

The state of the evidence

Mental health services and barriers to implementation

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Executive summary

The move to community-based mental health care

 Psychiatric services in developed countries were highly centralized as a result of the massive programme of building psychiatric hospitals. The process of running down and closing these hospitals has resulted in decentralization, with the establishment of community-based services. In many developing countries, the great majority of people with psychiatric conditions are managed in the community, but with very few specialized professionals. In many of these countries, the development of psychiatric services continues to have a low priority despite the high level of chronic disability caused by psychiatric illnesses.

Individuals and their families must have access to affordable psychiatric services and to sufficiently trained health workers to correctly diagnose and treat the problems. An optimal balance between specialist and primary health care services is needed. Mental health legislation also requires a balance between the right to individual liberty, the right to treatment, and protection of the public. In those countries which lack a mental health law, it is of high priority that one be enacted.

New interventions

In the last two decades there have been major advances in both drug and social treatments for a wide range of psychiatric conditions. New types of antipsychotic drugs and antidepressants have been introduced which have fewer side effects than the older drugs, but are more expensive. Cognitive-behavioural therapies, which aim to alter faulty thinking patterns and equip patients with helpful strategies to combat symptoms, have been introduced both for neuroses and for schizophrenia and manic-depression. Involving families in treatment has been shown to improve the outcome for alcoholism, eating disorders, depression, schizophrenia, and childhood neuroses and behavioural problems. These innovative developments greatly extend the range of effective psychiatric interventions, but are available to very few patients, even in developed countries.

Making drug and psychosocial treatments available to all who could benefit

Disseminating effective psychosocial treatments is a major challenge in all countries. In developing countries in which psychiatric services need to be established in primary care facilities, the costs of providing appropriate psychiatric training to the staff and of ensuring an uninterrupted supply of essential drugs must be budgeted for nationally. Some drugs may be purchased under generic names from non-profit organizations. There are good examples of training paramedical staff to prescribe a limited range of psychotropic medication. In addition, with minimal training, they can use flow-charts for diagnosis, assessment, management and referral.

In the absence of specialized professionals, paramedical staff and family members can be trained to help other families cope better with a mentally ill member. Although the responsibility for the care of people with psychiatric illness falls almost entirely on the family in developing countries, a genuine collaboration between professionals and family members is rare.

The therapeutic value of work

Work is a crucial factor in the social reintegration of psychiatric patients. However, in developed countries it is very difficult to find a job if you have a history of mental illness. The recent development of social firms or co-operatives has provided an answer to this problem. In order to improve the quality of life of people with mental illness living in the community, it is essential to forge strong links between mental health services and departments of employment, welfare and housing.

The growth of users and relatives organizations

Non-governmental organizations for users and relatives have grown to become national advocacy groups, as well as providers of services, in many developed countries. They are still embryonic in most developing countries. The recognition that users have a legitimate voice is empowering and also has the effect of reducing the stigma of mental illness.

Special groups and their needs

Children and Adolescents: In most countries in the world, the development of psychiatric services for children has lagged behind those for adults.

Children and adolescents are more exposed to the psychiatric consequences of poverty, famine and loss of parents in developing countries, precisely where child psychiatric services are least in evidence. With the spread of universal education, schools are becoming the most appropriate venue for health related interventions for children.

Primary care workers need to be based in schools and to be equipped with skills to identify emotional and behavioural problems in children, and to treat and manage them. The possibility also exists of training mothers in the better care of infants to prevent later problems in psychological development.

Substance Misuse: The scale of misuse of psychoactive substances, including multiple substance use, has grown dramatically worldwide in the past three decades. A wide range of effective treatments is available for alcohol and drug problems, including psychosocial, medical and educational interventions. These are best located in primary care services, which should collaborate with available community agencies, including self-help groups. Equal attention should be given to measures to reduce the demand for psychoactive substances and to reduce the supply.

The Elderly: Older people are at high risk for suicide (particularly men), depression and dementia. The psychiatric problems of the elderly are increasing yearly as the proportion of older people rises steadily worldwide. At the same time, the dissolution of the extended family under the pressures of urbanization and industrialization is slowly removing the natural support networks that sustain the elderly. Therefore there is a pressing need to support and improve the care already provided to the elderly by their families, including the provision of respite care, and the incorporation of mental health assessment and management into general health services for the elderly.

Mental health care in developed and developing countries

Introduction



The development of psychiatric services has diverged markedly in developed and developing countries. In the former, services became strongly centralized through a massive programme of building psychiatric hospitals in the nineteenth and early twentieth centuries. These were usually sited outside towns and cities. These hospitals were enclosed worlds, isolated from the rest of society, and patients, once admitted, were likely to remain for the rest of their life.

In developing countries a few psychiatric hospitals were built by the colonial powers, but these were often designated for their own personnel to the exclusion of the local population. With the ending of colonial rule, the psychiatric hospitals were taken over by the new governments, but they have never catered to more than a tiny proportion of the population. In India, for example, there are only about 25,000 psychiatric beds for a population exceeding one billion (Wig, 1997). Consequently, in developing countries families continue to be the main source of care and support for people with psychiatric disorders, including those of the greatest severity.

Following the end of the Second World War, the focus of care in developed countries began to shift from the psychiatric hospitals to community based services. This was in response to changes in the attitudes of staff, increasing public awareness of abusive practices in the hospitals, and the introduction in 1955 of chlorpromazine, a drug with specific antipsychotic action. In North America, Europe and Australia the process of deinstitutionalization (transferring services from psychiatric hospitals to community facilities) has proceeded steadily, resulting in the closure of many psychiatric hospitals. In Italy, Law 180 was enacted in 1978 preventing the admission of patients to psychiatric hospitals, though psychiatric beds in general hospitals remain available. In England and Wales, by 2000 only 14 of the 130 psychiatric hospitals were still open. In Valencia, Spain, the last of the 8 psychiatric hospitals was closed in 2001. The neglect of mental hospitals continues

to date in both developed and developing countries.

The old psychiatric hospitals represent a large investment of capital in both the buildings and the grounds, and of revenue in the staff. The land on which they stand has become quite valuable as cities have expanded to incorporate the once-distant asylums. In many countries the sites of the psychiatric hospitals have been sold to developers and the funds raised have been invested in community services. Staff in the psychiatric hospitals have been redeployed to work in the community. The dominant model in the organization of comprehensive psychiatric care in many European countries has been the creation of geographically defined areas, known as *sectors*; this concept was developed in France in the mid-20th century. From the 1960s on, the organizing principle of sectorization has been widely applied to many areas in almost all countries in Western Europe, with sector size ranging from 25,000 to 30,000 population.

Deinstitutionalization has not however been an unqualified success and community care still faces many operational problems. Among the reasons for the lack of better results are that some governments have not allocated resources saved by closing hospitals to community care, and that professionals have not been adequately prepared to fully understand and accept the changing place of care and roles. Critics of the community based approach claim that it has led to many more mentally ill people becoming homeless or being imprisoned (Lamb, 1976). However, follow-up studies of cohorts of long-stay patients discharged from psychiatric hospitals have shown that if community services are well organized and adequately funded, these negative outcomes can be avoided, with improvement in the patients' quality of life (Trieman et al, 1999; Leff et al, 2000; Rothbard et al, 1999).

In many developing countries on the other hand, care programmes for the individuals with mental and behavioural problems continue to have a low priority. There is no psychiatric care for the majority of the population: care is still mostly limited to a small number of institutions – usually overcrowded, understaffed and inefficient – and services do not reflect the needs of the ill individuals or the range of approaches available for treatment and

care. The public seeks help in these centres as a last resort. Many hospitals continue to operate under legislation that is more penal than therapeutic. For example, in 15% of countries around the world, (WHO Project ATLAS. Preliminary analysis of information collected during an initial study, from October 2000 to March 2001, from 181 countries) the laws governing admission and discharge are more than 60 years old; these laws place barriers to admission and discharge. Also, since there are few specialized professionals, the community resorts to the available traditional healers. Most of these countries do not have adequate national level training programmes for psychiatrists, psychiatric nurses, clinical psychologists, psychiatric social workers and occupational therapists.

A result of all these factors is a negative institutional image of the mentally ill which is added to the stigma of being mentally ill. Even now, these institutions continue to be out of step with the developments and human rights of persons with mental illness as seen from reports on mental hospitals in several countries. However, stimulated by the accumulating evidence of the inadequacies and failures of the psychiatric hospital coupled with the appearance of "institutionalism", (the development of disabilities as a consequence of social isolation and institutional care in remote asylums) many developing countries have initiated the process of de-institutionalization.

Community-based mental health care



De-institutionalization can be defined as a basic precondition of any serious mental health care reform. De-institutionalization is not synonymous with de-hospitalization. This has to be seen as a complex process leading to the implementation of a solid network of community alternatives. Closing mental hospitals, without community alternatives is as dangerous as creating community alternatives without closing the mental hospitals. Both have to occur at the same time.

To prevent and treat mental disorders a spectrum of services is needed, including mental health promotion, illness prevention, early intervention, treatment and rehabilitation (Jenkins and Üstün, 1998; Rahman et al, 1998). The complexity of

delivering these services to meet community needs is a challenge. For example, community education, school and workplace mental health promotion require collaboration between different government departments and other stakeholders. Chronic mental disorders require integrated treatment and support services to reduce disability, increase social functioning and improve quality of life (Katschnig et al, 1997).

For other more prevalent conditions, cost effective treatments are now available to remove active symptoms and disability (Nathan and Gorman, 1998) and can often be applied by primary health care providers (Saraceno et al, 1995; Abas et al, 1995; Üstün and Sartorius, 1995). For this, individuals and/or their families or other members of the community must recognize the problem, have accessible and affordable professional services and sufficiently trained health workers to correctly diagnose and treat the problems. An optimal balance and collaboration between specialist and primary health care services and between hospital and community care is needed. Mental health legislation also requires a balance, between the right to individual liberty, the right to treatment and the legitimate expectation of community safety.

In most countries where deinstitutionalization has occurred, the process began with local initiatives and was only officially endorsed as government policy at a later stage. The exceptions are some countries in Europe and Latin America where the law was altered to start the process of change. For the transition to community care to be successfully achieved, it is essential to have the full backing of the government so that there is equity of services nationally, and so that mental health legislation is amended to meet new standards of caring for patients. The process of formulating new laws must be carried out in collaboration with representatives of the criminal justice system. In those countries where there is no existing mental health law, it is of high priority that one should be enacted.

In some countries, even when decisions have been made to deliver a balanced spectrum of services nationally, the outcome has often fallen short of its full potential because insufficient attention was given to structural, functional and financial issues that are principal barriers to successful policy

implementation. Examples that demonstrate the importance of those issues include:

- The deinstitutionalization of patients with severe mental illness needs to be linked to an upgrading of the health care system within the community that will have to receive the patients (Lamb, 1992).
- The utilization of primary health and social services to deliver care to people with mental illness requires that these services have sufficient training and structural linkages to specialist mental health service providers (Strathdee and Jenkins, 1996).
- Training mental health professionals as a means of expanding access to care requires that sufficient attention is given to issues of distribution and specific role based skills through certification and other means (Jenkins, 1999).
- The dependence on families and community support systems, including self-help groups, public housing etc, requires that sufficient structural and financial linkages be established to the mental health services (Whiteford, 1994).

Good quality care in the community is no cheaper than psychiatric hospital care (Hallam et al, 1994), and there are transitional costs which need to be met before the new service is fully established. Hence mental health budgets need to reflect this. Furthermore, in developing countries in which psychiatric services need to be established in primary care facilities, the costs of providing primary care workers with appropriate psychiatric training, and of ensuring an uninterrupted supply of essential drugs, must be budgeted for nationally. Health budgets are under constant pressure to expand from all medical and surgical specialties. In view of the heavy burden of disability produced by psychiatric disorders budgets for mental health need to be protected. (WHO, 1997)

In conclusion, community based mental health care is about empowerment of people with mental and behavioural disorders and refers to the stage in which the main goal is to develop a wide range of services within local settings. In this process, which has not yet begun in many regions and countries, it is aimed to ensure that some of the protective functions of the asylum are fully provided, and the negative aspects of the institutions are not perpetuated. The care in the community

approach aims to provide services which offer treatment and care with the following characteristics:

- services which are close to home through primary health care, including general hospital-care for acute admissions, and long-term residential facilities in the community;
- interventions related to disabilities as well as symptoms;
- treatment and care specific to the diagnosis and needs of each individual;
- wide range of services which address the needs of service users themselves and of other ill persons;
- services which are co-ordinated between mental health professionals and community agencies;
- mobile rather than static services, including those which can offer home treatment;
- partnership with carers and meeting their needs;
- legislation to support the above aspects of care.

The advent of new treatments for psychiatric conditions

In the last two decades there have been major advances in both drug and social interventions for a wide range of psychiatric conditions:

Drug therapies



New types of drugs have been introduced for treating the symptoms of psychosis. Following the introduction of chlorpromazine in 1955, a number of related antipsychotic drugs came on the market. These all had the disadvantage of causing severe neuromuscular side effects at therapeutic doses, which deterred many patients from taking them regularly. Clozapine, a drug which was free of these side effects, became available, but had the dangerous propensity of suppressing white cells in 1-2 percent of patients. Since 1973 four or five novel antipsychotic drugs have been introduced which lack the neuromuscular side effects of the older drugs and do not affect the white cells. Hence they are more acceptable to patients. However they are much more costly: for example, in the United Kingdom, the monthly cost of haloperidol is £5, while clozapine costs £241.

New types of antidepressant drugs have been developed which are considerably safer than the older types when taken as an overdose, but are also more expensive.

Psychosocial therapies

Cognitive-behavioural therapies, which aim to alter faulty thinking patterns and equip patients with helpful strategies to combat symptoms, have been introduced for depression (Beck et al, 1979), anxiety states, phobias (Marks, 1987), and obsessive-compulsive disorders (Marks et al, 1975). For each of these conditions the psychological treatment is as effective as drug treatments or better. Patients are generally reluctant to take drugs for long periods and greatly prefer non-drug treatments. Recently a cognitive-behavioural approach to psychotic symptoms (delusions and hallucinations) has been shown to be of benefit, particularly for patients who have responded poorly to antipsychotic drugs (Kuipers et al, 1998; Tarrrier et al, 1999).

Family therapy improves the outcome for adults with alcoholism, eating disorders, and depression, and for children with neuroses and behavioural problems. Working with families of people with schizophrenia adds a significant advantage to maintenance drug treatment in reducing the relapse rate (Leff, 2001) and has been endorsed by a Cochrane Review as evidence based (Pharoah et al, 1999).

These innovative developments greatly extend the range of effective psychiatric treatments, but are available to very few patients, even in developed countries with well-resourced national health services. The difficulty in disseminating these treatments is partly due to the lack of training in the necessary skills, and partly to the fact that there is no commercial organization with an interest in promoting the product.

Integrating psychiatric care within primary health care



Despite the major differences between mental health care in developing and developed countries, they share a common problem: the poor utilization of available psychiatric services. Even in countries with well established services, fewer than half of those individuals needing them make use of them. This is related to the stigma attached to the individuals with mental and behavioural disorders and the inadequacy of services provided.

This stigma issue was also highlighted in the US Surgeon General's Report of December 1999. The report noted: "Despite the efficacy of treatment options and the many possible ways of obtaining a treatment of choice, nearly half of all Americans who have a severe mental illness do not seek treatment. Most often, reluctance to seek care is an unfortunate outcome of very real barriers. Foremost among these is the stigma that many in our society attach to mental illness and to people who have a mental illness."

Integrating psychiatric care within general health care – which includes the opening of psychiatric admission wards in general hospitals – has the added advantage of reducing the stigma of an admission for psychiatric illness. In developed countries it is rare nowadays for patients with non-psychotic disorders to be admitted, and admission wards are almost exclusively occupied by patients with psychoses. The great majority of patients with non-psychotic disorders are treated by primary care physicians, only 5% of them being referred to secondary care (Goldberg & Huxley, 1980). However, up to one half of patients consulting primary care physicians with psychological disorders are incorrectly perceived as suffering from physical illnesses (Docherty, 1997; Goldberg & Huxley, 1992) leading to a waste of money on physical tests and delay in their receiving appropriate treatment, or its absence. This is partly because many patients present to their doctors with bodily rather than psychiatric complaints (Üstün & Sartorius, 1995). The problem is very serious because depression accounted for more than 10 per cent of years of life lived with a disability worldwide in 1990. Many episodes of depression become chronic, par-

ticularly if untreated: persistent symptoms were found in 32 per cent of 60 patients 12 to 15 months after remission (Paykel et al, 1995). Improvements in training of primary health care providers for assessment and management of mental disorders is a priority for both developing and developed countries.

The organization of mental services as part of primary health care is a general approach in developing countries. At one level it can be seen as necessity in the face of lack of trained professionals and resources to provide specialized services. At another level it is a reflection of the opportunity to organize mental health services in a manner that is devoid of isolation, stigma and discrimination. The approach of utilizing all the available community resources has an attraction of empowering individuals, families and communities to make mental health an agenda of people rather than professionals. However, currently mental health care is not receiving the attention that is needed. Even in countries where pilot programmes have shown the value of integrating mental health care within primary health care (e.g. Brazil, Colombia, India, Sudan) the expansion to cover the whole country has not occurred.

Treatment interventions through primary health care

Drug treatments

Psychiatric drug treatments can be delivered by primary care physicians in developed countries, although they are not always as skilled in their use as psychiatrists. This is particularly the case with antidepressant drugs which tend to be prescribed in too low a dosage. In developing countries even the cheapest, most basic drugs may be available only sporadically, or not at all. This problem stems from a combination of insufficient central funds and an inadequate infrastructure for distribution. It has been tackled successfully in Sichuan Province, China, by training village medical auxiliaries in the use of three low cost psychiatric drugs: an antidepressant, an antipsychotic, and carbamazepine, which is effective both for stabilizing mood disorders and controlling epilepsy. In a similar initiative in Belize, Central America, well trained psychiatric nurse practitioners have been prescribing psychotropic medication for some years, a service

which has been positively evaluated (Kohn et al, 2000). This exemplifies the approach recommended by the Expert Committee on the Use of Essential Drugs (WHO, 1988).

Continuous maintenance medication is often required for the psychoses (schizophrenia and manic-depressive illness) and sometimes for depressive disorders. An interruption in the supply of drugs can lead to relapse of these conditions. In certain circumstances, drugs may be purchased under generic names from non-profit organizations such as ECHO (Equipment for Charitable Hospitals Overseas) and UNIPAC (UNICEF Procurement and Assembly Centre), which supply drugs of good quality at economic prices (World Health Organization, 1990).

Even with a very limited range of psychotropic drugs to prescribe, the health worker will need to decide which are indicated for particular clients. Flow-charts have been developed for psychiatric conditions that incorporate decisions about diagnosis, assessment, management and referral. Their advantage is that they can be used with minimal training (World Health Organization, 1990).

