessities (such as food) for survival, are at much greater risk to suffer mental disorders. In turn, the disabling effects of mental disorders impair the ability of persons to search for and sustain productive employment. Furthermore, between 40 and 50% of mental health care costs are borne out of pocket in LAMIC and, consequently, mental disorders further impoverish the individual. Thus, the relationship between poverty and mental disorders has been likened to a vicious cycle (Fig. 1). The rising tide of suicides and premature mortality in some countries, as seen in the alcohol-related deaths of men in Eastern Europe, the suicides of farmers and weavers in India, the suicides of young indigenous peoples in southern America and the suicide of
young women in rural areas in China, can be at least in partly linked to rapid economic and social change. The efficacious treatment of mental disorders has been found not only to lead to clinical improvement but also, from an economic perspective, to lead to significantly reduced total health care costs—thereby, helping the individual reallocate their income to meeting other needs of daily living.

Gender influences the control men and women have over the determinants of their health, including their economic position and social status, access to resources and treatment in society. A major indicator of gender disadvantage is the experience of intimate partner violence. There is established evidence linking domestic violence with an adverse impact on women's mental health in rich and poor countries. A recent population-based survey from India demonstrated the strong relationship between sexual violence within marriage, a relatively taboo subject, as a risk factor for depression in women. Being married during adolescence and being widowed or separated, both experiences associated with gender disadvantage, were also risk factors. Many societies in LAMIC, such as in south Asia, continue to be characterized by a dominant patriarchal matrix. Thus, for example, boy children are often favoured over girls, a value system that is largely to blame for the growing sex imbalance in the population. The birth of a girl, especially when a mother has already borne girls, is associated with an increased risk of depression in mothers. Gender roles also serve to explain why alcohol abuse is much commoner in men than in women in most LAMIC.
Loss, trauma and displacement as a consequence of war and disasters are frequently encountered in LAMIC—these are major risk factors for mental disorders. Recent disasters, such as the Asian tsunami and earthquakes in many Asian countries, are testimony to the grave impact of natural disasters on populations in this relatively crowded continent. After the immediate impact of such disasters on physical survival, mental disorders are a major health concern in people who have survived—bereavement, displacement and loss of livelihoods are key risk factors. Another major source of global suffering, again mostly concentrated in LAMIC, is war and civil violence. There is a large body of evidence documenting the high rates of mental disorders in people who have been exposed to organized violence in LAMIC; as might be expected, the more violent or inhuman the experience, the worse the impact on mental health.

Interventions for mental disorders

Perhaps, the most important development in the evidence base on mental disorders in LAMIC in the past few years has been on interventions. There is a substantial evidence base on the efficacy of pharmacological, psychological and social treatments for specific mental disorders from rich countries; however, vast variations in social, cultural and health system factors limit the generalizability of this evidence to LAMIC. Until recently, any discourse on mental health in LAMIC was stunted by the fact that while we had good evidence on the burden of mental disorders and their social determinants, we could say precious little about what treatments worked—any effort to generalize the evidence from rich countries was met with disdain, given the huge costs and extensive human resources needed for these approaches, and the relative lack of communicable and nutritional disorders in their populations. Interventions needed not only to be tested for their clinical efficacy in LAMIC, but they also needed to be generalizable and replicable—thus, their affordability and feasibility hinged on utilizing locally available health resources, which in effect meant mainly using community or primary or general health care resources.

Three randomized, controlled trials studying the efficacy of treatments for depressive disorders in India, Uganda, and Chile have been published in recent years. All these trials targeted poor populations and tested treatment options that were intended to be feasible, affordable and acceptable to the populations being studied. The Indian trial recruited general health care attenders and randomized them to receive either antidepressant, individual problem solving, or placebo. The Chilean trial recruited women attending primary care clinics and
randomized them to receiving a stepped care intervention or usual care. The Ugandan trial was a community-based cluster randomized trial of group therapy for men and women. Briefly, the results from the Indian trial were that antidepressants (fluoxetine) were superior to placebo, especially in the short term after which adherence declined rapidly which accounted for the absence of a significant effect at 6 and 12 months. Group therapy was highly effective in Uganda; only 6.5% of participants in the intervention villages were depressed at the endpoint, as compared to over half the participants in the control villages. This remarkable effect was sustained at 6-month review. The stepped care intervention in Chile offered both group therapy and antidepressants, based on the clinical assessment by a primary care nurse or social worker. At 6 months, 70% of the intervention group had recovered compared to 30% of the usual care group. All the trials showed significant improvements in disability levels in the intervention group; the Indian trial also showed that treatment produces significant reduction in total health care costs, whereas the Chilean trial showed that the incremental cost for each depression-free day for the intervention was just over 1 US$ per day, about the cost of a one way bus fare in Santiago.