Psychosocial treatments

In developed countries there is usually a cadre of psychiatric staff based in the community who could deliver these effective new treatments. However there is a logistic problem in training a sufficient number of them in the requisite skills. Training in psychosocial interventions that have been proven efficacious is time-consuming, and during training the staff member is absent from the work site and has to be replaced. Funds need to be made available both for the training and for replacement staff. Managers are often reluctant to commit funds to the short term investment, even though there are long term economic gains in terms of reduced hospitalization rates (Cardin et al, 1985; Zhang et al, 1994). Even when staff are trained, they are not always able to utilise their skills efficiently. This is partly due to the pressure of their case load, and partly to the lack of adequate supervision and support for work that is emotionally demanding. In order to integrate psychosocial interventions into a clinical service it is necessary to achieve a culture change in the whole service by educating all the staff, including man-

agers, in the value of the interventions, and training a core group of workers who can provide mutual support (Fadden, 1998).

A cascade model of training in family work, cognitive-behavioural approaches for schizophrenia, and assertive community treatment has been established in Britain for psychiatric personnel (the Thorn Initiative) (Lancashire et al, 1997). Two national training centres accept trainees from anywhere in Britain, and provide training both in the necessary skills and, for selected individuals, to become trainers themselves. Six satellite training centres are now operating and a further six are being established. However, even after several years of operation of this programme only a small proportion of families who could benefit from this intervention are receiving it. This technological innovation is not available for most of the world, although training in family work is becoming established in certain centres in Europe and the US.


A model of this kind is inappropriate for a developing country due to lack of sufficient psychiatrically trained personnel available to work at the community level. Furthermore, even when providers exist, there is often maldistribution, due to their commitment to private patients and a reluctance to practice in rural communities. The strategy of training health workers in the use of a limited range of drugs cannot be applied to psychosocial treatments, since the effective components in these complex interventions have yet to be identified. A different approach has been attempted in Britain which may be applicable to developing countries. A voluntary organization for patients with schizophrenia and their families (the National Schizophrenia Fellowship) has introduced a novel programme which uses family members as trainers for other families (Carers Education and Support Project). The training programme for ten to twelve carers is delivered in ten three hour sessions. It aims to improve carers' understanding of severe mental illness, to reduce stress and ease the burden of caring, and to improve communication skills (Shore & Holmshaw, 1998). Although not yet fully evaluated, this strategy is promising. However, the approach to working with families will need to be modified to be sensitive to local cultures, as has been achieved successfully in Malaysia (Razali et al, 2000) and China (Xiong et al, 1994; Zhang et al, 1994). In all these endeavours it is crucial to rec-

ognize that the family is not the target of treatment but is a partner in the treatment process. Effective working relationships between families and mental health staff depend upon consultation, co-operation, mutual respect, equality, sharing of complementary resources and skills, and clarity of expectations (Community Liaison Committee of the Royal Australian and New Zealand College of Psychiatrists, 2000).

Although the responsibility for the care of people with psychiatric illness falls almost entirely on the family in developing countries, a genuine collaboration between professionals and families remains in its infancy. For example, in India there are a few places where family interventions have been delivered (Shankar & Menon, 1993; Verghese et al, 1991), but these are specialized facilities and such approaches are not available in routine service settings. The importance of the family's commitment to the caring role cannot be overemphasized, particularly since there is evidence that the manifestly better outcome for patients with schizophrenia in developing countries (Jablensky, 1992) is partly due to a greater tolerance by relatives for symptoms and disturbed behaviour (Wig et al, 1987; Whyte, 1991)

Combating social exclusion

Work as a therapeutic activity

 Long-term care in a psychiatric hospital excluded patients from participation in society. Since these institutions provided a total environment (Goffman, 1961) including shelter, work and recreation, there was no reason for patients to step outside the gate, even if they were allowed to do so. Transferring patients to homes in the community does not automatically ensure reintegration into society. There are a number of barriers to social integration including stigmatizing attitudes of the public, patients' lack of social skills, and the difficulty in obtaining a job in open employment. Work is a crucial ingredient in the reintegration of psychiatric patients since it can provide them with social contact with ordinary citizens, it can give them a sense of worth through contributing to society, it can alleviate the poverty that many endure (*see Socioeconomic Factors and Mental Health*), and it can help to reduce delusions

and hallucinations. Patients discharged from psychiatric hospital who have a job are much less likely to be rehospitalized than those who are unemployed, regardless of their level of symptoms (Jacobs et al, 1992). The provision of sheltered workshops in the community maintains the social isolation of patients from mainstream society, and usually requires them to undertake repetitive, unsatisfying packing or assembly tasks. A preferable alternative is the recent development of social firms or co-operatives (Saraceno, 1997), which are a particular feature of the community psychiatry movement in Italy. A comparison of patients with schizophrenia in Bologna, Italy, and Boulder, Colorado, USA, found that 30% of the Italian patients worked more than 30 hours per week compared with 8% of the American patients, and the Italian patients earned two and a half times as much and enjoyed a better quality of life (Warner et al, 1998). Social firms for people with psychiatric disabilities are now reasonably well established in Europe, with Germany having by far the largest number (Grove et al, 1997).

In developing countries, in which families provide virtually all the care for people with psychotic illnesses, they are often able to find tasks within a family enterprise which their relative is able to perform. In this event, mentally ill family members can feel they are contributing to the family's welfare and are included in a social unit. However, the spread of urbanization and industrialization inevitably curtails these opportunities for employment. Therefore social firms represent a way forward in both developed and developing countries. Their development could be encouraged by tax incentives from the government and by the involvement of local businessmen as advisors.

In order to improve the quality of life of people with mental illness living in the community, it is essential to forge strong links between mental health services and departments of employment, welfare, and housing.

The user movement

The growth of users and relatives organizations



The past two decades have seen the rise of the user movement. Non-governmental organizations for users and relatives have grown to become national advocacy groups in many developed countries, for example, the National Alliance for the Mentally Ill in the USA, ENOSH in Israel, MIND in Britain. Through providing information about mental illness and raising public consciousness about the issues, these organizations play a vital role in combating stigma (*see Stigmatization and Human Rights Violations*). They have also become active players in policy development.

In Great Britain, MIND, receives a substantial grant from the government. Through such mechanisms, users are able to express their views of the kinds of services they would like to receive, and act as a pressure group on providers of mental health services, including the government. In developed countries, users are increasingly being included on bodies that make decisions about the development of psychiatric services. This recognition that users have a legitimate voice is empowering and also has the effect of decreasing stigma.

In developing countries they are currently small in membership or non-existent, though they are becoming established in Latin America in countries such as Argentina and Brazil. However, they are often locally based without a national identity, which inhibits them from acting as a pressure group for the improvement of services, and from providing adequate support to all users and relatives who need it.

In some countries there is a growing self-help movement organized by and for users.

Services needs of some special groups

Psychiatric problems in children and adolescents



In most countries in the world, the development of psychiatric services for children has lagged behind those for adults, with the deficiencies being greatest in low income countries.

Between 10 and 20 per cent of children and adolescents are affected annually, their psychiatric morbidity accounting for five of the top ten leading causes of disability for those aged 5 and above (Murray & Lopez, 1996). In Latin America and the Caribbean alone, 17 million children suffer from moderate to severe psychiatric disorders in need of care (Presentation, PAHO/WHO Directive Council, 1997). In many developing countries there is a paucity of adequately trained child and adolescent mental health professionals.

Adolescents, a group at high risk for psychiatric disturbances, often have to be treated in facilities for adults. Substance abuse in children and adolescents also is a worldwide problem (Belfer & Heggenhougen, 1995) and has severe consequences in terms of morbidity and mortality

Children and adolescents are more exposed to the psychiatric consequences of poverty, famine and loss of parents in developing countries, where child psychiatric services are least in evidence. In the absence of a cadre of adequately trained child and adolescent mental health professionals, it is unrealistic to plan for the institution of these services in developing countries in the near future. Instead the focus should be on equipping mental health workers with basic skills in the detection and treatment of child psychiatric disorders, as in Alexandria, Egypt, where child counsellors have been trained to work in schools (El-Din, 1993). With the spread of universal education, schools are becoming the most appropriate primary venue for health related interventions for children. Since child mental health symptoms do not differ significantly across cultures, it is feasible to use expertise from child psychiatry services in developed countries to compile training packages for primary care workers in developing countries (Nikapota, 1993), (Thabet & Vostanis, 1998). These training materials

should be adapted so that they are culturally appropriate. These workers need to be based in schools and to be equipped with skills to identify emotional and behavioural problems in children and to treat and manage them. They should also be able to identify vulnerable children and to employ preventive strategies. Other forms of outreach are needed to work with children and adolescents who resist coming to conventional settings for care. Multi-function health clinics, after-school programmes, and activities programmes can be venues for counselling activities.

The possibility exists of training mothers in better care of infants in an attempt to prevent later problems in psychological development. A pilot project in one of the deprived townships in Cape Town has demonstrated the feasibility of this approach (Cooper et al, in press). Mothers of older children have been successfully trained to befriend postnatally depressed mothers in Ireland, with the aim of improving mother-infant interaction.

Children and adolescents with diagnosable serious mental illness require treatments analogous to adult treatments. However, caution must be used in the consideration of the use of psychopharmacologic agents that are not approved for use with children and adolescents. Though most care can now be done on an outpatient basis, for children and adolescents with the most serious problems and marginal support from families, appropriate inpatient care is indicated. Inpatient care should always be considered for suicidality and psychotic conditions.

Children continue to be traumatized in great numbers by armed conflict, by epidemics such as HIV/AIDS, and by natural disasters. Wars directly affect children by violence inflicted on them and their families, and indirectly by the emotional trauma caused to their carers. Eighty percent of the victims of war are children and women (Lee, 1991). Displacement due to war resulted in approximately 21.5 million refugees in 1999. AIDS is now a pandemic in sub-Saharan Africa, Russia and parts of Asia. Over one quarter of the youth population in sub-Saharan Africa is infected. The mental health consequences are both direct, including dementia and depression, and indirect, through loss of parental figures and stigmatization. For children not raised in situations of armed con-

flict or disaster, there is increasing awareness of the high prevalence of physical and sexual abuse, neglect and poor parenting, and the serious and enduring effects of these experiences on mental health.

Substance misuse

The scale of misuse of psychoactive substances has grown dramatically world wide in the past three decades. In many countries there has also been a rising prevalence of multiple substance use. Those at high risk include indigenous peoples, prisoners, young people, and refugees. A particularly vulnerable group are people with severe psychiatric illness, whose treatment and management is seriously compromised by concomitant substance misuse. While these problems are most prevalent in Western countries, they exist everywhere.

A wide range of effective treatments is available for alcohol and drug problems, including psychosocial, medical and educational interventions. Such interventions are best located in primary care services, particularly in developing countries, where specialized services may be absent. All available community agencies, including self-help groups, should be enlisted to assist substance users in recovery and rehabilitation.

Equal attention should be given to measures to reduce demand for psychoactive substances and to reduce supply. This obviously requires collaboration between health and other governmental departments. Given that elimination of substance misuse is unlikely in the foreseeable future, there is growing interest in harm reduction strategies. (World Health Organization, 1998). This includes providing oral opioids such as methadone as maintenance therapy for injecting opioid users, and setting up syringe exchange facilities or making syringes legally available for drug injectors who are unwilling to abstain from injecting drugs. These strategies not only reduce mortality and morbidity among injecting drug users, but reduce the spread of infectious diseases such as hepatitis and HIV infection.

The service needs of multiple substance users and people with psychoses who also misuse substances should be considered. The latter require care from psychiatric services and drug abuse services, so that inputs from both need to be co-ordinated.

The Elderly

At the other end of life, the elderly are at high risk for suicide (particularly men), for depression, and for dementia. Rates of suicide are proportionately higher in older people in virtually all countries in which they have been measured reliably. Men over the age of 75 are the group with the highest incidence of all (De Leo, 1997). Some 70 per cent of older suicide victims are considered to have been suffering from a mental illness, most frequently a major depressive disorder (Conwell, 1997). In the United Kingdom, depression severe enough to warrant treatment is found in between 11 and 16 per cent of elderly people living at home (Copeland et al, 1987). This high rate is attributable to the existence of physical health problems (Robert et al, 1997). Presence of depression further increases the disability among this population. Depressive disorders among the elderly goes undetected even more often than among younger adults because it is often mistakenly considered a part of the ageing process.

The main causes of dementia are Alzheimer's disease and cerebrovascular disease, their relative importance varying from country to country (Jorm, 1991). The incidence rises approximately exponentially with age, but is lower in Asian countries than in Europe or North America (Jorm & Jolley, 1998). The prevalence of dementia reaches nearly 40% in people aged 90 years.

The mental problems of the elderly are increasing yearly as the proportion of older people in the population rises steadily worldwide. At the same time, the dissolution of the extended family under the pressures of urbanization and industrialization is slowly removing the natural support networks that used to sustain the elderly.

Special policy and service issues regarding the elderly include therefore the need to support and improve the care already provided to the elderly by their families, incorporating mental health assessment and management into general health services for the elderly, and providing respite care to family members who are still often the carers.

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The state of the evidence

Socioeconomic factors and mental health

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Executive summary



This paper presents some of the current evidence that shows the links between socioeconomic determinants and mental disorders.

The authors have chosen to focus on depressive and anxiety disorders for several reasons. First, these are the commonest of all mental disorders. Second, these disorders account for the largest proportion of the aggregate burden attributed to mental disorders, mainly because of their high frequency. Third, these disorders are typically seen in the general health care settings and can be managed effectively by general health workers with basic skills and training. Finally, there is good evidence of an association with socioeconomic determinants and depressive and anxiety disorders.

However, it needs to be recognized that severe, but far less common, mental disorders such as schizophrenia also cause a significant burden to society, for instance consuming most of the resources devoted to specialist mental health services. It is also evident that socioeconomic determinants play an important influence on other mental disorders, notably alcohol and substance abuse. Thus, policies, which are geared to reducing the impact of socioeconomic determinants on depressive and anxiety disorders, are likely to have a beneficial effect on the risk and outcome of other mental disorders as well.

This working paper has used research and programme evidence from across the world to demonstrate the following issues:

The burden of depression and anxiety

- The prevalence rates of depressive and anxiety disorders varies between settings. Clinically significant disorder occurs in up to 20% of adults living in the community. The prevalence rate is higher in health settings, between 15% and 40% of adults attending primary care and general medical clinics. Depression and anxiety typically occur together and the term depression is used in this document to refer to both types of emotional disorders.
- Depressive and anxiety disorders are not transient disorders; about half of all sufferers have a chronic or recurrent course.

- Women are significantly more vulnerable to suffer these disorders than men. Some of the factors responsible for this increased risk may lie in the unequal status of women in most societies across the world.

Socioeconomic factors and depression

- Socioeconomic disadvantage is strongly associated with the presence of depressive and anxiety disorders. This disadvantage can take many forms from obvious material deprivation to more subtle ways reflecting lack of opportunities due to poorer education, greater risk of adverse life events or other forms of covert or overt social discrimination.
- Irrespective of the average per capita income of a society, persons who are at the bottom end of the social hierarchy are at a greater risk to suffer these disorders than those who are at the upper end, an effect which seems to be more pronounced in more unequal as well as poorer societies. Thus overcoming poverty might contribute to improve mental health but it is unlikely to be enough; a more equitable distribution of resources remains important.
- A variety of social phenomena associated with rapid urbanization by globalization may be detrimental to mental health through increasing stress or reducing natural protective factors. Examples of such phenomena include squalid living conditions in urban areas for migrants, and the breakdown of families as sources of social support.
- Depressive and anxiety disorders are disabling and can prevent sufferers from carrying out their tasks at home and in employment. Depressive and anxiety disorders have adverse economic implications for the individual, their families and society.


Implications for interventions and policy

- The vast majority of persons with depressive and anxiety disorders never receive treatment. Few consult mental health professionals. If they do seek health care at all, they do so from general health care professionals and traditional medical practitioners.
- There is evidence, mostly from developed countries, that some forms of treatments are effica-

cious and cost-effective for common mental health conditions such as depression and anxiety. These interventions can be easily delivered by general health care workers. Improved treatment is a priority though that alone would not lead to a reduction of the prevalence in the community.

- Social and economic policies may impose an unacknowledged burden on society by influencing the prevalence of depressive and anxiety disorders. Policies aimed at reducing poverty and improving economic equity are likely to have the unanticipated benefit of improving mental health and reducing the burden of depression.
- Some intervention programmes may help to reduce the impact of poverty on mental health. Poverty reduction and full employment policies should have benefits in reducing prevalence. Provision of micro-credit as a means of reducing dependence on informal moneylenders may also reduce financial strain. Investing in mainstream education and school completion should improve the individual's long-term opportunities and improve mental health, especially in the developing world.
- General practitioners and community health workers must be involved in mental health policies and programmes. The emphasis in health policy must be to achieve adequate skills for the diagnosis and treatment of depressive and anxiety disorders in general health care settings. Treatment with antidepressant medication and inexpensive psychosocial interventions should be available everywhere. These programmes can be implemented at little additional cost, because they use existing human and infra-structural resources.
- Research is badly needed, especially from the less developed world, to strengthen the evidence base. Longitudinal research into the causes of depressive and anxiety disorders, and identifying the links between socioeconomic inequalities and depressive and anxiety disorders is required. This research should be designed so as to inform and evaluate changes in social and economic policy.

Introduction


 As the nations of the world come closer to each other in this era of globalization, it is important to consider what relationship exists between socioeconomic factors and mental health within and between countries. It would be fair to say that, till recently, the relationship between poverty and mental health was a topic which was rarely taken seriously by health, social, or economic policies. Amidst various health priorities and concerns about economic inequality and poverty, where does mental health fit in? Can we really be mentally well when our bodies are sick and our stomachs empty? Can cash-strapped health services divert resources to mental illness with its vague, fuzzy boundaries and connotations of asylums, shock therapy and madness? Isn't mental illness largely due to consumerism and materialism rather than lack of essential things? Is mental illness a consequence of the material deprivation that some of the poorest members of our global village have to endure? These are just some of the clichés and challenges one faces in a discourse on impoverishment and mental health. This paper presents evidence to demonstrate that, far from being a luxury item or a matter of concern only for rich nations, mental illness is closely associated with poverty and inequality and may impede some aspects of economic development. The relationship between socioeconomic status and mental disorder has important implications for all the nations of the world.

In presenting the evidence and implications of socioeconomic determinants of mental health, this paper will focus on depressive and anxiety disorders. The reasons for this focus are that depression is the commonest of all mental disorders and, arguably, poses the greatest public health burden. However, other mental health problems such as schizophrenia, dementia and alcohol and drug dependence are major sources of disability in their own right. For speciality mental health services, the costs of health and social care for schizophrenia and other functional psychoses are the main burden. Dementia will become an ever increasing issue within the developed and developing world as the population ages. Alcohol problems are a common source of work absence in all areas of the world. Nevertheless, it has become apparent that

depression leads to more disability in aggregate than these other mental health problems and poses a special burden on primary health care services. The paper tackles the issue in three parts. First, it presents the global evidence to justify that depression is a serious global public health issue. Second, it presents evidence to demonstrate that there is a relationship between poverty, socioeconomic inequality and depression. Third, it considers policies and programmes, which may reduce the public health and individual burden posed by depression.

Depressive & anxiety disorders

What is depression and anxiety?

 The symptoms of depression and anxiety are common and reported in all populations of the world¹. There needs to be a distinction drawn between the ups and downs of emotional life that everyone experiences and the more severe depressions and anxiety disorders seen in a clinical setting. Clinically significant depressive and anxiety disorders are largely a matter of judgement on behalf of the clinician and patient and the precise case definition used in a study can therefore markedly influence the prevalence. Over the past 30 years there has been a considerable amount of progress in measuring the symptoms of depression and anxiety in a reliable way. Relatively brief, standardised interviews exist that can be used in all the countries of the world. Though some methodological issues remain, these are relatively minor.

Symptoms of depression and anxiety

There is now a professional consensus about the major symptoms of depression and anxiety. For example, depression is characterised by a number of symptoms, in addition to a lowering of mood. These are loss of interest, poor concentration and forgetfulness, lack of motivation, tiredness, irritability, poor sleep and changes in appetite. The hallmark "negative" attitudes of depressed individuals is perhaps the most disabling aspect of the illness. Anxiety is associated with a fearful feeling, worrying thoughts and physical symptoms such as palpitations, tingling sensations, headaches and chest pain. The symptoms of depression and anxiety are universal and occur in all societies that have

been studied². Furthermore, depression and anxiety in the primary or general health care setting typically occur together. In this document, the term “depression” is used to denote the clinical presentation of both depression and anxiety. The presentation of symptoms, however, does appear to vary between different countries. In many developing countries, subjects with depression complain to doctors mainly of their physical symptoms (such as tiredness). The psychological symptoms are present when they are directly asked^{3,4}. Similarly, there is also some variation in how these symptoms are labelled around the world. For example, in Zimbabwe, the idiom of *kufungisisa* or “thinking too much” is used to describe psychological symptoms⁵.

The burden of depression

The evidence of high prevalence of depression has been building up over the past 20 odd years from a range of settings in high-, middle- and low-income countries from all regions of the world⁶⁻¹². These studies reveal community prevalence figures that vary between different countries but can be up to 20% in some studies. For example, the prevalence in the UK psychiatric morbidity survey was about 14%. The case definition used in this study reflected a severity appropriate for treatment in primary health care. Just over 2% of the UK population had the more severe depressions that are familiar to psychiatric specialists. Prevalence estimates in attendees at primary health care, the sector catering for the poorest members of some societies, show levels that can be as high as 40%¹³⁻¹⁵. Depression often runs a chronic or recurrent course with nearly half of patients in treatment settings remaining ill for 12 months or more^{16,17}.

There is now a large body of evidence demonstrating the considerable disabling effects of depression both in the community and primary health sector (see below)^{13,18,19}. In addition to disability, there is evidence that depression can also lead to increased mortality. The risk of death by suicide in persons with depression or substance abuse is well-described²⁰. There is growing concern of the rising rates of suicide in many developing countries, particularly amongst adolescents and young adults in whom suicide is one of the three leading causes of death. In India, for example, the suicide rate increased by 6.2% per annum between 1980 and

1990, during which period the population growth rate was 2.1%; the highest growth in suicide rates was for young adults²¹. Deliberate self-harm (i.e. self-harm which does not lead to death) is far commoner than completed suicide and is fast becoming the commonest reason for emergency medical treatment in some developing countries such as Sri Lanka²².

Depression is also associated with poor physical health. Even after excluding suicide, recent cohort studies from the UK and USA have demonstrated a higher mortality rate in patients with depression^{20,23}. There is also an increased risk of ischaemic heart disease in those with depression²³. It has been suggested that the impact of socioeconomic inequalities on physical health may be mediated by an effect on psychological health²⁴.

Primary care is regarded as the cornerstone of health care in both the developed and developing world. Most treatment of depression occurs in primary health care rather than in specialist settings. However, despite the considerable evidence of the effectiveness of drug and psychological treatments for depression, albeit largely from the developed world²⁵, the vast majority of patients in developing countries do not receive these treatments. Instead, they are prescribed a cocktail of medicines aimed at various symptoms, such as painkillers, vitamins and sleeping medicines^{13,26}. Thus, policies which strengthen the treatment services in primary care and improve the availability of antidepressants and brief and effective psychological interventions are needed to help reduce the burden of illness for affected persons.

Depression & Disability

Depression and anxiety are exceptionally disabling conditions and the disability is often not widely acknowledged, in part because of the stigma associated with these illnesses. In the Medical Outcomes Study in the US the disability associated with a variety of chronic medical conditions such as diabetes, arthritis and depression were compared. Depression was the most disabling condition of all those investigated²⁷. Depression is disabling for a variety of reasons. The symptoms of depression such as poor concentration and lack of motivation impair the ability to carry out everyday tasks. Irritability combined with these can affect

the relationships with other family members and fellow workers. The “negative” attitudes of depression can impair judgement and reduce problem-solving abilities. It is perhaps this latter aspect of depression that is especially worrying in relation to socioeconomic inequalities. It is likely that depression impairs the ability of poor people to deal with the difficult circumstances they experience.

Arguably, for the poorest people in the world, problem-solving abilities are essential in order to deal with their circumstances. One particular area with adverse consequences is the impact of depression in women on their children. Postnatal depression is common and it can have adverse effects on the intellectual and emotional development of children^{28, 29} leading to cycles of disadvantage.

The relationship between the severity of disorder and disability is an important concern from a public health perspective. Depression can be thought of along a single continuum of severity. Disability increases in line with the increase in severity. In aggregate, mild depressive conditions may lead to more disability in the population than that attributable to the less common, more severe disorders³⁰. This paradoxical situation, in which less severe cases of a disorder are more important, is common in public health. It has important implications, nevertheless, for public policy and research as indicated below.

Public health and depression

The Global Burden of Disease (GBD) estimates developed by WHO, the World Bank and the Harvard School of Public Health^{31a}, revealed that mental and neurological disorders accounted for 11% of the total Disability Adjusted Life Years (DALYs) lost due to all diseases and injuries in 1999^{31b}. Based on the analysis of trends, projections indicate that the burden due to mental and neurological disorders will increase to 15% by the year 2020.

The GBD study ranked depression as the 4th leading cause of burden among all disease, accounting for 4.1% of total burden. It will rise from 4th to 2nd leading cause of DALYs by 2020. It will then be second only to ischaemic heart disease for DALYs among both sexes. It is notable that for the developing regions it will be the highest ranking cause of burden. These estimates have demonstrat-


ed that depression causes an enormous burden on society.

Taking the example of ischaemic heart disease, risk factors such as smoking and high blood pressure have been identified, and public health interventions target those risk factors and try to reduce their frequency in the population. We need such public health oriented research into depression that will then lead on to primary preventive programmes and to improved access to efficacious treatment for people with depression.

Summary

- Depression and anxiety disorders are two of a range of mental health disorder problems but they are the most common and thus important from a public health perspective.
- In primary or general health care settings, depression and anxiety typically occur together and the term depression is used in this document to reflect both types of emotional states.
- Depression exists in all countries of the world, even if there is variation in how patients present their complaints to health workers.
- Depression is one of the most disabling conditions seen in medical practice. An important source of disability is the impairment in problem solving ability.
- Most treatment of depression occurs in primary health care, not in specialist care. Even though effective pharmacological and brief psychological treatments have been developed, most patients do not seek nor receive appropriate treatment.
- Depression leads to as much burden as ischaemic heart disease; a public health approach is required.


Socioeconomic inequalities and depression

 The definitions and use of terms in the area of socioeconomic inequalities can be especially confusing. From an epidemiological perspective it is useful to think of a variety of measurable indicators of socioeconomic inequalities. Occupational status is used by many governments as an indicator, which reflects the status or skill

level within the employed population. Unemployment, those without work who are actively seeking employment, can also be included under this heading. There is relatively little that governments can do to change the distribution of occupational status in a country, but unemployment is potentially more amenable to government economic policies. Low income and poverty are other important indicators of socioeconomic status that are also possible to influence. There are broadly two approaches to defining poverty – one based on income and the other on resources available to a household (deprivation). Though these measures are associated with each other there is, surprisingly, a little overlap between occupational status, low income and deprivation. These can therefore be studied separately and their relative importance investigated. Finally, educational attainment is also a commonly used measure of socioeconomic status.

The evidence of an association between poverty and depression

Poverty

 There is now a substantial body of evidence, which demonstrates the relationship between poverty and socioeconomic inequalities with depression. In the United Kingdom there is good evidence showing an association between low standard of living (not owning a car and/or a house) and the prevalence of depression^{32,33}. British data also suggest that socioeconomic measures appear to delay recovery rather than increase the onset of new episodes³³. However it is also possible that those with poor mental health have a reduced capacity to earn, and this might account for some or all of the observed socioeconomic gradient. This explanation has been called social selection. There is some evidence for social selection³⁴⁻³⁶ but it does not appear to be able to explain the whole socioeconomic gradient. There is evidence from a longitudinal study in the USA that low income is associated with depression³⁷.

Evidence is beginning to accumulate demonstrating a similar association between economic disadvantage and the presence of depression in developing countries too. For instance, a community study from Indonesia found strong associations between depression and the presence of household ameni-

ties such as electricity, and ownership of a television³⁸. In this study, the rates of depression in the least developed villages were twice those in the most developed villages. A recent community survey of 3,870 persons in Chile found that depression was associated with several socioeconomic adversities. On multivariate analyses, acute financial strain, described as a recent drop in income, and lower educational level remained significantly associated with the prevalence of depression¹¹. Similar results have been reported from Northern Brazil, Pakistan, Lesotho, and Zimbabwe^{4, 12, 39, 40}. There is also evidence, from prospective longitudinal studies in less developed countries, that economic deprivation is associated with incidence and persistence of depression. A study from Zimbabwe showed that economic variables, such as being in debt and having cash savings, were associated with the incidence of depression⁴¹. Impoverishment was also associated with the persistence of morbidity; thus, individuals with depression whose economic difficulty resolved over a period of a one-year study, had much higher recovery rates than those who developed fresh economic difficulties¹⁷.

Unemployment in men

There is good evidence from the UK that unemployment in men increases the risk of depression⁴². The association between unemployment in women and the disorder is more complex. Many women without work, especially with children, do not regard themselves as unemployed. There is also the possibility that loss of job to a woman is regarded as less of a threat to self-esteem, at least in women with a partner.

Poor educational achievement


Education, which is strongly correlated with poverty, emerges as a factor strongly associated with the prevalence of depression in many developing countries⁴³. The mechanism through which education might protect persons from depression is unclear. However, it is plausible that education is an important determinant of present and future life opportunities which promote mental health in later life. In any case, it is important to realize that the socioeconomic variables beloved by epidemiologists might have different meanings and significance in different societies.

Gender inequality and depression

Women have been shown to be 2 to 3 times at greater risk to suffer from depression in most societies. It is likely that the severe adversities faced by women, in part as a result of gender inequality increases their vulnerability⁴⁴. Gender inequality operates within households unlike other types of inequality, which operate between households. Thus, gender inequality is superimposed on income and other inequalities. Factors associated with gender inequality include domestic violence and restriction of opportunities for education, employment and adequate health care. Further, the unique reproductive roles played by women may also predispose them to depression in different stages of the reproductive cycle, for example depression after childbirth⁴⁵. [See paper on Gender Disparities and Mental Health for a fuller discussion on this subject]

Causal pathways between socioeconomic factors and depression

Do socioeconomic factors cause depression?

 Poverty was defined many years ago as “the mother of all diseases”. However there may be more explicit links between poverty and depression than many other conditions. We also need to understand more about the links and mechanisms if we are to plan preventive policies in a sensible way. At present, there is little real understanding about the mechanisms or mediating factors between low socioeconomic status and depression. The following section gives some plausible ideas about the importance of various factors.

Social supports

There is evidence that lack of social supports may increase the risk of depression. Low socioeconomic status might decrease a person’s ability to engage in social activities.

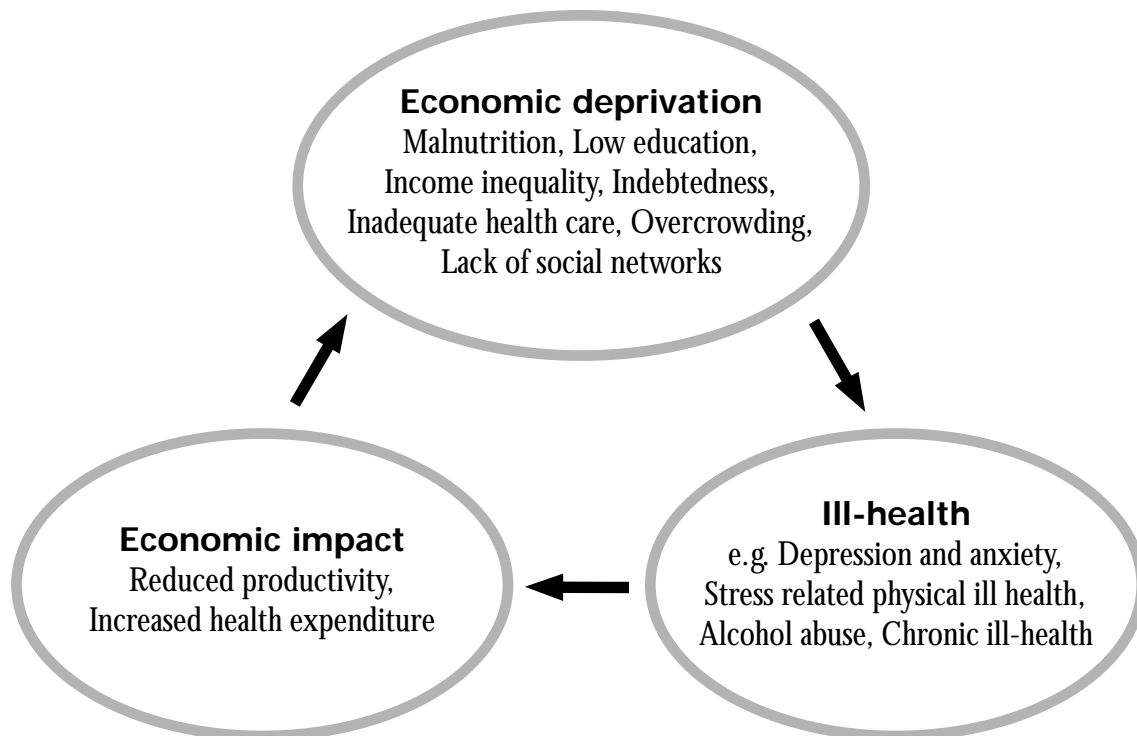
- Unplanned urbanisation has and is posing great strains on traditional social support systems across the developing world⁴⁶. The lack of social support and the breakdown of kinship structures is probably the key stressor for the millions of

migrant labourers to the urban centres of Asia, Africa and South America, leaving behind millions of dependants in the rural areas whose only hope of survival are the remittances their relatives will send from distant cities.

- In developed countries, increased mobility of labour has reduced family ties and also led to the decline of the extended family.
- Brown and Harris, identified factors such as having no one to confide in as one of the vulnerability factors for depression⁴⁷. For young women who are married far from their parental homes and live for most of the year without their husbands, it is not hard to imagine why they may be more likely to be depressed.

Lack of control on resources

- There are the obvious material stresses, which accompany poverty. The daily worries about paying essential bills and being able to afford food in the face of inflationary pressures and insecure employment could be expected to wear even the strongest mind down. It is not surprising then that those individuals who experienced an income drop, mostly poor people, have a higher prevalence of depression¹¹.
- The ability to deal with new difficulties is harder for those with less money. A car that has broken down or a leaking roof requires money, and for the poor these will be much greater stresses.
- One of the most consistent predictors of mental disorder in developing country studies is lack of education. Education might provide a means of escape from poverty or access to knowledge and other ways to resolve problems^{11, 38, 43}. The lack of opportunity in a society where there is huge income inequality, high unemployment, and underemployment, and no social welfare provision can be expected to lead to feelings of hopelessness, anger and despair.
- There is the well-recognized association between poverty and a higher burden of physical ill health, particularly infectious diseases, and inadequate access to good, affordable health care. This may mean that many poor persons with mental health problems go untreated, or treated inappropriately and suffer for long periods as has been already described earlier.

The vicious cycle of impoverishment and mental disorder:**Social comparison**

The potential stresses imposed by absolute poverty may be considerably different from those of relative poverty. It is suggested that the psychological impact of “relative” poverty is the result of both the indirect (e.g. increased exposure to behavioural risk factors due to psychosocial stress) and direct (e.g. physiological effects of chronic mental and emotional stress) effects of psychosocial circumstances associated with social position. One proposed mechanism is that of “cognitive comparison”, whereby people are made aware of the vast differences in socioeconomic status that prevail. The knowledge of how the richer “other half live” affects psychosocial well being and thus, overall health status⁴⁸.

Does depression worsen poverty?

There is a reason to support this possibility with evidence for two major mechanisms. First, the evidence that mental disorders lead to disability which has been described earlier. A range of studies has conclusively demonstrated that depression is profoundly disabling leading to a range of social

and occupational disabilities⁴⁹. For example, studies of primary care attendees in India and Zimbabwe showed that subjects with depression spent more than twice the number of days in the previous month in bed or being unable to do their daily activities as compared to others^{13,49}.

Second, there is evidence that persons with depression receive more health care especially in primary care. Most people with depression consult for physical symptoms and in many health systems, both in developing and developed countries, this can lead to numerous costly consultations, investigations and polypharmacy¹⁵. Often governments are not capable or willing to finance treatment and the costs are then transferred to the sufferers who resort to the private sector. No matter who pays the bill, depression drains away precious resources. There are no reliable economic estimates from developing countries but there is substantial evidence of the enormous economic burden of depression in developed countries⁵⁰.

Cycle of impoverishment and mental disorder

Thus, the nature of the relationship between impoverishment and mental illness is complex, bi-directional and dynamic, leading to a vicious cycle of impoverishment and mental illness (Figure 1). An example of such a vicious cycle could be as follows: an episode of depression is triggered by material deprivation and domestic violence, depression in turn robs the woman of the necessary coping skills and energy to overcome her problems and leads her to spend money and time seeking relief from various health practitioners, often without any benefit.

Illustrative narratives demonstrating linkages



The following are some narratives from various countries, which demonstrate the research linkages between socioeconomic factors and depression.

Suicides of farmers in India

Since the mid-1990s, the seasonal monsoon has consistently failed in some central regions of India leading to low harvests and, subsequently, lower incomes for farmers. The ones who have suffered the most have been the poorest subsistence farmers, those who were not credit-worthy enough to get bank loans and had to borrow money from loan-sharks at exorbitant rates of interest to tide over the financial crisis. With their crops failing, the farmers were faced with the stark choice of selling whatever few assets they still had or become bonded labor to the moneylender until the debt was repaid. It is not surprising, then, that these circumstances led to suicide. There have been more than 200 reported suicides by farmers in recent years, and these figures only reflect the government statistics. Although these figures may appear small, they must be seen in the context of representing an occupational group of subsistence farmers in a geographically defined region of India. There is evidence that farmers from the backward castes were disproportionately more affected.