There is also a growing evidence base for the treatment of severe mental disorders. Health service evaluations have shown that community-based care models, such as community-based rehabilitation and community outreach programmes in India, are able to reach out to people in rural and impoverished communities, producing tangible benefits in terms of improved clinical outcomes, reduced levels of disability and reduced family care-giving burden. Two randomized, controlled trials of family-based interventions for people with schizophrenia in China have reported that the intervention led to improved compliance with treatment, reduced rates of hospitalization, shorter periods of hospitalization and increased duration of employment—which presumably improved the economic condition of the patient. Other evidence for community-based interventions supports their efficacy; an unblinded, matched, community-based trial in Yunnan, China, which involved multiple sectors and leaders in the community and emphasized community participation and action, education in schools, literacy improvement and employment opportunities, led to a significant reduction in the incidence of drug abuse and a marked improvement in knowledge and attitudes towards HIV/AIDS and drug use.

On the basis of an economic approach, Hyman et al. reported on the results of a series of analyses compared the cost-effectiveness of different interventions to reduce the burden of psychiatric disorders in developing countries (Table 2). On the basis of these analyses, a
mental health care package consisting of (a) outpatient treatment of schizophrenia and bipolar disorder with first generation antipsychotic or mood stabilizing drugs and psychosocial treatment, (b) proactive care of depression in primary care with generic Selective Serotonin Reuptake Inhibitors (SSRIs) (including maintenance treatment of recurrent episodes) and (c) treatment of panic disorder in primary care with generic SSRIs was arrived at. The cost per capita of such a package was estimated to be $3–4 in Sub-Saharan Africa and South Asia, and $7–9 per capita in Latin America and the Caribbean. On the basis of this package, for every $1 million invested, 350–700 healthy years of life would be gained over and above what would occur without intervention. These are just the health gains, independent of other economic benefits of mental health care such as reduced inappropriate use of health care, sickness absence from work and premature mortality, the economic value of which may well in fact exceed the investment costs associated with mental health system development.

Current mental health care and resources in LAMIC

The evidence based on the burden of mental disorders in LAMIC and, above all, the moral and economic rationale for investing in mental health care in developing countries, is relatively recent—thus, it should perhaps come as no surprise that the actual investment in evidence-based mental health services in LAMIC is grotesquely out of proportion to the need. The recent Mental Health Atlas20 has reviewed global mental health resources—the findings of this survey show that although the majority of global burden of mental disorders is located in LAMIC, >90% of global mental health resources are located in high-income countries. The median number of psychiatrists in high income countries is 200 times greater than that in low income countries; put another way, there are approximately 1800 psychiatrists for 702 million people in Africa compared to 89 000 psychiatrists for 879 million people in Europe.20 Similar inequities are evident for all other mental health professional groups (such as psychiatric nurses). In the African and south-east Asian regions, more than half the countries, which provided information on actual budgets for mental health, spent <1% of their total health budgets on mental health. These figures revealing a grotesque inequity in distribution hide other inequities—thus, within LAMIC, most mental health resources are concentrated in urban and affluent areas and in psychiatric hospitals. Thus, even though deinstitutionalization and integration of inpatient mental health care within general hospitals is the stated policy objective, 74.4% of psychiatric beds in LAMIC are to be found in psychiatric hospitals.
Furthermore, some high-income countries continue to rely to an ever-increasing degree on the already meagre mental health resources of LAMIC to sustain their own mental health systems.\textsuperscript{46}

Thus, it would not be surprising that the vast majority of mental health needs in LAMIC is unmet. The World Mental Health Surveys