Poverty and maternal depression in South Africa

In an informal settlement in Khayelitsha, South Africa, the prevalence of depression amongst women who have recently given birth has been found to be 35% – roughly three times the expected rate based on studies in other countries²⁸. The women in this community are largely migrants from rural areas who come to an impoverished peri-urban settlement in search of employment and access to resources such as health care, especially at key times such as during pregnancy. Circular migration patterns between the countryside and the city may have an effect on social support and networks. Most of these women enjoy very little support from male partners, and many relationships do not last through the pregnancy. The women's own mothers, a traditional source of support and assistance through pregnancy and early parenthood, are often far away in rural areas. Both maternal depression and economic hardship have been found to impact on children's development. There is an association between maternal depression and impaired mother-infant interaction. This impairment has in other contexts been found to be a key predictor of poor social, emotional, and cognitive development in children. This could potentially lead a cycle of deprivation and demoralisation.

Poverty, income inequalities and depression in Chile

Chile shows the lowest proportion of people living below US\$1/day among the ten most income unequal countries in the world⁵¹. General morbidity and mortality indicators are in line with those encountered in most developed countries. However, the prevalence of depressive disorders is higher than in other countries with more poverty¹¹. Depression tends to concentrate on the most socially disadvantaged sectors of society. The poorest, especially under financial strain, the less educated, the unemployed, and the socially isolated show the highest prevalence of depression. These findings support the hypothesis that marked inequalities can act as risk factors for depression.

Depression and ageing in developing countries

The mental health of elders is even less well understood or acknowledged either by the community or the medical profession in developing countries. A major reason for this is that the elderly comprise less than 10% of the population in most developing countries. This is bound to change in the future with the falling birth rates and rising longevity leading to predictions that over the next 20 years this oldest sector of the population will exceed 100 million in India alone. The implications of this demographic ageing are grave, for few developing countries have systematic social welfare, pension or health care systems sensitive to the needs of the elderly. Further, all developing countries are facing dramatic socioeconomic changes which are accompanied by the gradual breakdown of traditional extended family systems which have formed the bulwark for the care of the disabled and chronically ill⁵².

Summary

- There are strong cross-sectional associations between low income, low education and other indicators of poverty and depression
- There is evidence that depression impairs economic performance
- The evidence available cannot definitively point to whether depression is caused by deprived socioeconomic conditions or if these disorders lead to deprivation. It is likely that a combination of both is the best answer to this etiological puzzle.

Implications for health policies and programmes



The implication of the evidence we have reviewed is that policies and programmes aimed to reduce poverty, provide education and reduce socioeconomic inequalities are highly likely to help reduce the prevalence of depression. Reducing the prevalence should also have some economic benefits, in addition to health benefits for individuals and a reduction of the burden on health services. However, the present economic development policies adopted by many countries,

particularly in the developing world, are fuelling socioeconomic inequalities⁵¹. From a public health perspective, the evidence on socioeconomic determinants and depression can be used to consider a number of primary and secondary preventive strategies.

Primary prevention

Primary prevention is used to describe policies that aim to reduce the prevalence of incidence. The evidence to support the efficacy of interventions in this field is weak, mainly because few if any interventions have been tried and/or evaluated in terms of their impact on depression. It is difficult to persuade governments or international agencies to invest in these programmes compared to primary prevention programmes for malnutrition or infectious diseases. Based on the earlier discussions, we now consider examples of primary preventive strategies:

■ Investing in education

The key factor may not be whether 100% of children are in primary school, but rather the proportion of children who fail to complete the minimum years needed to obtain a secondary school certificate [10-12 years in most countries]. This is a far more significant landmark in society for without it, the number of years of schooling is irrelevant to prospective higher educational institutions or employers. Thus, even though there are impressive gains in increasing school enrolment, there may need to be further emphasis on reducing school drop-out rates; in many developing countries, less than half the children who are in primary school go on to complete their 10 years of secondary education. Several reasons may account for high dropout rates, such as the need to earn money very early in life and childhood mental health problems⁵³. Because education permits greater choices in life decisions and influences aspirations, self-image and opportunities⁵⁴, it is likely that investment in education will lead to improved mental health of the population. In many developing countries, this investment will need to focus on women who may be less likely to access adequate education.

■ **Micro-credit: safe loans to the poorest**

In many developing countries, indebtedness to loan-sharks is a consistent source of stress and worry. This was best demonstrated by the narrative on farmers and suicide from India. Indeed, it is not uncommon for the children of a family to spend their lives toiling to repay the interest of relatively small loans taken out by their parents. It is clear that here lies another potential preventive strategy in that local banks could step in and review their process of assessing credit-worthiness for persons who belong to the poorest sectors of society. Radical community banks and loan facilities such as those run by SEWA in India and the Grameen Bank in Bangladesh could be involved in setting up such loan facilities in areas where they do not exist. Provision of such loans may reduce mental illness by removing the key cause of stress: the threat posed by the informal moneylender.

■ **Working towards healthier families**

In Khayelitsha, South Africa, a community-based intervention to improve mother-infant interaction is currently underway. Women from the community, all mothers themselves, were recruited and given training based partly on the World Health Organization's PEIMAC programme. Most women have not completed high school. Treatment focuses on emotional support for the mother as well as an educational component, which teaches mothers about infants' interactivity and the importance and value of child-focussed interaction from birth onwards. The intervention is being run as a controlled trial, and impacts on both mother and infant are being assessed by a team blind to whether the intervention has been delivered to a particular mother. An important feature of the intervention is that it is low cost and is of such a nature that if it proves successful it should be possible to integrate the programme into the existing primary health care system. This programme may lead to evidence for the effectiveness of prevention of maternal depression, and possibly, the adverse effects of maternal depression on infant development.

■ **Health promotion**

Most public health campaigns such as the Defeat Depression Campaign in the UK have generally aimed to increase awareness of depression, and

increase knowledge about the effectiveness of interventions available in health services. There is also the potential to use health promotion to publicise "stress reduction" techniques that could be used more widely. Similarly, changing the characteristics of the workplace and working practices could have benefit on mental health. At present, these ideas are necessarily speculative but deserve further development and evaluation.

Secondary prevention

The key to secondary prevention, is to strengthen the treatment of depression in primary health care. There needs to be much greater cooperation and collaboration between mental health and primary care health workers. There would need to be greater emphasis on training general health workers on common mental health problems. Individual clinicians need training to recognize and effectively treat depression. The message is clear: patients with depression and anxiety are already in your clinic. These disorders are amongst the commonest of all health problems; they are profoundly disabling and prone to chronicity and there are cheap and effective pharmacological and psychosocial remedies for them. Just as clinicians must treat tuberculosis even if they cannot get rid of the overcrowding, so must we challenge the mental despair of clinicians who argue that if their patients are poor they must be depressed and there is little they can do about it. The greatest evidence that this belief is untrue is evidenced by the fact that the majority of the poor do not get depressed, they are only at greater risk than the rich.

■ **Integration of mental health in primary health care**

The integration of primary mental health into primary health care has been the mantra of the WHO for over a decade. The models for such integration are likely to vary considerably between different health systems. In areas such as the KwaZulu/Natal province in South Africa which experiences severe adversities such as poverty, high levels of violence and high rates of HIV/AIDS, there is enormous pressure on primary health care services to deal with physical illness. In this context of scarce resources, a programme was able to train primary health care nurses in KwaZulu/Natal to provide a comprehensive care approach which

took account of psychosocial and emotional factors amongst their clients⁵⁵. However, structural factors in the Organization of health care may inhibit providers' capacity to deliver appropriate comprehensive care. Any focussed intervention to deal with depression and other morbidity at primary health care level must be supported by a commitment on the part of health system management at all levels to viewing these issues as important and worthy of professional attention. Research from more developed countries has suggested that some resource intensive models such as those which employ formal psychotherapy and care managers to ensure compliance could be more cost-effective for the treatment of depression. Thus simpler and affordable interventions need to be implemented possibly focusing on those at higher risk. Some interesting and innovative programmes were developed and used many years ago. For instance in the absence of health professionals, lay community leaders and other health workers were trained to deal with mental disorders in Cali, Colombia⁵⁶ with good results. In Chile, work is underway to test the cost-effectiveness of a simple, stepped care treatment package for depressed women from impoverished backgrounds in Santiago, Chile^A. Early results are promising and suggest that effective interventions can be delivered by people with minimal training, at a low cost and, most importantly, are well accepted by the local population. A randomized controlled trial for the treatment of depression in general health care has also been recently completed in Goa, India; the trial will provide data on efficacy and cost-effectiveness of anti-depressant and psychological treatment^B.

■ Medical pluralism in mental health care

Mental health manpower cannot meet the needs of all persons with depression, especially in developing countries. On average, there is about one psychiatrist for every million people in large areas of sub-Saharan Africa. The population of India, now exceeding 1 billion people, has less than 4,000 psychiatrists. The vast majority of psychiatrists in developing countries work in large mental hospitals or in private practice. The vast majority of those with depression are treated, if at all, by general health care providers, traditional and religious healers, Non-Governmental and voluntary organizations and families⁵⁷. NGOs support sufferers and

families in ways, which are often ignored by formal mental health services, such as advocacy for the rights of the mentally ill and provision of community-based interventions. Traditional medical practitioners are often consulted for depression and may provide psycho-spiritual interventions which are consonant with the cultural attributions that sufferers have about their illness⁶⁰. The private medical sector is a major provider of general health care in many developing countries⁵⁹. Its involvement in the implementation of mental health programmes would be imperative.

■ Integration of mental health into existing health promotion programmes

Depression typically occurs in situations of extreme stress. There are several examples of existing public health priorities in which depression are of great relevance such as maternal and child health, reproductive and sexual health, adolescent health and violence prevention. Attaching mental health interventions onto these programs would imply using existing resources and manpower and providing more comprehensive care, which reflects the broad concerns of health. Such integration can be implemented with minimal additional cost and would have the advantage of greater access to sufferers as a result of the lesser stigma than would be attached to seeking help from mental health services.

■ Intersectoral cooperation

In Pakistan, the Gujarkhan demonstration project involves community leaders, schoolteachers, and primary health care workers. For instance mass educational campaigns were launched and mental health issues were introduced into the school curriculum as a form of reducing stigma as well as educating families on how best to protect their mental health⁶⁰. Similar projects have also been developed in Latin America and other parts of the world but the evaluation of these initiatives is less well known. These initiatives can help to increase the involvement of communities in deciding and implementing solutions for their own problems. Local participation is a fundamental requisite for the success of any of these programmes.

Summary

- Policies aimed at reducing poverty and inequality will have an effect in reducing the burden of depression.
- Primary prevention of depression could include poverty reduction programmes, full employment policies, investment in education, micro-credit arrangements and public health promotion campaigns.
- Secondary prevention would require integration of mental health care in primary health care by providing training and support to health care providers and improving collaboration with private, traditional and non-governmental health sectors.

Conclusions



This working paper has presented evidence, which demonstrates the public health importance of depressive and anxiety disorders for all countries independent of their level of development. We have argued for a close association between socioeconomic adversity and depression, an association that is present in most societies, again irrespective of the stage of economic development. This association is in both directions. Though there is still some uncertainty, all the evidence suggests that poor socioeconomic conditions can cause depression and that depression can reduce socioeconomic functioning. In the long run we need further research and evaluation of the kind of primary prevention programmes we have proposed as these are probably among the most suitable ways of dealing with the burden of depression in the community. There is also a need to address the burden of depression by strengthening primary care assessment and treatment. The paper has highlighted policies and programmes, which could work towards primary and secondary prevention of depression.

Despite the compelling evidence of an association between depression and economic deprivation, it is important to recognize that the majority of people living even in squalid poverty remain well, cope with the daily grind of existence and do not succumb to the stressors they face in their lives. Indeed, this is the real challenge for public health

researchers; to identify the protective qualities in those who do not become depressed when faced with awful economic circumstances for therein lies a potential to help and prevent mental health problems. Could informal local community social networks protect some from depression? Could religious or spiritual involvement limit alcohol abuse in some men and help prevent suicide in women and teenagers? Could micro-credit schemes which are challenging the existing notions on who knows how to handle money properly help prevent some from succumbing to despair? Could being close to one's family provide the necessary confidante and support? Could a caring local councillor's efforts to clean up a slum help reduce the suicide rate? These are the practical research questions arising from the relationship between poverty and mental illness.

In societies where mental health services are poorly developed, it may be argued that preventive strategies aimed at strengthening protective factors in local communities may be a more sensible investment of scarce resources than duplicating the extensive mental health care systems of the developed world (whose existence has not led to any significant reduction in the prevalence of mental disorders). Thus, funding research on depression with a local significance should be an important consideration in allocation of research funds in developing countries. Future longitudinal research is needed in order to establish causal directions, and the mechanisms linking depression with low socioeconomic status.

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The state of the evidence

Stigmatization and human rights violations

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Executive summary

General theoretical considerations

 Stizein, to tattoo or to brand, was a distinguishing physical mark placed during Greek times on slaves who were thus branded so that others would know that they were inferior or less valued members of society. Through Latin, the word has moved to modern languages as Stigma, a form of social construction to indicate a distinguishing mark of social disgrace that, at the same time, conveys a social identity. Stigma consists of two fundamental components: (1) the recognition of the differentiating “mark” and (2) the subsequent devaluation of the person. Stigmatizing conditions could develop from bodily physical deformities, group identifications such as race, sex, or religion, or assumed blemishes of individual character underlying cultural beliefs about the nature of mental disorders or unemployment. Stigma develops in the context of social relationships and interactions, and its strength and resilience depend on three dimensions: visibility, controllability, and origin. The more visible the mark, the more the blemish is perceived as being under the “control” of the bearer, and the more feared the impact such as conveying a sense of danger, the more the stigma. Cultural beliefs have led to the fear of mental illness and mental patients, hence the stigma. Stigmatizing attitudes are held by many, including health professionals and mental health personnel.

Effects of stigma

Stigmatization is closely related to prejudice in that the stigmatized person or group becomes the target of negative or prejudicial attitudes, but unlike prejudice, stigma involves definitions of character and class identification, hence, it has larger implications than mere prejudice. Negative attitudes include painting all mental patients as deranged, violent, homicidal, incompetent and incurable, morally flawed, unmotivated or inadequate and depicting them in the media as unpredictable and violent. Stigma and prejudice about persons with mental illness lead to discrimination and the denial of lawful legal entitlements. Surveys have shown that negative social attitudes toward persons with mental illness constitute barriers to reintegration and acceptability. These attitudinal barriers impact

negatively on social and family relationships, employment, housing, community inclusion, self-esteem, and prompt access to treatment opportunities.

Changing policies and deinstitutionalization

Mental illnesses and disabilities are highly prevalent worldwide. They have major economical impacts beyond merely those directly related to health budgets. The recognition of their negative impacts has led many countries to implement legislative revisions and to modify health plans and mental health systems such as community alternatives, deinstitutionalization, and proper budgetary allocations.


Research on stigma

Research findings have led to the identification of strategies and best models for combating stigmatizing attitudes in populations such as choosing the best content for public campaigns and the targeting of specific subpopulations.

Efforts to combat stigma


A number of national and international programmes, campaigns, and reform efforts have been described to reflect the variety of initiatives being undertaken to combat the stigma of mental illness. Strategies most frequently used by different groups around the world are listed based on a review of what worked in different settings.

Objectives and purpose

 Despite their relatively high frequency, sadly, the most frequent contact the general public has with mental illness is through the media where, often, mental patients are depicted as unpredictable, violent and dangerous (Steadman and Coccozza, 1978). Such depictions stem from sensational reporting of crimes purportedly committed by a person with a mental illness, or from movies in which a popular plot, long exploited by the cinematographic industry, is that of the “psycho-killer” (Byrne, 1998). The association between mental illness and violence is only one of the many negative stereotypes and prejudicial attitudes held by the public about persons with a mental illness that help perpetuate stigmatizing and discriminatory practices against them.


The objectives of this document include a review of the theoretical elements that lie at the foundations of stigma as a social construct and its negative consequences on persons with mental illness and their families, and to describe programs and research initiatives geared at managing, or erasing, the stigma about mental illness. The purpose is to help mental health planners and governments to adopt more comprehensive mental health policies. Such policies should address not only the legislative and budgetary aspects of mental health programs, but also the education of the public on mental health issues, the promotion of good mental health practices, and the prevention of mental conditions in the population.

Historical elements

 Stizein, to tattoo or to brand in Greek, was a distinguishing mark burned or cut into the flesh of slaves or criminals by the ancient Greek, so that others would know who they were and that they were less valued members of society. Although the Greek did not use the term stigma in relation to mental illness, stigmatizing attitudes about the illnesses were already apparent in the sense that mental illness was associated with concepts of shame, loss of face, and humiliation (Simon, 1992) as in Sophocles’ *Ajax*, or Euripedes’ *The Madness of Heracles*.

Later, and throughout the Christian world, the word *stigmata* became associated with peculiar marks on individuals re-enacting the wounds of Christ on their bodies, mostly on their palms and soles (Paul, Gal 6: 17). This religious connotation is not the same as the other derivative of the Greek word, *stigma*, which is a form of social construction to indicate a distinguishing mark of social disgrace that, at the same time, conveys a social identity. The Inquisitorial attitude toward witches, as dictated in the *Malleus Maleficarum (The Hammer of the Witches 1486/1971)*, apart from being highly misogynous, also represents a negative and condemning attitude toward mental illness. This attitude might have been the origin of the stigmatizing attitudes toward persons with mental illness from the rise of rationalism in the 17th century to our days in Christian cultures (Mora, 1992). “Madness” has long been held among Christians as being a form of punishment inflicted by God on sinners (Neaman, 1975).

Theoretical considerations

 Goffman (1963) thought of stigma as an attribute that is “deeply discrediting” so that stigmatized persons are regarded as being of less value and “spoiled” by the stigmatizing condition. He classified these conditions in three groups: “abominations” of the body, such as physical deformities, “tribal identities” such as race, sex, or religion, and “blemishes of individual character” such as mental disorders, or unemployment. *Stigma*, however, is not a static concept, but a social construction that is linked to values placed on social identities. It is a process consisting of two fundamental components: the recognition of the differentiating “mark”, and the subsequent devaluation of the bearer (Dovidio, Major and Crocker, 2000). These authors conceive of stigma as a relational construct that is based on attributes, so that, stigmatizing conditions may change with time and from a culture to another. Stigma, then, would develop within a social matrix of relationships and interactions and will have to be understood within a three-dimensional axis involving perspective, identity, and reactions.

Perspectives pertain to the way the stigma is perceived. Stigma is different, whether it is perceived by the person who does the stigmatizing (perceiv-

er) or by the person who is being stigmatized (target). Identities relate to group belongingness, and they lie in a continuum from entirely personal to group-based identifications. Finally, Reactions are the ways the stigmatizer and the stigmatized react to the stigma and its consequences; reactions could be measured at the cognitive (knowledge), affective (feelings, tones and attitudes), and behavioural levels.

Along with these three dimensions it is also important to distinguish three major characteristics of the stigmatizing mark: “visibility”, or how obvious the mark is, “controllability” which relates to the origin or reason for the mark and whether it is under the control of the bearer, and “impact” or how much those who do the stigmatizing fear the stigmatized (Crocker, Major and Steele, 1998). The more visible the mark, the more it might be perceived to be under the control of the bearer, and the more feared the impact such as conveying an element of danger, the more pronounced the stigma.

Mental patients who show visible signs of their conditions because their symptoms or the side effects to medications make them appear abnormal, who are socially construed as being weak of character or lazy, and who display threatening behaviours, usually score high on any of these three dimensions. By a process of association and class identity, all mental patients are equally stigmatized; the individual patient, regardless of level of impairment or disability, is lumped together into a class; class belongingness reinforces the stigma against the individual.

The description of the characteristics of stigma, or *what* it is, and *how* it develops begets the question of *why* it develops. Unfortunately, there is little literature on the subject, but Stangor and Crandall (2000) while indicating that very little is known about the development of stigma, advance the theory that three major components will be required: function, perception, and social sharing. They theorize that an original “functional impetus” is accentuated through “perception”, and subsequently consolidated through social “sharing” of information. The sharing of stigma becomes part of a society that creates, condones, and maintains the stigma-

tizing attitudes and behaviours. These authors further indicate that the most likely candidate for the initial “functional impetus” is the goal of avoiding threat to the self.

Initial perception of tangible or symbolic threat

Perceptual distortions that amplify group differences

Consensual sharing of threats and perceptions¹

Tangible threats are “instrumental” in the sense that they threaten a material or concrete good, while those that are symbolic threaten beliefs, values, ideology, or the way in which the group ordains its social, political or spiritual domains.

In relation to mental illness, cultural perceptions seem to indicate that it poses a tangible threat to the health of society because it engenders two kinds of fear: the fear of potential immediate physical threat of attack and the fear that we may all share of losing our own sanity. In addition, to the extent that mental ill persons are stereotyped as lazy, unable to contribute, and hence, a burden to the system, then, mental illness may be also seen as posing a symbolic threat to the beliefs and value system shared by members of the group.

More specifically, the stigma associated with mental illness can also be attributed to the traditional division of venues for treatment and health care systems. The division between the two systems meant that persons with mental illness were sent away to mental institutions or asylums consequently segregating them from those who were physically ill and who were cared and treated for in general hospitals in their own communities. The decision to send persons with mental illness to far away mental hospitals, although well intentioned in its origins, contributed to their dislocation from their communities, and the loss of their community ties, friendships and families. At a more systemic and academic level, the segregation between the two systems of health also meant the banishment of mental illness and of psychiatry from the general stream of medicine. At a different level, the lack of effective therapies that influenced most of psychiatric work for centuries also contributed to the asylum mentality. The few therapeutic successes, such as the cure for pellagra or for syphilis, only helped to reinforce the idea that the patients that remained in the mental hospitals suffering from other mental illnesses were incurable.

1. Adapted from Stangor and Crandall, p. 73

Myths and stigma



Stigma, or the feeling of being negatively differentiated because of being affected by a particular condition or state, is related to negative stereotyping and *prejudicial* attitudes. These in turn, lead to *discriminatory* practices that deprive the stigmatized person from legally recognized entitlements. Stigma, prejudice, and discrimination are, therefore, inextricably related. Unlike prejudice, however, stigma involves definitions of character and class identification, so it has larger implications and impacts. Often, prejudice stems from ignorance, or unwillingness to find the truth. For example, a study conducted by the Canadian Mental Health Association, Ontario Division (Ontario, Canada), in 1993-1994, found that the most prevalent misconceptions about mental illness included that mental patients were dangerous and violent (88%), that they had a low IQ or were developmentally handicapped (40%), that they could not function, hold a job, or had anything to contribute (32%), that they lacked will power or were weak or lazy (24%), that they were unpredictable (20%), and, finally, that they were to be blamed for their own condition and should just shape up (20%).

In a survey among first year university students in the United States, it was found that almost two-thirds believed that “multiple personalities” were a common symptom of schizophrenia (Torrey, 1995). The same author reports on a different poll conducted among the general public in which 55% of respondents did not believe that mental illness existed and only 1% acknowledged that mental illness was a major health problem. Some of these myths also surfaced in a study conducted in Calgary, Alberta, Canada, during the pilot study for the World Psychiatric Association (WPA) Programme “Open the Doors” (Stuart and Arboleda-Florez, 2001). In this study, it was found that respondents believed that persons with schizophrenia could not work in regular jobs (72%), had a split personality (47%), or were dangerous to the public because of violent behaviour (14%). In Africa, people’s thoughts about mental illness are strongly influenced by traditional beliefs in supernatural causes and remedies. Even policy makers frequently hold the opinion that mental illness is often incurable and unre-

sponsive to accepted medical practices (Gureje and Alem, 2000).

Unfortunately, high levels of knowledge could coexist with high levels of prejudice and negative stereotypes. For while most of the myths about mental illness could be traced down to prejudice and ignorance of these conditions, enlightened knowledge does not necessarily translate into less stigma unless the tangible and symbolic threats that it poses are also eradicated. This could only be done through better education of the public and consumers about the facts of mental illness and violence, and through the provision of consistent appropriate treatment to prevent violent reactions. Good medication management should also aim at decreasing the visibility of symptoms among patients (consumers), and at providing better public educational programs on mental health promotion and prevention.

Human Rights infringements



Outright discriminatory policies ending in abuses of human rights and denial of legal entitlements can often be traced to stigmatizing attitudes, plain ignorance about the facts of mental illness, or lack of appreciation of the needs of persons with mental illness. These policies and abuses are not the preserve of developing countries only.

In countries with established economies, health insurance companies openly discriminate against persons who acknowledge that they have had a mental problem. Life insurance companies, as well as income protection insurance policies make a veritable ordeal out of collecting payments due to temporary disability caused by mental conditions such as anxiety or depression. Many patients see their payments denied or their policies discontinued. Government policies sometime demand that mental patients be registered in special files before pharmacies could dispense needed psychiatric medications. At a larger level, many developed countries provide only a modicum of funds from their national research budgets for research in mental conditions. In Canada, for example, mental health research commands less than 5% of all the health research budgets, yet mental illness affects directly 20% of Canadians (CAMIMH, 2000)

In developing countries, beliefs about the nature of mental conditions, sometimes enmeshed with religious beliefs and cultural determinants, tend to delay needed treatment by penalizing and stigmatizing not only the patients, but also their families, even when they are entitled to access treatment opportunities (Gureje and Alem, 2000). Within the Chinese culture, mental illness is highly stigmatic for the whole family not just the individual afflicted. The emphasis on collective responsibility leads to the belief that mental illness is a family problem. Thus, Chinese caregivers may prefer to cope with mental illness within the context of the family as long as possible. The downside to this approach is the subsequent delay in treatment that may result (Ryder, Bean and Dion, 2000).

In general, illness and disability due to mental disorders have received little attention from governments in developing countries including African governments. Mental health services have been poorly funded and most countries lack formal mental health policies, programmes, and action plans. In 1988 and 1990 two resolutions designed to improve mental health were adopted among African countries. A survey conducted two years later to follow-up on what progress had resulted from these resolutions unfortunately showed disappointing findings (Gureje, Alem, 2000).

In Uganda, per capita yearly expenditures for mental illness is only US\$ 4.00, well below the US\$ 10.00 recommended by the World Bank (The Monitor, 1998). In Nigeria, excessive workloads, frequent transfers, responsibility without authority, and other inherently poor management practices are blamed for the poor mental health conditions of employees and the consequences if they happened to complain about their difficulties (Vanguard Daily, 2000).

Consequences of stigma



Sartorius (1999) sustains that the stigma of mental illness affects the requirements for care of good quality in mental health. In his view, stigma attitudes compromise access to care through perceptions among policy makers and the public that persons with mental illness are dangerous, lazy, unreliable and unemployable. Eventually, these attitudes impact on the willingness of author-

ities to provide proper financial resources for their care.

Some researchers argue that persons with mental illness are not stigmatized. They base their conclusions on measurements of social distance that show acceptance of mental patients, findings showing that what is stigmatizing is the behaviour and not the label, and the fact that mental patients themselves are rarely able to report concrete instances of rejection. These findings, however, are contrary to multiple other reports among patients and their families, and even among mental health personnel who feel that their work is less appreciated and remunerated than similar intense work with other patient populations. Link et al (1992) refute findings denying the pernicious effects of stigma on the basis that these studies have been flawed by the types of questions they have asked and, consequently, by the types of replies that they have obtained. Real life perceptions and patients' testimonials tell a different story about how it feels to have a mental illness.

Michelle, a vivacious 25 year-old office worker, tells about her major disappointment with her family and family friends who simply expected her to have an abortion when she announced that she was pregnant. They assumed that her schizophrenia would incapacitate her to deliver and to care for her baby. They were also afraid that her medications could have teratogenic effects on the baby. She carried her baby to term and is taking care of it despite the opposition of family and friends.

Michelle's experience is not uncommon. For many persons with mental illness, the stigma of their illness is worse than the disease and it spreads a cloud over every aspect of their lives, and even the lives of other members of the family.

John, a 19-year-old university student, had to accept the termination of a relationship he had just started with a girl from his neighbourhood. Her parents objected to the relationship and decided to send her to another city for her education, in part in an attempt to break up the relationship, once they knew that John's mother's frequent hospitalizations for the past several years were not due to "diabetes", but to a manic depressive illness. John described the experience with some resignation, "it seems as if I have to carry the sins of my parents".

In the study by the Canadian Mental Health Association, Ontario Division, in 1993-1994 quot-

ed above, mental patients felt that social and family life (84%), along with employment (78%) and housing (48%), were the areas most commonly affected by stigma. In that survey respondents also felt excluded from the community (22%) and complained that stigma has a negative impact on their self-esteem (20%).

In a survey conducted among members of their own support organization by “survivors” of mental illness in Thunder Bay, Ontario, Canada (P.A.C.E. Report, 1996), they identified housing, employment, and transportation in public buses as degrading and outright discriminatory.

“I have to lie to my landlord to get a place to live, like tell him you are on disability, if it is not visible or physical, they don’t take you. Even slumlords won’t take you because they don’t want psychiatrically ill people living in their buildings.”

In this Report, “survivors” found that “mental health barriers” among the public often lead to stigmatization, prejudice and stereotyping and that they were not listened to, or understood. They also felt ignored, avoided, or treated without respect and sensitivity. They reported that these attitudes could also be found during their interactions with social assistance personnel and with clinical staff.

“At the agency the staff talk about patients and how crazy they are. No wonder there is such stigma in the community.”

And another patient commented poignantly about health staff:

“At the hospital, they take your clothes away. They put you in pyjamas ... it strips away your identity. You know, we are not all crazy. We don’t all see the boogiemans around the corner. Some of us have legitimate complaints. But if you are always told ‘oh, you are overreacting’ you know, you don’t know what you are talking about or stuff like that, after a while you start to believe that yeah, maybe I am. There are some doctors who don’t know, you know, an oesophagus from an asshole.”

In *The Last Taboo* (Simmie and Nunes, 2001), one of the authors, Scott Simmie, describes his feelings after a bout of major depression:

“Stigma was, for me, the most agonizing aspect of my disorder. It cost friendships, career opportunities, and – most importantly – my self-esteem. It wasn’t long before I began internalizing the attitudes of others, viewing

myself as a lesser person. Many of those long days in bed during the depression were spent thinking, ‘I’m mentally ill. I’m a manic-depressive. I’m not the same anymore’. I wondered, desperately, if I would ever again work, ever again be ‘normal’ It was a godawful feeling that contributed immensely to the suicidal yearnings that invaded my thoughts.”

Violence and mental illness



Few popular notions and misconceptions are so pervasive and stigmatizing as is the belief that persons with mental illness are dangerous and violent. This could be hardly surprising when practically no month goes by without the media reporting on the sad story of yet another horrendous crime committed by an alleged mental patient. At times, the story also mentions that the culprit is suspected to be “psycho”, “paranoid”, “depressed”, or “schizophrenic”. This type of news, even when reported conscientiously and accurately, arouses fear and apprehension and pushes the public to demand measures to prevent further crimes. Persons with mental illness in general bear the brunt of impact because of the actions of the few.

The grotesque and sensationalistic portrayal of persons with mental illness in the media (Rovner, 1993) pales in comparison to how they have been portrayed in movies right from the beginning of this industry in the early 1900s. Wahl and Harman (1989) found that 85.6% of relatives of persons with mental illness identified movies about “mentally ill killers” as the most important contributor to the stigma of the illness. Movies have not only stigmatized those with mental illness, their negative stereotypes have extended also to psychiatrists who are often portrayed as libidinous lechers, eccentric buffoons, vindictive, repressive agents of society, or evil minded, and in the case of female psychiatrists, as loveless and unfulfilled women (Gabbard and Gabbard, 1992).

Media accounts of crimes allegedly committed by mental patients reinforce the association between violence and schizophrenia in the public mind. Such association has been traced to be directly related to how mental illness and persons with mental illness are portrayed in the media (Philo, 1997). Unfortunately, the media do not inform the

public that only a very small minority of mental patients commits serious crimes, or that the percentage of violence that could be attributed to mental illness as a portion of the general violence in the community is also small (Monahan, 1997).

The association between mental illness and violence, specifically schizophrenia, although confirmed epidemiologically (Arboleda-Florez, 1998), remains still unclear and seems to flow not so much through direct links of causality, but through a series of confounders and covarying potential causes. Studies that purport to demonstrate an association between mental illness and violence still need to concentrate on several aspects of the relationship:

- they need to demonstrate that the association is one of causality;
- they need to tease out the contextual elements in which the violence occurs;
- they need to measure the risk of violence from a public health perspective; and
- they need to identify measures that could help manage the risk among those patients who could become violent.

Fear, as already indicated above, is the primary impulse to the development of stigma. The fear of mental illness, and the subsequent stigmatization of those with mental illness, is largely based on fears that they are unpredictable and dangerous. Unfortunately, one single case of violence is usually sufficient to counteract whatever gains mental patients have made to be accepted back into the community.

Changing policies and deinstitutionalization



The recognition worldwide that the large prevalence of mental conditions and their associated disabilities have major impacts not only on health budgets, but on the total economy, has spurred national governments to face the challenges and develop strategies to cope with mental illness in their respective countries. In the United States, the 1999 Report of the Surgeon General urged the nation to rally the national will to find better ways to fight mental conditions including


among others, a fight against stigma (Surgeon General Report, 1999).

Government initiatives worldwide include a whole revamping of mental health systems to integrate the care of persons with mental illness in the mainstream of the health system, reorganization of budgetary allocations to protect access to mental health treatment, restructuring of mental health facilities, and introduction of legislation to protect the rights of persons with mental illness and their legal entitlements that tend to get eroded by discrimination.

Many of these initiatives are known generically as “deinstitutionalization policies”, because they have in common characteristics such as the divestment of mental hospitals, the treatment of mental patients in general hospitals, and their reintegration in their communities of origin. Important and enlightened as these initiatives have been, many have not met with the success expected simply because it is not enough to just transfer the patients to the community, or to deny beds to newly diagnosed patients. An integrated and seamless mental health system should cover the whole spectrum of needs for early diagnosis, treatment, and psychosocial rehabilitation, as well as initiatives for public education on the recognition and prevention of mental conditions and the promotion of mental health in the population.


Specifically, deinstitutionalization initiatives have to be implemented together with the development of adequate community systems to house those with mental illness and to provide for their successful reintegration into the community. Often, the lack of these community systems worsens the stigma held against persons with mental illness when they are observed walking aimlessly in the downtown areas of large cities, loitering in town squares, shopping centres or markets, or being destitute and homeless. In addition, mental health legislation has to be made more flexible and responsive to contemporary mental health policies and the realities of the mental health system.

Recent research on stigma of mental illness

 Although there does not seem to be a one-to-one relationship between exposure to environmental stressors such as stigma and discrimination, and adaptational outcomes, research on stigma has demonstrated that it has negative outcomes on physical health and on self-esteem (Miller and Major, 2000). Persons with mental illness often experience prejudice similar to those who suffer racial or ethnic discrimination, but the practical effects are complex and affected by a number of factors such as age, sex, the degree of stigma felt by the patient, and the degree of self-stigmatization (Hayward and Bright, 1997).

Stigmatization and prejudice have often been confirmed in research studies as one of the reasons why many persons do not seek, or postpone until too late, seeking assistance (Wills, 1983). Recent research has also demonstrated that the fear of mental illness is not just related to the behaviour sometimes demonstrated by persons with mental illness, but to the label itself and the consequences that flow from the illness. Thus, in the pilot site of the WPA Programme “Open the Doors”, Edmonton, Canada, respondents rated “loss of mind” as more disabling than any other handicapping condition (Thompson *et al*, under review). In the same study, the Calgary group found that greater knowledge was associated with less distancing attitudes, but that exposure to persons with mental illness was not correlated with knowledge or attitudes (Stuart and Arboleda-Florez, 2001). Link *et al* (1999) came to a similar conclusion regarding the split between knowledge and attitude among the general public. The Alberta, Canada, groups concluded that broad approaches to increase mental health literacy (Jorm, 2000) may not be as effective among already highly educated population groups as would specifically focused interventions among small groups such as high school students, or clinical workers. Corrigan and Penn (1999) have come to the same conclusion in regard to the specific group targeting approach, which they extend to the targeting of specific beliefs about mental illness among ethnic minorities.

Efforts to combat the stigma of mental illness

 National and international organizations and associations as well as national and local governments have come to appreciate the need to change attitudes toward persons with mental illness and to sensitize the public to the notion that mental conditions are no different than other conditions in their origin and that diagnosis and treatments are available and effective. Campaigns like “Changing Minds” organized by the Royal College of Psychiatrists in the UK (www.changingminds, 2001) are based on providing information to the public so as to dispel myths and stereotypes about those with mental illness. The campaign has used leaflets, pamphlets, films and other ways of mass communication. In one well-known film, “1 in 4”, the message is direct and pithy as it emphasizes that mental health problems can touch anyone:

1 in 4, the film proclaims, could be your Brother, your Sister. Could be your Wife, your Girlfriend...] in 4 could be your Daughter...] in 4 could be me...it could be you

Pamphlets produced for the campaign emphasize messages indicating that social despair and isolation have replaced old methods of physical isolation:

For centuries people with mental illness were kept away from the rest of society, sometimes locked up, often in poor conditions, with little or no say in running their lives.

Today, negative attitudes lock them out of society more subtly but just as effectively.

One of the major goals of the Australian National Mental Health Promotion and Prevention Action Plan (1999) has been improving mental health literacy in the population. With this in mind, a series of campaigns like the Australian National Community Awareness Program (CAP) and the Australasian “Psychiatric Stigma Group” have been aimed at increasing mental health literacy among the general population. The former, CAP, was a four-year program liberally funded to increase community awareness of all mental conditions. Specifically, it had three goals: to position mental health on the public agenda, to promote a greater understanding and acceptance of those experiencing mental illness, and to dispel myths and misconceptions about mental illness. The program had a built-in evaluation based on benchmark survey and

pre-post tracking design. The most significant results include, that while tolerant attitudes were consolidated, they did not increase; that there was a slight increase in the awareness of services; and that there was no clear evidence of behaviour change (Rosen, 2000).

The Australasian Psychiatric Stigma Group has more modest goals mostly by linking consumers, providers, and many other interested groups in a public evaluation of the impact of stereotyping and stigma on the lives of psychiatric service-users, their carers, and the lives of providers (Rosen, 2000).