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<thead>
<tr>
<th>Disorder</th>
<th>Intervention</th>
<th>Example</th>
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<tr>
<td>Schizophrenia</td>
<td>Older (neuroleptic) antipsychotic drug</td>
<td>Haloperidol</td>
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<tr>
<td>Treatment setting: hospital</td>
<td>Newer (atypical) antipsychotic drug</td>
<td>Risperidone</td>
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<tr>
<td>outpatient</td>
<td>Treatment coverage (target): 80%</td>
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<tr>
<td>Bipolar affective disorder</td>
<td>Older antipsychotic drug psychosocial treatment</td>
<td>Haloperidol with family psychoeducation</td>
</tr>
<tr>
<td>Treatment setting: hospital</td>
<td>Newer antipsychotic drug and psychosocial treatment</td>
<td>Risperidone with family psychoeducation</td>
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<tr>
<td>outpatient</td>
<td>Treatment coverage (target): 50%</td>
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<tr>
<td>Depression</td>
<td>Older mood-stabilizing drug</td>
<td>Lithium carbonate</td>
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<tr>
<td>Treatment setting: hospital</td>
<td>Newer mood-stabilizing drug</td>
<td>Sodium valproate</td>
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<tr>
<td>outpatient</td>
<td>Treatment coverage (target): 50%</td>
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<tr>
<td>Panic disorder</td>
<td>Newer antidepressant drug (SSRI; generic)</td>
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<tr>
<td>Treatment setting: primary health care</td>
<td>Episodic treatment</td>
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<td>Treatment coverage (target): 50%</td>
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Interventions for reducing the burden of major psychiatric disorders in developing countries (from the Disease Control Priorities Project).\textsuperscript{44} Interventions in bold are the most cost-effective treatments of choice. Reprinted with the permission from the World Bank.
show that although disorder severity is correlated with probability of treatment, between 76.3 and 85.4% of persons with mental disorders in LAMIC in different countries received no treatment in the 12 months before the interview.\textsuperscript{18} In a Nigerian survey, for example, of the 23% of participants who had seriously disabling mental disorders, only about 8% had received treatment in the preceding 12 months.\textsuperscript{47} Thus, a substantial proportion of patients rely entirely on their families for care; however, families often suffer great hardships in caring for their mentally ill relatives, particularly for chronic and progressive neuropsychiatric disorders such as dementias.\textsuperscript{48} Patients with severe mental disorders consume most mental health resources—thus, much of the scarce specialist mental health system is largely concerned with the care of adults with severe mental disorders. However, even this care cannot be considered as adequate for most. Drug treatments and custodial treatments dominate in large psychiatric hospitals, many of which are relics of the colonial era; in such hospitals, care is often compromised by poor standards of care, lack of community care programmes to improve the odds that patients who have been discharged are able to recover fully and remain in good health and, in some instances, denial of basic human rights.\textsuperscript{49}

The alternative sectors for mental health care are primary health care and traditional medical care. The integration of mental health in primary health care has been a \textit{mantra} for several decades—it retains its relevance today as much as ever, for two key reasons. First, mental health resources are unlikely to be adequate to address the burden of mental disorders even in rich countries, leave alone LAMIC. Second, most patients with mental disorders, particularly less severe disorders, prefer to seek care from their own family or primary care health care providers. However, there is precious, little evidence that integration of mental health care into routine primary care has been sustainable and effective.\textsuperscript{50} There are a number of obstacles to scaling up efficacious interventions to the ‘real-world’ primary care context in LAMIC, notably: the low recognition rates of mental disorders by primary care doctors, for example because of somatic presentations and because they do not have enough time to elicit psychological symptoms; the inadequate use of evidence-based medications and the frequent use of non-evidence-based medications; the stigma associated with mental disorders and the lack of availability of psychosocial interventions to address the social determinants of mental disorders.

Traditional medical practitioners (TMP) are frequently consulted; in some communities in Africa,\textsuperscript{51} they dominate mental health care provision. The report of the Alma-Ata International Conference on Primary Health Care concluded that ‘Traditional medical practitioners . . . are often part of a local community, culture and tradition, and
continue to have high social standing in many places, exerting consid-
erable influence on local health practices. It is therefore well worth-
while exploring the possibilities of engaging them in primary health
care and of training them accordingly. 52 Although several models for
integrating TMP have been advocated, and attempted, none of them
have been systematically evaluated or replicated. While efforts to inte-
grate this extremely valuable human resource in mental health care are
a necessity, one must also bear in mind that abuses of human rights
can also occur within the context of traditional medicine; this was tra-
gically demonstrated by the Erwaddi disaster in south India in 2001
when several persons with mental disorders were burned to death
when a fire swept their healing temple at night—they were unable to
escape due to the fact they were chained to their beds.