SANE Australia is a national charity that helps people affected by mental conditions. One major and famous feature of this group is the popular TV soap opera *"Home and Away"* in which a storyline is about a young character that develops schizophrenia (SANE, 1999). SANE has a function similar to NAMI (National Alliance for the Mentally Ill) in the United States and CAMIMH (Canadian Alliance on Mental Illness and Mental Health, 2000); they are all umbrella family groups that lobby for better education, more research funding, and more accessible treatment opportunities for persons with mental illness.

In New Zealand, a National Plan (1998) has been devised as part of the Blueprint for Mental Health Services to combat stigma and discrimination associated with mental illness. An important component of this plan is the involvement of aboriginal communities. A similar program has been envisioned in Canada with the aboriginal communities that seek to empower them to organize their own cultural resources to develop programs and services that meet their own physical, mental and spiritual needs (Nishnawbe Aski-Nation, 1990).

In the United States of America, the National Institute of Mental Health (NIMH) has an extensive educational campaign available in pamphlets, booklets and on the internet. The information provided covers a wide variety of topics ranging from specific mental conditions to issues such as suicide or youth and violence. The web site (www.nimh.nih.gov/practitioners/patinfo.cfm#top) provides updated information on research topics, treatment, new medications and programs, and legislative initiatives. The site also has a Spanish portal. The U.S. Center for Mental Health Services

Knowledge Exchange Network (KEN) provides online information (www.mentalhealth.org) on stigma.

Although not written anywhere yet as publications, but only as internal government documents, the mental health programmes presently devised in El Salvador (2000) are worth mentioning as initiatives from developing countries. In El Salvador, an extremely active advocate for better mental health policies, the present First Lady of the Nation, in her capacity as Director of the Secretaría Nacional de la Familia (National Family Secretariat) had started to set up a National Mental Health Council (Consejo Nacional de Salud Mental) in October of the year 2000, that would encompass the gamut of citizens and organizations that might have a function on issues pertaining to mental health in the country. Organigrams, plans and sets of functions and activities for the Council were thrown in disarray, however, and the development work delayed, by the earthquakes that have devastated the country since the beginning of this year, 2001. Yet, the groundwork already done in the organization of the Council gave impetus for a massive mobilization of national forces to set up community grassroots activities bent on immunizing the population against the deleterious mental health effects and impacts of the catastrophe, the prevention of panic reactions especially among young children, and the immediate treatment of those already affected by post-traumatic stress reactions.

Mental health and professional organizations have joined forces with government bureaucracies and educational establishments all over the country to develop on-the-field training for nurses, teachers, and other local community human resources personnel through sessions on training-for-trainers mental health counsellors and for the delivery of group therapy initiatives and individual counselling. Many of these activities are being carried out from semi-destroyed schools and government buildings, in the fields below half – uprooted trees, or in the plazas or street corners of little towns, right in the middle of the debris and rubble that is still being shaken by ongoing milder tremors. The experience of El Salvador on emergency mental health action, and the impact that it has had on demystifying mental illness and emotional problems and, hence, decreasing stigma, is one of those untold stories of how humans can mobilize and rise to the circum-

stances as long as they are given a few tools and the empowerment to act.

In Tajikistan, where the population has a hostile and fearful attitude toward psychiatric illness, stigma is a problem. In 1998, the Union of Mental Health Support, a national NGO, was created to prevent stigma related to psychiatric disorders and to provide appropriate measures and assistance to psychiatric institutions. A draft law, approved by the Ministers of Health, Justice, Social Welfare, Economics, and Labour, will be submitted to Parliament. The new law is needed because the existing laws allow for the abuse of psychiatry for political purposes. If the new law passes, it will be one of the most modern psychiatric laws in the area. Also encouraging is that within the last year a survey was conducted to assess community attitudes toward mental illness and psychosocial distress. The survey results will be used in the design of a community education and awareness campaign (Baibabayev, Cunningham and de Jong, 2000).

The Republic of Slovakia is another country that, since 1991, is struggling to reform its mental health care system to address better issues such as stigma. While some progress has been made in the past 10 years, the speed of reform has been slow. Factors contributing to morbidity from mental illness in Slovakia include the fact that the high hopes that blossomed immediately following the change in political power have remained mostly unrealized. This has resulted in a sense of hopelessness in the population. How to destigmatize persons with mental illness remains one of the three major mental health concerns in Slovakia. Reform efforts however are currently being intensified and there is an increased interest in the field of psychiatry among young physicians (Breier, 2000).

At an international level, two programmes, one from the World Psychiatric Association (WPA) and the other from the World Health Organization (WHO), merit a more extensive review. The WPA initiated in 1998 its Global Programme Against Stigma and Discrimination Because of Schizophrenia. Although the "Open the Doors" (www.openthedoors.com) programme is circumscribed to schizophrenia, its results in the different countries where it has been implemented are equally applicable to any other mental condition. The Programme was first pilot-tested in Calgary

and Alberta, Canada in 1998, and has now moved to Spain, Austria, Germany, Israel, Italy, Greece, Egypt, India, and China. The Programme has targeted different audiences according to locations, but depends heavily on local action groups that organize themselves to plan and initiate projects that mobilize local resources into action to combat the stigma associated with this disease.

The WPA Programme (2000) has produced four volumes containing how-to guidelines and information on schizophrenia. Volume One is a step-by-step how-to guide to develop local programmes; Volume Two is a compendium of the latest knowledge on the diagnosis and treatment of schizophrenia including psychosocial reintegration strategies; Volume Three includes reports from different countries; and Volume Four is a collection of reports from other countries where similar initiatives are on-going or being planned. A final volume is being planned with an annotated bibliography of practical materials. All these materials are downloadable from the WPA Programme web site.

The World Health Organization (2001) has launched its initiative, "Stop exclusion. Dare to care" aimed at combating stigma and at rallying support for more enlightened and equitable structures for the care of those with mental illness and the acceptance of mental health as a major topic of concern among member-states. This initiative brings timely information to correct the myths surrounding mental conditions such as the beliefs that they affect only adults in rich countries, that they are not real illnesses but incurable blemishes of character, or that the only alternative would be to lock mental patients in institutions.

"Stop exclusion. Dare to care" provides a sobering reminder of the extent of mental conditions throughout the world with about 45 million persons worldwide suffering from schizophrenia alone, not to mention the many million of persons who suffer from depression, dementia, alcoholism or other mental problems. Sadly, it also shows how the majority of these persons are deprived of even the most basic treatments, such as, for example, persons suffering from alcohol dependency of whom only 22% receive treatment, or persons affected by epilepsy of whom, in some countries, less than 10% have access to treatment. The WHO Mental Health Programme makes the point that

mental health should be made part of the general health care services in countries and that it is the ethical responsibility of nations to be inclusive of all citizens and respect their human rights.

This WHO Mental Health Programme invites individuals, families, communities, professionals, scientists, policy makers, the media, and NGOs to join forces and to share a vision where individuals recognize the importance of their own mental health; patients, families and communities feel sufficiently empowered to act on their own mental health needs; professionals will not only treat those with mental illness, but will also engage actively in mental health promotion and preventative activities; and policy makers will plan and devise policies that are more responsive to the needs of the entire population.

“Stop exclusion. Dare to care” has so far used as methodologies the distribution of pamphlets, posters, booklets, and stickers, and through the many collateral organizations and distribution channels open to WHO, it aims at providing incentives to national governments and health care organizations to change policies and to become actively involved in the reorganization of services and in the development of appropriate mental health policies.

The conceptual elements of all these programs follow cognitive methodologies for behavioural change. Their three major goals are similar:

- to increase awareness and knowledge of the nature of mental illness;
- to improve public attitudes toward those who suffer from mental illness and their families; and
- to generate action to prevent and to eliminate stigma and discrimination.

Strategies to combat stigma



Sartorius (1999) recommends that breaking the cycle of disadvantage resulting from stigma should be made a priority. He describes several steps leading to disadvantage such as disease, impairment, the stigma linked to these two, discrimination, reduction of opportunities for rehabilitation and role malfunctioning, and places the corresponding interventions at each one of these steps. Apart from recovery with proper treatment

and therapeutic efforts to reduce disability, several strategies to combat stigma and discrimination because of mental illness have been found successful by different groups around the world. Usually, these include the participation of all those who care and who treat those with mental illness, as well as the patients, or consumers themselves. The following are the strategies most frequently used:

- Speakers' bureaux that train and organize individual consumers, or patients, and their families to provide talks to specialized groups such as students, nurses, or business people, about their mental illness and how they are coping and managing their lives.
- Plays and other artistic expressions offered by consumers that highlight the importance of the illness and its debilitating effects as well as the impact of stigma and discrimination.
- Organization of special mental health curricula in public schools according to level of maturity, age, and grade of the students.
- Targeting particular groups that consumers consider tend to stigmatize them with some regularity such as emergency room personnel, the clergy, or bureaucrats, and offer them information, talks, or presentations about mental illness.
- One size does not fit all. Differentiate anti-stigma campaigns according to specific target groups rather than mounting massive generic public efforts.
- Work closely with the media and prepare “infokits” that provide timely information when issues pertaining to mental conditions break out in the news.
- Participate actively in organized activities such as World Mental Health Day sponsored by the World Federation for Mental Health (October 10 each year), or Mental Health Awareness Week.
- Become a “stigma-buster” by being aware and be ready to denounce local or national news, advertisements, or movies that stigmatize, ridicule, or demonize people with mental illness as violent, unpredictable or dangerous.
- Advise decision-makers on the difficulties that persons with mental illness face in securing proper housing and employment, and in accessing treatment, or using public facilities.

- Help consumers and families organize themselves locally and join nationally in “consumer movements”.
- Organize local groups and help amalgamate them into single national conglomerates or Alliances for Mental Health. For example, help form a National Association for Mental Health that works in close association with professional groups such as the National Psychiatric, Psychological, Nurses, or Social Workers Associations, that could speak with authority to national governments on behalf of persons with mental illness.
- Stimulate national groups or mental health conglomerates to lobby the government to introduce legislation that combats stigma and that outlaws discrimination whether based on group characteristics or individual physical or mental disabilities.
- Stand up and be ready to clear out prejudice and misconceptions about the persons with mental illness.

Conclusion



Empowerment is intrinsic to the mental health of communities. The support and involvement of communities in the development, implementation, and organization of their own health structures and programs lead to the realization at the community level of the impact and the ramifications to health of social scourges such as drug and alcohol abuse, family and social violence, suicide and homicide, and mental illness themselves.

Centuries of prejudice, discrimination and stigma, however, cannot be changed solely through government pronouncements and legislative fiats, important as they are. The successful treatment and community management of mental illness relies heavily on the involvement of many levels of government, social institutions, clinicians, caregivers, the public at large, the patients or consumers themselves, and their families. Successful community reintegration of mental patients and the acceptance of mental illness as an inescapable fact of our social fabrics can only be achieved when communities take control and become masters of their own mental health structures, programmes, services and organizational arrangements.

There is a need, therefore, to engage the public in a dialogue about the true nature of mental illness, their devastating effects on individuals, their families, and society in general, and the promises of better treatment and rehabilitation alternatives. An enlightened public working in unison with professional associations and with lobby groups on behalf of persons with mental illness can leverage national governments and health care organizations to provide equitable access to treatment and to develop legislation against discrimination. With these tools, communities could then enter into a candid exchange of ideas about what causes stigma and what are the consequences of stigmatizing attitudes in their midst. Only these concerted efforts will, eventually, dispel the indelible mark. the stigma caused by mental illness.

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The state of the evidence

Gender disparities in mental health

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Executive summary



This paper examines current evidence regarding rates, risk factors, correlates and consequences of gender disparities in mental health. Gender is conceptualized as a structural determinant of mental health and mental illness that runs like a fault line, interconnecting with and deepening the disparities associated with other important socioeconomic determinants such as income, employment and social position.

Gender differentially affects the power and control men and women have over these socioeconomic determinants, their access to resources, and their status, roles, options and treatment in society. Gender has significant explanatory power regarding differential susceptibility and exposure to mental health risks and differences in mental health outcomes. Gender differences in rates of overall mental disorder, including rare disorders such as schizophrenia and bipolar disorders, are negligible. However, highly significant gender differences exist for depression, anxiety and somatic complaints that affect more than 20% of the population in established economies. Depression accounts for the largest proportion of the burden associated with all the mental and neurological disorders and is a particular focus of this paper. It is predicted to be the second leading cause of global burden of disease by 2020.

To address this mounting problem, a much improved understanding of the gender dimensions of mental health is mandatory. Evidence is available on some aspects of the problem but serious gaps remain. It is known that:


- Rates of depression vary markedly between countries suggesting the importance of macro-social factors. Nevertheless, depression is almost always reported to be twice as common in women compared with men across diverse societies and social contexts.
- Despite its high prevalence, less than half the patients with depression disorder are likely to be identified by their doctors in primary care settings. Gender differences in patterns of help seeking and gender stereotyping in diagnosis compound difficulties with identification and treatment. Female gender predicts being prescribed psychotropic drugs. Even when presenting with identical symptoms, women are more likely to be diagnosed as depressed than men and less likely to be diagnosed as having problems with alcohol.
- Men predominate in diagnoses of alcohol dependence with lifetime prevalence rates of 20% compared with 8% for women, reported in population based studies in established economies. However, depression and anxiety are also common comorbid diagnoses, highlighting the need for gender awareness training to overcome gender stereotypes and promote accurate diagnosis of both depression and alcohol dependence in men and women if they are present.
- Comorbidity is associated with mental illness of increased severity, higher levels of disability and higher utilization of services. Women have higher prevalence rates than men of both lifetime and 12 month comorbidity involving three or more disorders. Depression and anxiety are the most common comorbid disorders but concurrent disorders include many of those in which women predominate such as agoraphobia, panic disorder, somatoform disorders and post traumatic stress disorder.
- Reducing the overrepresentation of women who are depressed must be tackled as a matter of urgency in order to lessen the global burden caused by mental and behavioural disorders by 2020. This requires a multi-level, intersectoral approach, gendered mental health policy with a public health focus and gender-specific risk factor reduction strategies, as well as gender sensitive services and equitable access to them.
- Gender acquired risks are multiple and interconnected. Many arise from women's greater exposure to poverty, discrimination and socioeconomic disadvantage. The social gradient in health is heavily gendered, as women constitute around 70% of the world's poor and earn significantly less than men when in paid work.
- Low rank is a powerful predictor of depression. Women's subordinate social status is reinforced in the workplace as they are more likely to occupy insecure, low status jobs with no decision making authority. Those in such jobs experience higher levels of negative life events, insecure housing tenure, more chronic stressors and reduced social support. Traditional gender roles

further increase susceptibility by stressing passivity, submission and dependence and impose a duty to take on the unremitting care of others and unpaid domestic and agricultural labour. Conversely, gains in gender development that improve women's status are likely to bring with them improvements in women's mental health.

- Globalization has overseen a dramatic widening of inequality within and between countries including gender-based income disparities. For poor women in developing countries undergoing restructuring, rates of depression and anxiety have increased significantly. Increased sexual trafficking of girls and women is another mental, physical, sexual health and human rights issue. The mental health costs of economic reforms need to be carefully monitored.
- Finally, the epidemic of gender based violence must be arrested. The severity and the duration of exposure to violence are highly predictive of the severity of mental health outcomes. Rates of depression in adult life are 3 to 4 fold higher in women exposed to childhood sexual abuse or physical partner violence in adult life. Following rape, nearly 1 in 3 women will develop PTSD compared with 1 in 20 non victims. Current levels of detection of violent victimization are poor and primary health care providers require better training to intervene successfully to arrest the compounding of mental health problems.
- Rates of psychiatric comorbidity and multi somatization are high, but neither well identified nor treated. The gendered nature of comorbidity poses complex therapeutic challenges regarding detection and appropriate models of care.
- Research needs to be conducted into the relationship of violence to comorbidity. Women are at significantly increased risk of violence from an intimate and are over represented amongst the population of highly comorbid people who carry the major burden of psychiatric disorder. Equally, research is needed to understand better the sources of resilience and capacity for good mental health that the majority of women maintain, despite the experience of violence in their lives.
- Access to safe affordable housing is essential if women and children are to escape violent victimization and the cessation of violence is highly

therapeutic in reducing depression. Improved balance in gender roles and obligations, pay equity, poverty reduction and renewed attention to the maintenance of social capital would further redress the gender disparities in mental health.

Background


 Data on the size of the global burden of mental disorders reveal a significant and growing public health problem (Murray & Lopez, 1996). Mental illness is associated with a significant burden of morbidity and disability and lifetime prevalence rates for any kind of psychological disorder are higher than previously thought. Rates are increasing in recent cohorts and affect nearly half the population (Kessler, McGonagle, Zhao et al, 1994; WHO & ICPE, 2000).

Despite being common, mental illnesses are under diagnosed by doctors. Less than half of those who meet diagnostic criteria for psychological disorders are identified by their primary care providers (Üstün & Sartorius, 1995). Patients, too, appear reluctant to seek professional help. Only 2 in every 5 people experiencing a mood, anxiety or substance use disorder report seeking assistance in the year of the onset of the disorder (WHO & ICPE, 2000).

Other factors besides patient reluctance determine mental health care service utilization. Of increasing importance is the way mental health care is financed and organized including the shift to “user pays” health policies. Income level and medical insurance status can significantly predict access, particularly to specialist care (McAlpine & Mechanic, 2000; Alegria, Bijl, Lin et al, 2000)


Overall rates of mental disorder are almost identical for men and women (Kessler, McGonagle, Zhao et al, 1994) but striking gender differences in the patterns of mental illness.

Gender, human rights and the global burden of disease

 Gender is a critical determinant of health, including mental health. It influences the power and control men and women have over the determinants of their mental health, including their socioeconomic position, roles, rank and social status, access to resources and treatment in society. As such, gender is important in defining susceptibility and exposure to a number of mental health risks.

If it is accepted that both women and men have a fundamental right to mental health, it becomes impossible to examine the impact of gender on mental health without considering gender-based discrimination and gender-based violence. Consequently, a human rights framework is needed to interpret gender differences in mental health and to identify and redress the injustices that lead to poor mental health. Many of the negative experiences and exposures to mental health risk factors that lead to and maintain the psychological disorders in which women predominate involve serious violations of their rights as human beings including their sexual and reproductive rights. The 1999 Human Development Report, referring to the increase in organized crime related to globalization, noted an escalation in the trafficking of women and girls for sexual exploitation – some 500,000 girls and women trafficked to Western Europe alone – and described trafficking as one of the “most heinous violations of human rights”. The multiple, severe mental health consequences of sexual violence and abuse are discussed below.

Gender and patterns of mental disorder

 In examining the role of gender in mental illness a distinction needs to be made between the low-prevalence and severe mental disorders such as schizophrenia and bipolar disorder, where no consistent gender differences in prevalence rates have been found, and the high-prevalence disorders of depression and anxiety where large gender differences in rates have been consistently reported. Depression and anxiety, often associated with somatic complaints, are known to affect around 1 in 5 people in the general community and more than 2 in 5 primary care attenders in a variety of countries (Üstün & Sartorius, 1995; Patel, 1999).

General population studies indicate that lifetime prevalence rates for schizophrenia and bipolar disorder range from 0.1% to 3% for schizophrenia and from 0.2% to 1.6% for bipolar disorders (Piccinelli & Homen 1997) and no significant gender differences have been reported.