Implications for policy and practice

The evidence base on mental disorders in LAMIC, briefly described
above, may be summarized as follows: mental disorders are common
in all countries; they are associated with mortality and morbidity, and
with other health concerns that are considered public health priorities
for LAMIC; poverty, gender disadvantage, conflict, social exclusion
and displacement are key social determinants of mental disorders;
locally available, affordable and acceptable interventions are effective
for the treatment of mental disorders; mental health resources are extre-
meely scarce in LAMIC and most persons with mental disorders do not
receive even basic, evidence-based care. The implications for policy and
practice of this evidence remain unchanged from the 10 recommen-
dations made in the World Health Report 2001 (Fig. 2). Perhaps, some
key issues stand out in the light of the evidence.

The first major implication is to improve the care and services for
people with mental disorders, across the life span and across all sectors
of the health and social welfare systems. While strengthening the
mental health skills of existing health care practitioners is mandatory,
it is also time to acknowledge that the existing health care system, par-
ticularly in the primary care sector, is unlikely to shoulder the burden
of mental health care without additional resources. However, these
resources may be largely composed of relatively low-cost health
workers, such as those who have been found to be effective in deliver-
ing interventions for common and severe mental disorders in the trials
cited earlier. Such new human resources may also serve to utilize their
skills (notably around detection of disorders and provision of psychos-
ocial treatments) to help address the burden of other chronic disorders
(including HIV/AIDS). Service development must be equitable: planning
must ensure that rural populations, and vulnerable groups in the population receive their fair share of services. A key programmatic implication is that mental health care must be piggybacked onto all existing health programmes—for example, integrating mental health into the global HIV/AIDS care programmes and the Integrated Management of Childhood Illnesses programme. There is a need to go beyond orthodox models of health care to maximize the existing resources in the community, such as TMP. There are several models advocating on how services should be developed inter-sectorally.53

Second, there is a need to address the very low levels of mental health literacy and associated stigma, again at all levels of society. Raising mental health literacy may help improve understanding about the risks to mental health and methods of coping with these risks, and thus promote mental health in the community. One such awareness programme was assessed in a controlled trial in Rawalpindi, Pakistan. This trial shows that delivering education regarding mental health and illness to secondary school students is effective in raising awareness in the wider community and may thus help raise mental health literacy and promote mental health at large.54 Non-governmental organizations in many developing countries are now playing a key role in raising awareness about mental health and pioneering a range of community programmes targeted to different population groups to promote mental health and prevent mental illnesses.55 Much local health policy is now influenced by the agendas of international agencies and donors. Thus, advocacy is needed as much with local stakeholders as with those in ivory towers in rich countries who, while benefiting from the considerable investment in mental health care in their countries, seem to believe that mental health is not quite an important enough matter for people in LAMIC.

Fig. 2 Recommendations of World Health Report.4

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<tr>
<th>Public mental health priorities</th>
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<tr>
<td>1. Provide treatment in primary care</td>
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<td>2. Make psychotropics available</td>
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<td>3. Give care in the community</td>
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<td>4. Educate the public</td>
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<td>5. Involve communities, families and consumers</td>
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<td>6. Establish national policies and legislation</td>
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<td>7. Develop human resources</td>
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<td>8. Link with other sectors</td>
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<td>9. Monitor community health</td>
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<td>10. Support more research</td>
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Finally, we need advocacy, not only just to combat stigma and address the vast unmet need for mental health care, but also to challenge events in our world, which we know harm human well-being (and their mental health). Unrestrained economic reforms, which lead to the loss of employment of vulnerable populations in societies with no social welfare net, amount to no less than sanctioning their starvation and the only escape route available to many is suicide. The seemingly endless tragedy of organized violence, sponsored both by nation states and terrorist organizations, and accompanied by scant regard for human rights or social justice, cannot be ignored in any discourse on global mental health. It is a moral imperative for all health practitioners to challenge actions aimed at imposing a global hegemony of ideas and policies, particularly those that will harm the health and survival of those with the least to gain, and most to lose.

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References