Differences in rates of disorder are only one dimension of the role played by gender in mental

health and illness. Beyond rates, gender is related to differences in risk and susceptibility, the timing of onset and course of disorders, diagnosis, treatment and adjustment to mental disorder.

A comprehensive review of schizophrenia research found frequent reports of gender differences in age of onset of symptoms. Men typically had an earlier onset of symptoms than women and poorer pre-morbid psychosocial development and functioning (Piccinelli & Homen, 1997). Despite later onset, some studies report that women experience a higher frequency of hallucinations or more positive psychotic symptoms than men (Lindamer et al. 1999). Similarly, while the population prevalence rates of bipolar disorder appear not to differ, gender differences occur in the course of the illness. Women are more likely to develop the rapid cycling form of the illness, exhibit more comorbidity (Leibenluft, 1997) and have a greater likelihood of being hospitalized during the manic phase of the disorder (Hendrick, Altschuler, Gitlin et al. 2000).

A number of studies report that women with schizophrenia have higher quality social relationships than men. However, a cross national survey drawn from Canada, Cuba and the USA (Vandiver, 1998) found that this was only true for Canadian women; Cuban men reported higher quality of life than Cuban women. A Finnish study on gender differences in living skills, involving self care and shopping, cooking and cleaning for oneself, found that half the men but only a third of the women lacked these skills that are so important for independent living (Hintikka et al., 1999). Thus skills inculcated through gender socialization can affect long term adjustment to and outcome of a severe mental disorder.

Gender specific exposure to risk also complicates the type and range of adverse outcomes associated with severe mental disorder. When schizophrenia coexists with homelessness, women experience higher rates of sexual and physical victimization, and more comorbid anxiety, depression and medical illness than men (Brunette & Drake, 1998).

Gender and Depression

Depression contributes most significantly to the global burden of disease and it is the most frequently encountered women's mental health problem (Piccinelli & Homen, 1997). Unipolar or major depression occurs approximately twice as often in women as in men and is predicted to be the second leading cause of global disease burden by 2020 (Murray & Lopez 1996). Any significant reduction in the overrepresentation of women who are depressed would make a significant contribution to reducing the global burden of disease and disability. Depression and anxiety are the most common comorbid disorders and a significant gender difference exists in the rate of comorbidity (Linzer et al., 1996). Comorbidity contributes significantly to the burden of disability caused by psychological disorders (Kessler et al, 1994; Üstün & Sartorius 1995, WHO & ICPE, 2000).

The gender difference in depression is one of the most robust findings in psychiatric epidemiology. A comprehensive review of almost all general population studies conducted to date in the United States of America, Puerto Rico, Canada, France, Iceland, Taiwan, Korea, Germany and Hong Kong, reported that women predominated over men in lifetime prevalence rates of major depression (Piccinelli & Homen, 1997). This difference is documented in clinical and community samples and

National Comorbidity Survey: Prevalence rates of selected disorders

Mental Disorders	Lifetime Prevalence Female	Lifetime Prevalence Male	12 Month Prevalence Female	12 Month Prevalence Male
Major depressive episode	21.3%	12.7%	12.9%	7.7%
Alcohol dependence	8.2%	20.1%	3.7%	10.7%
Antisocial personality disorder	1.2%	5.8%	NA	NA

Source: Kessler et al., 1994

across racial groups (Kessler et al., 1994; Gater et al., 1998, WHO & ICPE, 2000). Depression may also be more persistent in women (Bracke, 2000) and female gender is a significant predictor of relapse (Kuehner, 1999).

The US National Comorbidity Survey (Kessler et al., 1994), like many other studies before and since (Üstün & Sartorius 1995; Linzer et al., 1996; Brown, 1998), found women had a higher prevalence of most affective disorders and non affective psychosis and men had higher rates of substance use disorders and antisocial personality disorder.

The most common disorders were major depression and alcohol dependence and these disorders are often co-morbid for men with alcohol dependence. Both showed large gender differences in prevalence, as seen in the following table.

In addition, while completed suicide rates are higher in men, a nine country study reported that women had consistently higher rates for suicide attempts (Weissman, Bland, Canino et al, 1999). Gender-based violence is a significant predictor of suicidality in women, with more than 20% of women who have experienced violence attempting suicide (Stark & Flitcraft, 1996). Rates of both suicide ideation and suicide attempts vary widely between countries (Weissman, Bland, Canino et al, 1999).

Women also have significantly higher rates of post traumatic stress disorder (PTSD) than men (Kessler et al, 1995). General population surveys have reported that around 1 in every 12 adults experiences PTSD at some time in their lives and women's risk of developing PTSD following exposure to trauma is approximately twofold higher than men's (Breslau et al, 1998), and thus paralleling the difference found in rates of depression.

Gender and Comorbidity

Depression and anxiety are common comorbid diagnoses and women have higher prevalence than men of both lifetime and 12 month comorbidity of three or more disorders (Kessler et. al., 1994, WHO & ICPE, 2000). Almost half of patients with at least one psychiatric disorder have a disorder from at least one other cluster of psychiatric disorders (Üstün & Sartorius, 1995). These clusters included most disorders, apart from alcohol

dependence, in which women have already been found to predominate (Russo, 1990), including depressive episode, agoraphobia, panic disorder and generalized anxiety; somatization, hypochondriasis and somatoform pain. Psychiatric comorbidity, with depression as a common factor, is a characteristic finding of many studies on women's mental health (Brown et al. 1996; Linzer, Spitzer, Kroenke et al, 1996) and a repeated finding from studies on the mental health effects of violence from an intimate (Resnick et al., 1997).

Recent research findings have pointed to the need for improved recognition of the presence and significance of comorbid conditions. Comorbidity is associated with increased severity, higher levels of disability and higher utilization of services and is concentrated in a small group of people. Highly comorbid people, who as a group represent about one sixth of the population between 15 and 54 years in the US, have been found to carry the major burden of psychiatric disorder (Kessler et al, 1994). When all lifetime disorders were examined in the National Comorbidity Survey only 21% occurred in people who over their lifetime had experienced only one disorder, while 79% of lifetime disorders, in this sample, were comorbid disorders. For 12 month disorders, the findings were even stronger. It is therefore of considerable importance that women had significantly higher lifetime and 12 month comorbidity of three or more disorders than men in this and other studies (Üstün & Sartorius 1995, WHO ICPE, 2000).

Subsequent analysis of data from the National Comorbidity Survey reported strong associations between panic attacks and panic disorder and major depression, with panic attacks being predictive of the first onset of major depression and primary depression predicting a first onset of subsequent panic attacks. Of gender significance was the finding that this relationship was weaker when the influence of prior traumatic experiences and histories of other mental disorders were statistically controlled in the analysis (Kessler, Stang, Wittchen et al, 1998).

The multi-country WHO study on Psychological Problems in General Health Care also found that current panic attacks and a diagnosis of panic disorder were frequently associated with the presence of a depressive disorder. Women predominate in all

three disorders – panic attacks, panic disorder and depressive disorder. The combination of these disorders resulted in a long lasting and severe disorder that was linked to a higher rate of suicidality. (Lecrubier & Üstün, 1998).

Comorbidity and compounding over time

It is not only the co presence of multiple disorders at one point in time that needs urgent attention. Clinicians, policy makers and researchers also require a better understanding of why psychological disorders compound and proliferate over the life course of a sub group of highly comorbid people, women in particular, in order to devise effective interventions.

For example, patients who are initially free from disability, but then experience a depressive illness, can experience a change in their disability status which may gather momentum over time. Ormel, Vonkorff, Oldehinkel et al. (1999) found that the risk of onset of physical disability, even after controlling for the severity of the physical disease, increased 1.5 fold three months after the onset of a depressive illness and 1.8 fold at 12 months. The risk of onset of social disability increased even more significantly from a 2.2 fold risk at 3 months to a 23 fold risk at 12 months.

Of particular importance is the need to identify women who have a history of and/or are currently experiencing violent victimization. Violence related health outcomes including higher rates of depression and post traumatic stress disorder increase and compound when victimization goes undetected. This results in increased and more costly utilization of the health and mental health care system (AMA, 1992; Koss, 1994; Acierno, Resnick and Kilpatrick, 1998).

Gender bias

Research



Gender bias has skewed the research agenda. The relationship of women's reproductive functioning to their mental health has received protracted and intense scrutiny over many years while other areas of women's health have been neglected. Recent research suggests that the

impact of biological and reproductive factors on women's mental health is strongly mediated and, in many cases disappears, when psychosocial factors are taken into account. For example, research on menopause has revealed that emotional well being in middle aged women is positively associated with their current general health status, psychosocial and lifestyle variables, but not with their menopausal status nor their hormone levels (Dennerstein, Dudley and Burger, 1997).

By contrast, the contribution of men's reproductive functioning to their mental health has been virtually ignored. The few studies that have been conducted reveal that men are emotionally responsive to many of the same events as women. For example, men as well as women experience depression following the birth of a child and there is a high level of correlation between parents regarding depressive symptoms (Soliday, McCluskey-Fawcett and O'Brien, 1999).

Health programmes directed towards women have typically had a narrow focus on reproductive health and fertility control, especially in developing countries. The preoccupations of health planners, aid agencies and researchers are not necessarily shared by the women towards whom these programmes are directed. In a study conducted in the Volta region of Ghana, nearly three quarters of the women, when asked to identify their most important health concerns, nominated psychosocial health problems such as "thinking too much" and "worrying too much", not reproductive health concerns (Avotri & Walters, 1999). The explanations women gave of their health problems stressed heavy workloads, the gendered division of labour, financial insecurity and unremitting responsibility for the care of children.

Treatment

Gender bias and stereotyping in the treatment of female patients and the diagnosis of psychological disorders has been reported since the 1970's (Broverman, Vogel, Broverman et al., 1972). Recent research findings are less consistent. Some have found that doctors are more likely to diagnose depression in women compared with men, even when they have similar scores on standardized measures of depression or present with identical symptoms (Callahan, Bertakis, Azari et al, 1997;

Stoppe, Sandholzer, Huppertz et al, 1999). However, no gender difference in the detection of depression and anxiety disorders by doctors was found in the multi country WHO study of psychological problems in general health care (Gater et al, 1998). Detection or identification of psychological disorder is an important first step in improving the quality of care, but one which must be followed by effective treatment to have a positive effect on outcome.

Female gender is a significant predictor of being prescribed psychotropic drugs. It has also been reported that women are 48% more likely than men to use any psychotropic medication after statistically controlling for demographics, health status, economic status and diagnosis (Simoni-Wastila, 2000).

Gender differences exist in patterns of help seeking for psychological disorder. Women are more likely to seek help from and disclose mental health problems to their primary health care physician while men are more likely to seek specialist mental health care and are the principal users of inpatient care. Men are also more likely than women to disclose problems with alcohol use to their health care provider (Allen, Nelson, Rouhbakhsh et al, 1998). This suggests that gender based expectations regarding proneness to emotional problems in women and proneness to alcohol problems in men, as well as a reluctance in men to disclose symptoms of depression, reinforce social stigma and constrain help seeking along stereotypical lines.

Despite these gender differences, most women and men experiencing emotional distress and/or psychological disorder are neither identified or treated by their doctor (Üstün & Sartorius, 1995). An additional problem is that many people with psychological disorders do not go to their doctors. In a recent US study, almost three fifths of those with severe mental illness received no speciality care over a 12 month period (McAlpine & Mechanic, 2000). If help is not sought in the year of onset of a disorder, delays in help seeking of more than 10 years are common in many countries (WHO & ICPE, 2000). If there is significant unmet need, as well as poor identification of disorder in people who do go to primary care providers in relatively well-resourced developed countries, the situation is likely to be much worse in developing countries.

Funding, organization and insurance

The organization and financing of mental health care makes an important contribution to social capital, and is an indicator of access and equity in mental health care.

To reduce gender disparities in health care in relation to the disorders in which women predominate, requires that barriers to accessing care are lowered and patient preferences are heeded.

Women's overrepresentation amongst those living in poverty, means that cost will be a significant barrier to mental health care. A "user pays" system where consumers either pay directly out of their own pockets for services or to cover the cost of health insurance, will further disadvantage poor women who are over represented amongst those experiencing depression, anxiety, panic disorder, somatization disorder and posttraumatic stress disorder.

Depending on the way mental health care is funded, medical insurance status can significantly predict access to speciality care. One US study reported that those with insurance were six times more likely to have access to care than those without (McAlpine & Mechanic, 2000). Lack of insurance interacts with other aspects of the socioeconomic disadvantage experienced by the severely mentally ill, in comparison with those with no identifiable mental disorder.

Both income level and the organization and financing of mental health can exert an influence on the likelihood of mental health services being utilized and the particular sector of service provision likely to be accessible. A three country study, using data from the 1990-1992 National Comorbidity Survey, the 1990-1991 Mental Health Supplement to the Ontario Health Survey and the 1996 Netherlands Mental health Survey and Incidence study, examined interrelationships between income, organization and financing of mental health care and differential use of mental health treatment. The three sectors of mental health care provision examined were the general medical, speciality and human services sectors. Ontario was the only place where income was unrelated to the sector of care for patients, indicating equity of access. In relation to human development, it is perhaps no coincidence that Canada also ranks first on the Human Development Index and the Gender Development

Index (UNDP, 2000). In the US, income was positively related to speciality sector treatment and negatively related to treatment in the human services sector. In the Netherlands, patients in the middle income group were less likely to receive speciality care and those in the high income group less likely to receive care from the human service sector (Alegria, Bijl, Lin et al, 2000).

If access to care is not blocked by cost considerations, those in greatest need are likely to seek treatment. Another Canadian study revealed that single motherhood status was the strongest independent predictor of mental health morbidity and utilization of mental health services. Low income was the next strongest predictor and of course, recall here too, that low income is interrelated with single motherhood status (Lipman, Offord and Boyle, 1997).

The trend to managed care in some countries, when associated with reductions in the intensity and duration of treatment, is likely to impact most on those with chronic disorders who are also most likely to be experiencing social disadvantage.

Gender sensitive services

To reduce gender disparities in mental health treatment, gender sensitive services are essential. If women are to be able to access treatment at all levels from primary to specialist care and inpatient as well as outpatient facilities, services must be tailored to meet their needs.

To ensure that the assistance available is also meaningful to those seeking treatment, the full range of patients' psychosocial and mental health needs must be addressed. This involves services adopting a life course approach, by acknowledging current and past gender specific exposures to stressors and risks and by responding sensitively to life circumstances and ongoing gender based roles and responsibilities.

Gender sensitivity will not improve unless client based preferences inform models of treatment and the provision of care. For women generally, but especially low income ones, services have to be made genuinely accessible. This includes having access to services during the weekend or evening hours, short waiting times and locating services close to public transport routes. With regard to the

doctor patient relationship, preferred health care providers are those who show a sense of concern and respect and are willing to talk and spend time with patients. Integrated services where social and clinical services are available on one site are also preferred by women (O'Malley, Forrest and O'Malley 2000).

Some women with mental illness or substance use disorders are also parents and carers. Services need to be aware of the impact of this role on women's lives and their willingness to seek help, including fears that their children will be taken from them, if they do seek treatment (Mowbray et al., 1995). For women experiencing postnatal psychological disorder such as postnatal depression and postpartum psychosis, but also for women experiencing emotional distress, exhaustion and parenting difficulties, mother-baby units that allow joint admission can be useful. To reduce stigma, such units should operate as part of general maternity hospitals and services. Mothers and babies should not be sent to psychiatric hospitals.

Services that attempt to assist women with severe mental illness need to move beyond stereotypical assumptions and roles regarding women and not only provide access to living and social skills but also to vocational training and employment support.

Violence and severe mental illness

Violence-related mental health problems are poorly identified, victimization histories are not routinely taken and women are reluctant to disclose a history of violent victimization unless physicians ask about it directly (Mazza & Dennerstein, 1996).

At the same time, violent victimization, especially severe childhood sexual abuse (CSA), significantly predicts admission as an inpatient to a psychiatric facility during adulthood. A New Zealand study (Mullen, 1993) found women whose childhood sexual abuse involved penetrative sex, were sixteen times more likely to report psychiatric admissions than those who had been subjected to lesser forms of abuse. Given the significance of CSA as a predictor of inpatient admission, it is important that inpatient and residential services provide women with adequate safety and privacy. Even after controlling for the effect of coming from an unstable family home where one or both parents were

absent, had mental health problems or were in conflict, CSA remained a significant predictor of later psychopathology.

Gender and risk



Emerging evidence indicates that the impact of gender in mental health is compounded by its interrelationships with other social, structural determinants of mental health status, including education, income and employment as well as social roles and rank. There are strong, albeit varying, links between gender inequality, human poverty and socioeconomic differentials in all countries. Gender differences in material well being and human development are widely acknowledged. According to the 1998 World Health Report :

Women's health is inextricably linked to their status in society. It benefits from equality, and suffers from discrimination. Today, the status and well being of countless millions of women world-wide remain tragically low (WHO, 1998: 6).

In every country, gender development continues to lag behind human development (UNDP, 2000) or as an earlier Human Development Report (UNDP, 1997) put it: "no society treats its women as well as its men". Women constitute more than 70% of the world's poor (UNDP 1995) and carry the triple burden of productive, reproductive and caring work. Even in developed countries, lone mothers with children are the largest group of people living in poverty (Belle 1990) and are at especially high risk for poor physical and mental health (Macran et al., 1996; Lipman, Offord and Boyle, 1997). Clearly, gender must be taken into account in looking at the way income disparities, inequalities and poverty impacts on mental health.

Gender and rank



There is a strong social gradient in health. Adverse mental health outcomes are 2 to 2 times higher amongst those experiencing greatest social disadvantage compared with those experiencing least disadvantage (Dohrenwend 1990; Kessler et al., 1994; Kunst et al., 1995; Bartley & Owen, 1996; Macran et al., 1996; Stansfeld et al., 1998). Environmental stressors, including increased numbers of negative life

events, experiences and chronic difficulties, are highly significant in accounting for the lower social class predominance of non-psychotic psychiatric disorders like depression and anxiety. Less control over decision making, the structural determinants of health and less access to supportive social networks correlate with higher levels of morbidity and mortality (Kessler et al., 1994; Turner & Marino, 1994; Brown, 1998).

While there is a large amount of evidence that confirms a strong relationship between socioeconomic status, position in the social hierarchy and mental health, most research has lacked a gender perspective.


Analyses of the social gradient in health have concentrated on the material indicators of inequality and social disadvantage. However, the social gradient in physical and mental health also operates on a symbolic and subjective level. Social position carries with it an awareness of social rank and a clear understanding of where one stands in the scale of things. The link between a sense of loss and defeat, entrapment, and humiliation denoting devaluation and marginalization, is strengthened by related research on social rank (Gilbert & Allan 1998). Depression is strongly related to several interrelated factors:

- Perceptions of the self as inferior or in an unwanted subordinate position, with low self confidence.
- Behaving in submissive or in non assertive ways.
- Experiencing a sense of defeat in relation to important battles, and wanting to escape but being trapped.

The very same qualities that characterize depression and low social rank, have been regarded as normal and desirable qualities of "femininity" and encouraged if not enforced through socialization, "tradition" and outright discrimination. By contrast, psychosocial resources, the wherewithal to exercise choice, having a confidant, social activities and a sense of control over one's life, form critical bulwarks against depression regardless of a woman's age (Zunzunegui et al., 1998). Feelings of autonomy and control significantly lessen the risk of depression occurring in the context of what might otherwise be considered as an important loss. Brown, Harris and Hepworth (1995) found

that when marital separation was initiated by the woman, only about 10% of such women subsequently developed depression. When the separation was almost entirely initiated by her partner, around half the women developed depression. Interestingly, the rate of depression increased again, if infidelity was discovered and not followed by separation.

Gender and work


 Women in paid work receive significantly lower wages than their male counterparts. Relative income inequality penalizing women and favouring men is structurally embedded as women typically earn around two thirds of the average male wage and this disparity has persisted over time. The level of gender development in a country is strongly related to rates of pay. Between 1993-1995, less than 10% of women were in low paid work in Sweden, where the ranking for gender development is higher than for human development. In contrast, in Japan and the US where gender development rankings are lower than human development rankings, more than 30% of women were in low paid jobs (UNDP, 1997).

The weakening of worker protection laws to attract foreign investment and the employment of girls and women as “outworkers” or sweated labour in garment and footwear industries and in export processing zones (EPZ), as well as their overrepresentation amongst sex workers, represent significant threats to mental and physical health and violations of women’s human rights.

The workplace itself is another area where rank is predictive of depression and linked to gender. Work characteristics, especially skill discretion and decision making authority are closely allied to employment grade and make the largest contribution to explaining differences in well being and depression. The highest levels of well being and the least depression are found in the highest employment grade; the reverse is true for those in the lowest grades who have a higher prevalence of negative life events, chronic stressors and less social support. Women are more likely to occupy lower status jobs with little decision-making discretion (Stansfeld, Head and Marmot, 1998).

Research on the subjective correlates of events related to subordinate status or lower rank, complements earlier work that documented the relationship between various objective measures of rank and the increased likelihood of poor health, depression and anxiety. Rank related variables are found in clusters, rarely in isolation and combine structural, material determinants, rank and symbolic indicators of social standing and gender roles. The resultant mix is strongly predictive of the common mental disorders. It includes low educational status, unemployment, low employment status and pay, insecure, “casual” employment, single parent status, homelessness and insecure housing tenure and inadequate income, poor social support and diminished social capital (Belle, 1990; Macran, Clarke and Joshi; 1996, Brown et al, 1996; Kawachi et al., 1999).

Gender roles

 Gender socialization, which stresses passivity, submission and lower rank, are not only reinforced for women by their structural position in paid employment – lower status, more “casual”, part-time and insecure jobs and lower rates of pay – but by their much larger contribution to unpaid domestic and caring work in the home. Women of reproductive age may carry the triple burden of productive, reproductive and caring work. Not surprisingly, gender differences in rates of depression are strongly age related. The largest differences occur in adult life, no differences are found in childhood and few in the elderly (Vazquez-Barquero et al., 1992; Beekman et al., 1995; Zunzunegui et al., 1998).

Gender differences in mental health cannot be explained by relying solely on role analysis to examine women’s mental health and structural analysis to examine men’s mental health. Even so, when social role variables such as marital status, children and occupational status were matched between women and men who participated in the multi country WHO study on Psychological Problems in Primary Care, the female excess in depression was reduced by 50% across all centres in the study (Maier, Gansicke, Gater et al, 1999).

To fully understand gender differences in mental health, there is a need to integrate a gender role

analysis with a structural analysis of the determinants of health because gender roles intersect with critical structural determinants of health including social position, income, education and occupational and health insurance status. Role patterns of women are not evenly distributed across income levels. A French study found that housewives and lone mothers are more common at the bottom and middle of the income scale and working women without children, married or not, are more common at the top (Khlal, Sermet and Le Pape, 2000). In addition, the measurement of women's income is problematic. A significant amount of income data is missing for women in many large scale surveys (Macran et al., 1996). The substitution of "family income" or "total household income", as a proxy measure of socioeconomic status has inherent problems. This proxy measure may bear little relationship to the way income is distributed within the household, especially in households where women are subjected to violence and experience high levels of coercive control over all aspects of their lives including the spending of money. To accurately assess women's income, information is necessary on their levels of access to and control over income within the household. Assuming equitable access to and distribution of "family income" is unwarranted, but continues to be widely practiced (WHO & ICPE, 2000)

Numerous studies have reported that low income mothers, especially lone mothers, have significantly higher levels of depression than the general population (Macran & Joshi, 1996; Salsberry, Nickel, Polivka et al., 1999). Compared with the general population, poor women are exposed to more frequent, more threatening and more uncontrollable life events, such as the illness and death of children and the imprisonment or death of husbands. They face more dangerous neighbourhoods, hazardous workplaces, greater job insecurity, violence and discrimination, especially if they belong to minority groups (Belle 1990, Brown 1998; Patel et al. 1999). Other gender based experiences, such as having two or more abortions, or experiencing sexual abuse or other forms of violence and adversity in childhood or adult life also contribute significantly to poorer mental health (Bifulco et al. 1991; Fellitti et al., 1998). These factors, separately and together, work to reduce the degree of autonomy, control and deci-

sion making latitude possible for women on low incomes.

Economic policies



Current evidence on the consequences of globalization and restructuring indicates that socioeconomic deprivation is increasing and income inequality is widening within and between many countries (UNDP, 2000). Considerable evidence links rising income inequality to increasing rates of common mental disorders, like depression, anxiety and somatic symptoms (Patel et al, 1999), increased rates of mortality from physical conditions (Lynch, Smith, Kaplan, House, 2000) and increased mental health related mortality associated with substance use disorders and suicide (Lorant, 2000). In Russia, the predictors of significant falls in life expectancy include fast paced economic change, high turnover of the labour force, increased levels of crime, alcoholism, inequality and decreasing social cohesion (Walberg, McKee, Shkolnikov et al, 1998).

The impact of globalization and structural adjustment programmes is especially severe in the poorest nations. Moreover, it occurs in gender distinct ways because of the separate roles men and women play and the different constraints they face in responding to policy changes and shifts in relative prices (Kirmani & Munyakho, 1996). Cutbacks in public sector employment and social welfare spending can cause the costs of health care, education and basic foodstuffs to become unaffordable, especially to the poor, the majority of whom are women (Bandarage, 1997).

Evidence on the gender specific effect of restructuring on mental health is persuasive. Data obtained from primary care attenders in Goa (India), Harare (Zimbabwe), Santiago (Chile) and from community samples in Pelotas and Olinda (Brazil) showed significant associations between high rates of depression, anxiety and somatic symptoms and female gender, low education and poverty (Patel et al., 1999). This study reveals how gender inequality accompanies but is also worsened by economic inequality and rising income disparity. The result of this interaction is a steep rise in the very mental disorders in which women already predominate.

Economic policies that cause sudden, disruptive and severe changes to the income, employment and living conditions of large numbers of people who are powerless to resist them, pose overwhelming threats to mental health. Disruptive, negative life events that cannot be controlled or evaded are most strongly related to the onset of depressive symptoms. An increase in the number of such events is paralleled by an increase in the numbers of women becoming depressed. The size of the contribution made by these events to common mental disorders is evident from a number of studies on women's mental health carried out over recent years in a range of countries.

Based on research carried out in Great Britain, Brown, Harris and Hepworth (1995) calculate that 85% of women from the community (as opposed to a patient group) who developed "caseness" for depression in a 2 year study period experienced a severe event in the 6 months before onset.

Depression was particularly likely to occur when a severe event (or events) was accompanied by vulnerability factors, especially those associated with low self-esteem and inadequate support. The matching of a current severe event with a pronounced ongoing difficulty was also critical to the onset of depression (Brown et al., 1990; Brown, 1998).

Severe, disruptive negative events could involve loss or danger but other features were more important in initiating depression. Most important of all was the experience of humiliation, defeat and a sense of entrapment, often in relation to a core relationship. Almost three-quarters of the severe events occurring in the six months prior to the onset of depression involved entrapment or humiliation whereas just over one fifth involved loss alone and only 5% concerned danger alone (Brown et al., 1995). Studies conducted in Zimbabwe at two different time points offer further insight into the strength of the relationship between the nature and frequency of severe events and associated rates of depression. In the first study, the annual incidence of depression was 18%, double that found in inner London (Abas & Broadhead, 1997). This increased to 30.8% in the second study (Broadhead & Abas, 1998). The excess of onset cases in the second study was primarily due to the increased numbers of severe and disruptive events and difficulties occurring in the intervening time period.

The severe events reflected, "the high levels of physical illness and premature death in family members, the predicaments associated with seasonal migration between rural and urban homes, problems associated with infertility and the large number of marital and other relationship crises" (Broadhead & Abas, 1998: 37).

Population based studies of women in Zimbabwe, London, Bilbao, the Outer Hebrides, rural Spain and rural Basque Country, Spain, found that women meeting the criteria for depression varied from a low of 2.4% in the Basque Country to a high of 30% in Zimbabwe. Negative, irregular, disruptive life events were found to trigger depression in all six sites. Taken together, these findings indicate that a strong linear relationship exists between the number and severity of events and the prevalence of depression (Brown, 1998).

Impact of gender-based violence on mental health



Where women lack autonomy, decision making power and access to income, many other aspects of their lives and health will necessarily be outside their control. In particular, gender differentiated levels of susceptibility and exposure to the risk of violence place stringent limitations on women's ability to exercise control over the determinants of their mental health.

Social research indicates that depression in women is triggered by situations that are characterized by humiliation and entrapment and that this occurs in relation to "atypical events" (Brown, Harris and Hepworth, 1995). This view is challenged by evidence about the chronic nature of much gender based violence and its direct link to increased rates of depression.

The prevalence of violence against women (VAW) is alarmingly high (WHO, 1998). Women compared to men are at greatly increased risk of being assaulted by an intimate (Kessler, Sonnega, Bromet et al., 1995). Violence in the home tends to be repetitive and escalate in severity over time (AMA 1992) and encapsulates all three features identified in social research on depression in women: humiliation, enforced inferior ranking and subordination, and blocked escape or entrapment.

Violence – physical, sexual and psychological – is related to high rates of depression and co morbid psychopathology, including posttraumatic stress disorder (PTSD), dissociative disorders, phobias and substance use and suicidality (Roberts et al 1998). Moreover, psychological disorders are accompanied by multi somatization, altered health behaviours, changed patterns of health care utilization and health problems affecting many body systems (Resnick et al., 1997; Roberts et al. 1998; Felitti et al., 1998). Being subjected to the exercise of coercive control leads to diminished self esteem and coping ability.

Violent victimization increases women’s risk for unemployment, reduced income and divorce (Byrne et al, 1999). For this reason, gender based violence is a particularly important cause of poor mental health because it further weakens women’s social position by operating on the structural determinants of health at the same time as it increases vulnerability to depression and other psychological disorders.

The high incidence of sexual violence against girls and women has prompted researchers to suggest that female victims make up the single largest group of those suffering from post traumatic stress disorder (Calhoun & Resick, 1993). A nationwide survey of rape in the US, found 31% of rape victims developed PTSD at some point in their lives compared with 5% of non victims (Kilpatrick, Edmunds & Seymour, 1992). PTSD also persists longer in women than in men (Breslau et al, 1998).

The mental health impact on the millions of women who are caught up in sexual trafficking has not been assessed. The trauma of repeated abuse and denial of any human rights is severe and ongoing. Mental health effects are likely to include all those previously identified in research on VAW and to parallel those experienced by other victims of torture. The likely causal role of violence in depression, anxiety and other disorders such as posttraumatic stress disorder is suggested by:

- Three to four fold increases in rates of depression and anxiety in large community samples amongst those exposed to violence compared with those not exposed (Mullen et al. 1998; Saunders et al. 1993).

- Severity and duration of violence predicts severity and number of adverse psychological outcomes, even when other potentially significant factors have been statistically controlled in data analysis. This has been found in studies on the mental health impact of domestic violence (Campbell & Lewandowski, 1997; Roberts et al. 1998) and childhood sexual abuse (Mullen et al., 1993).
- Marked reductions in the level of depression and anxiety once women stop experiencing violence and feel safe (Campbell et al., 1996) compared with increases in depression and anxiety when violence continues (Sutherland et al., 1998).

The evidence presented here indicates that the female excess in depression and other disorders reflects women’s greater exposure to a range of stressors and risks to their mental health, rather than an increased, biologically based vulnerability to psychological disorder.

Implications for policies and programmes



To reduce gender disparities in mental health involves looking beyond mental illness as a disease of the brain. This is not to deny that distress and disorder exist and require compassionate and scientifically based treatment nor that the stigma associated with all forms of mental illness must be eradicated. However, clinicians, researchers and policy makers also need to socially contextualize the mental disorders affecting individuals and the risk factors associated with them.

There is strong evidence that globalization and large scale restructuring have increased income inequalities and adverse life events and difficulties, with particularly severe impacts on women. Moreover this increase in gender based income disparities is associated with increasing rates of common mental disorders amongst women in a number of countries (Patel et al, 1999; Broadhead and Abas, 1998).

Governments need to monitor the mental health effects of their economic reforms and take urgent action to bring about a more gender equitable distribution of the benefits of globalization. Active measures need to be taken to protect social capital,

as this too, is powerfully related to how people rate their health (Kawachi et al, 1999). If gender based income inequalities are not reduced, the numbers of girls and women who are forced to rely on harmful and/or illegal activities for income, such as work in the sex industry, will continue to escalate.

Budgets for mental health will become rapidly depleted if funding is focussed on curative treatment and care. Medical treatment that is confined to the alleviation of presenting symptoms is at best a partial response. Such a response fails to address ongoing high levels of exposure to mental health risks or to reduce gender based levels of susceptibility. In other words, while improving identification and treatment of mental disorders is certainly necessary, it is clearly not sufficient to reduce their incidence.

Currently, the rates of detection, treatment and appropriate referral of psychological disorders in primary health care settings are unacceptably low. The high rates of depression in women and alcohol dependence in men strongly indicate a large unmet need for improved access, at a community level, to low or preferably no cost gender sensitive counselling services. Psychologists and social workers working in community based health services that are responsive to the psychosocial issues of those they serve, are well placed to provide cost effective mental health services.

All health care providers need to be better trained so that they are able to recognize and treat not just single disorders such as depression and alcohol dependence, but also their co occurrence. Clinicians need to be equipped to assess and respond to gender specific, structurally determined risk factors and to become proficient in providing much needed advocacy for their patients with other sectors of the health and social welfare system. Without these skills, rates of comorbidity among patients will compound. Skill in trauma focussed counselling is a priority for clinicians in all health sectors who encounter women (Acierno, Resnick and Kilpatrick, 1997).

Women's overrepresentation amongst those with psychiatric comorbidity (Kessler et al., 1994) together with the heightened burden of disability associated with comorbidity indicates the need to clearly identify gender specific risk factors for

comorbidity. In particular, the complex linkages between depression in women, multi somatization and psychiatric comorbidity in the context of a history of violent victimization need to be clarified.

Mental health care funding, too, must be responsive to the issue of psychiatric comorbidity. Clinicians need to have adequate consultation time with their patients to permit accurate diagnosis. Time and cost pressures on "throughput" may appear economic and efficient in the short term but are incompatible with providing patients gender sensitive, meaningful assistance with their mental health problems. Repeated utilization of the mental health care system consequent on the failure to accurately diagnose and treat is a far more expensive outcome in the long term.

The concept of "meaningful assistance" in mental health care needs to be promoted. Meaningful assistance implies a patient centred approach. Gender disparities in mental health will not be reduced until women's own mental health concerns and life priorities are taken into account in programme design and implementation (Avotri & Walters, 1999). Currently under diagnosed and poorly treated conditions, especially the combination of depression, violence related health conditions and significant psychosocial problems urgently require meaningful assistance.

Gender based barriers to mental health care, especially cost and access, bias and discrimination must be removed. Intersectoral collaboration across government departments and gender sensitive policy making in education, housing, transport and employment are required to ensure that the multiple structural determinants of mental health are facilitated to work in positive synergy, maintain social capital and support social networks (Kawachi et al, 1999). A free, universal medical insurance scheme is the only way to ensure mental health care will be accessible to the most socioeconomically disadvantaged group (Lipman, Offord and Boyle, 1997).

A public health approach to improve primary prevention and address gender specific risk factors for depression and anxiety disorders is indicated by a large body of evidence. Social safety nets and income security are especially important for women and their mental health. A public health approach necessarily broadens the notion of effec-

tive treatment. The most obvious way of reducing violence related mental health problems is to reduce women's exposure to violence. Women who have been but are no longer being battered show significant reductions in their level of depressive symptoms, while those who continue to experience violence do not (Campbell et al, 1993). Providing access to refuges and alternative forms of safe housing is thus a powerful mental health "treatment".

Better quality evidence needs to be collected that is informed by a gendered, social determinants, life course approach. Cross sectional research has revealed significant factors in the onset of depression but much more longitudinal research is required to understand how changes in social and household conditions mediate the course of depression and its chronicity (Bracke, 2000). If persistence in adversity is neither accurately measured nor disentangled from persistence in depressive symptoms, its role in the chronicity of depressive symptoms cannot be ascertained.

A priority for mental health promotion and intervention programmes is to incorporate a mental health focus in all programmes related to child health. The level of exposure to adverse childhood events has a strong graded relationship with all the major causes of adult morbidity and mortality and the behavioural risk factors associated with them (Felitti et al, 1999). Childhood sexual abuse, in particular, is predictive of multiple negative health outcomes including high rates of psychiatric morbidity as well as homelessness, prostitution, substance use disorders and suicidality. The earliest possible identification and protection of those exposed to adverse childhood events, and ideally the elimination of these events, is necessary to prevent re-victimization and arrest the progression and compounding of poor mental, physical, sexual and social health outcomes. Consequently, the goal of preventing childhood neglect and exposure to all forms of trauma and adversity must inform the design and implementation of maternal and child health, family violence services and social welfare and social security services.

At the same time, "zero tolerance" health education and promotion campaigns to reduce violence against women and children need to be designed using culturally appropriate formats in order to

counter traditional beliefs and attitudes that condone and perpetuate violence.

Conclusion



To address gender disparities in mental health requires action at many levels. In particular, national mental health policies must be developed that are based on an explicit analysis of gender disparities in risk and outcome.

Effective strategies for risk factor reduction in relation to mental health cannot be gender neutral while the risks themselves are gender specific and women's status and life opportunities remain "tragically low" worldwide (WHO, 1998). Low status is a potent mental health risk. For too many women, experiences of self worth, competence, autonomy, adequate income and a sense of physical, sexual and psychological safety and security, so essential to good mental health, are systematically denied. The pervasive violation of women's rights, including their reproductive rights, contributes directly to the growing burden of disability caused by poor mental health.

Consequently, a rights framework needs to be adopted to improve the ethical and interpretative dimensions of research, mental health care practice and policy. Mental health research has scarcely begun to address the impact of patient and human rights violations on mental health. These include the psychological effect of failure to gain informed consent, denial of patient privacy and dignity, and the use of treatments that may successfully alter mood but neglect ongoing exposure to experiences that grossly violate the right to mental health such as living in safety and freedom from fear. This omission needs to be rectified.

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